

Overcoming Procrastination: From Short-Term Relief to Values-Consistent Action

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Narrative Clinical Review

Abstract—Procrastination is voluntary delay of an intended action despite expecting later harm. It is not laziness, every delay, poor time management, or a diagnosis; delay may be strategic when it protects priorities or permits useful information. This narrative clinical review integrates self-regulation, temporal motivation, emotion-regulation, cognitive-behavioral, and communication-oriented accounts. Aversive, ambiguous, distant, or evaluative tasks invite immediate mood repair, while perfectionistic meanings, shame, and accumulated consequences make re-entry harder. Assessment should define the delayed behavior, triggers, substitute activity, function, consequences, and context, and consider anxiety, depression, ADHD, OCD, sleep disturbance, substance use, illness, and environmental constraints. Psychological treatment evidence is promising but heterogeneous, with the clearest support for cognitive-behavioral approaches. Useful components include choosing the next complete action, reducing friction, time-limited starting, implementation intentions, stimulus control, exposure to evaluation or uncertainty, precommitment, compassionate error correction, and review of reward and values. Strategies should match mechanism: a calendar cannot treat major depression or create childcare and safe working conditions. Communication-focused formulation is presented as an author-developed adjunct for translating diffuse resistance, shame, and competing commitments into clearer internal and interpersonal messages. The aim is not ceaseless productivity, but freedom to start, continue, stop, or decline deliberately, with less control by immediate avoidance and more by chosen priorities.

Index Terms—procrastination, self-regulation, avoidance, emotion regulation, implementation intentions, psychotherapy, action

I. INTRODUCTION

Procrastination is easy to moralize, yet its academic, occupational, financial, health, and relationship costs can be substantial. A patient intends to study, answer a message,

or attend an appointment, then turns to an activity that improves mood now. The future cost remains abstract until urgency turns it into crisis.

Meta-analytic mapping has linked procrastination with self-regulatory variables and outcomes while also showing substantial heterogeneity across measures and samples (van Eerde, 2003). The broad association pattern supports a multicomponent formulation rather than a single trait explanation.

Steel (2007) defines procrastination as voluntarily delaying an intended action despite expecting to be worse off. This separates it from unavoidable delay or a reasoned change in priorities. The paradox is temporal rather than simply irrational: the choice recurs as emotion, attention, and reward shift, so immediate relief remains vivid while future cost is discounted.

Earlier JPPC articles on social and persistent anxiety described avoidance, uncertainty, and communication difficulties that can impede action (Haverkamp, 2013; Haverkamp, 2017a, 2017b). These processes often contribute to procrastination, but the terms are not interchangeable. Procrastination can occur without an anxiety disorder, and similar outward delay can arise from depression, ADHD, OCD, sleep loss, pain, unrealistic workload, or a task that should be refused.

Core clinical propositions

- Not every delay is procrastination; priority, recovery, information gathering, and refusal can be adaptive.
- Procrastination is often an emotion-regulation strategy with a time-management consequence.
- The delayed unit should be defined as an observable action rather than a global project.
- Shame may increase urgency briefly but often makes the task more aversive and future avoidance more likely.
- Effective intervention changes cues, actions, predictions, rewards, and context—not only intentions.
- The goal is deliberate self-regulation and meaningful action, not maximum output.

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II. SCOPE AND METHOD

This narrative clinical review considers research and guidance available through 30 August 2025. Search concepts included procrastination, delay, self-regulation, temporal motivation, mood repair, task aversiveness, perfectionism, implementation intentions, precommitment, cognitive-behavioral therapy, acceptance, and digital intervention. Priority was given to meta-analyses, systematic reviews, influential theoretical studies, and randomized treatment trials. Earlier JPPC articles were read before citation. Procrastination research relies heavily on student and self-report samples, so generalization to clinical and occupational populations is made cautiously.

III. WHAT PROCRASTINATION IS—AND IS NOT

Three features are central: an intended action, a delay that is not fully imposed by circumstances, and an expectation of net disadvantage. A person who postpones a low-priority report to manage an emergency is prioritizing. A person who waits for a diagnostic result before making an irreversible decision may be gathering necessary information. A person who repeatedly avoids opening an important result because of distress, while knowing that delay threatens care, may be procrastinating.

The word voluntary requires nuance. Behavior can be selected without feeling freely chosen. Habit, attentional capture, anxiety, fatigue, and environmental design shape what occurs. Moral condemnation adds little. At the same time, a purely passive account can remove agency. A useful stance is compassionate responsibility: the process is understandable and influenced by conditions, and the person can learn to alter it.

Procrastination is also not synonymous with being late. Someone may delay and complete work through an intense final effort, meeting the deadline at high personal cost. Another person may begin early but miss a deadline because the task was underestimated or interrupted. Outcome and process should be assessed separately.

Table 1. Distinguishing forms of delay

Form	Defining feature	Example	Appropriate response
Strategic delay	Postponement protects a higher priority or improves information	Waiting for verified data before final analysis	Record the decision and review date
Recovery or pacing	Rest is required for health or sustainable performance	Pausing after a pain flare according to a care plan	Adapt workload and capacity
External blockage	Resources, authority, access, or another action is missing	Application cannot proceed without a document	Solve or escalate the dependency

Form	Defining feature	Example	Appropriate response
Avoidant procrastination	Delay reduces distress now despite expected later cost	Rechecking email instead of starting evaluated work	Target emotion, prediction, and first action
Perfectionistic delay	Action is conditional on impossible readiness or certainty	Refusing to submit until no criticism is conceivable	Define fit-for-purpose criteria and test imperfection
Executive difficulty	Sequencing, working memory, time estimation, or initiation is impaired	Materials and steps cannot be organized	Externalize structure and assess underlying causes
Deliberate refusal	The person does not endorse the task or boundary	Declining unpaid work outside the role	Communicate the decision rather than pathologize it

IV. THE SHORT-TERM RELIEF LOOP

Sirois and Pychyl (2013) conceptualized procrastination as prioritizing immediate mood repair over future goals. A task cues boredom, confusion, anxiety, resentment, or shame. An alternative—social media, tidying, another assignment, sleep—changes the feeling quickly. Relief reinforces the switch. Later, less time remains, consequences grow, and the task acquires additional shame. The next encounter is therefore more aversive.

This model explains why knowing a deadline and owning a calendar may be insufficient. The problem occurs at the moment of emotional contact with the task. A plan that does not specify what to do with discomfort can remain unused. Conversely, an emotion-regulation account should not ignore time, workload, skill, and environment. Some tasks are delayed because they are badly defined or impossible within the available resources.

Tice and Baumeister (1997) found that procrastination could be associated with lower stress early and greater stress and poorer performance later. The pattern captures the temporal trade: relief is purchased with future pressure. It does not mean every person or task follows the same course.

A. Task aversiveness

Tasks can be aversive because they are boring, effortful, ambiguous, frustrating, imposed, lonely, or likely to expose performance. The type matters. Boredom may respond to shorter intervals and immediate reward; ambiguity to clarification; evaluative fear to exposure and cognitive work; resentment to boundary or values discussion. Calling them all “lack of motivation” conceals the intervention target.

The task's representation can create aversiveness. "Prepare the conference" has no clear starting point and an uncertain end. "Open last year's checklist and list three required bookings" is bounded. Decomposition reduces cognitive load and changes the predicted cost without pretending the larger project is easy.

V. TEMPORAL MOTIVATION AND REWARD

Temporal motivation theory integrates expectancy, value, delay, and sensitivity to delay in explaining choice (Steel, 2007). Outcomes that are valuable but distant can lose against immediately available alternatives. As the deadline approaches, the delayed reward or punishment becomes vivid and motivation rises sharply. This produces the familiar cycle of inaction followed by crisis work.

Deadlines can help, but dependence on emergency has costs. Acute arousal may temporarily focus attention while damaging sleep, quality, and health. The person may conclude "I work best under pressure" because only pressure has reliably crossed the initiation threshold. The more precise statement may be "Pressure creates immediate consequences strong enough to compete with alternatives." Treatment seeks other immediate cues and rewards.

Artificial deadlines are not always credible. Ariely and Wertenbroch (2002) found that self-imposed deadlines can improve performance but may be less effective than evenly spaced external deadlines. A precommitment works when it changes consequences and is accepted in advance, not when it is an easily ignored date in the same calendar.

VI. ANXIETY, EVALUATION, AND PERFECTIONISM

Anxiety-related procrastination protects against feared information. Beginning reveals what one knows; submitting permits judgment; asking for help risks exposure. Social anxiety can make ordinary communication tasks feel evaluative, as described by Haverkamp (2013). Persistent anxiety can also produce repeated reassurance and review (Haverkamp, 2017b). The person may wait for confidence, but confidence often follows action rather than preceding it.

Perfectionism creates conditional rules: the work must be original, complete, and immune from criticism before it may be seen. These rules erase intermediate products such as notes, drafts, and feedback. The intervention separates generation from evaluation and defines standards appropriate to consequence. "Good enough" does not mean careless; it means fit for purpose at this stage.

Exposure can target the feared evaluation. Examples include sharing an incomplete outline with a trusted colleague, sending a concise question without rereading it ten times, or submitting a low-stakes task after one planned review. The prediction and outcome are recorded. The aim is not to

produce deliberate incompetence, but to learn whether normal imperfection is survivable and correctable.

Uncertainty can drive research that never ends. Before searching, define what information could materially change the decision and how much source quality is required. Once the threshold is met, continued search may be an anxiety behavior rather than scholarship. High-stakes clinical or legal decisions appropriately require more evidence than routine choices.

VII. SHAME AND SELF-CRITICISM

Procrastination often becomes an identity judgment: lazy, weak, irresponsible, fraudulent. Self-criticism may create a burst of threat-based effort, which makes it seem necessary. Over time, it pairs the task with shame and encourages concealment. A person avoids both the work and anyone who might ask about it.

Self-compassion is not a promise that consequences do not matter. It acknowledges suffering and common fallibility while supporting repair. The language can be concrete: "I delayed, the deadline is closer, and attacking my character is not completing the next step. I will notify the affected person and work for twenty minutes." Responsibility is behavioral rather than global.

Repair may include apologizing, renegotiating, or accepting a penalty. Attempts to hide the delay consume further attention and damage trust. Clear communication reduces the secondary problem even when it cannot remove the original consequence.

VIII. DIFFERENTIAL ASSESSMENT

Procrastination can be a presenting problem within several conditions. Depression may reduce energy, hope, concentration, and initiation. ADHD may impair time estimation, working memory, sequencing, and resistance to immediate stimuli. OCD can generate checking, repetition, or inability to achieve a "just-right" state. Generalized anxiety can produce endless scenario analysis. Social anxiety can inhibit contact and submission. Insomnia, pain, medication, substance use, and medical illness can reduce capacity.

The clinician asks about onset, childhood pattern, context, episodicity, mood, sleep, energy, substance use, physical symptoms, medication changes, and impairment. A lifelong cross-situational pattern differs from a new difficulty after bereavement or illness. Reduced need for sleep with increased energy and risky projects raises concern for mania or hypomania, even if important tasks remain unfinished.

Workload and power must be assessed. An employee given incompatible deadlines is not necessarily deficient in self-regulation. A caregiver without respite may be prioritizing survival. A task associated with harassment may be

realistically threatening. Treatment should not make an individual adapt silently to unsafe or exploitative conditions.

Stress-related prefrontal disruption, defensive freezing, and depressive loss of reinforcement can each resemble poor motivation; their presence should be assessed rather than inferred from delay itself (Arnsten, 2009; Roelofs, 2017; Dimidjian et al., 2006).

Table 2. Functional assessment of one delayed action

Element	Questions
Intention	What exactly did the person intend, by when, and whose goal is it?
Cue	When and where was the task encountered? What happened immediately before switching away?
Emotion and body	Boredom, anxiety, shame, anger, fatigue, pain, agitation, or numbness?
Prediction	What seemed likely if the person began, continued, asked, or submitted?
Alternative	What behavior replaced the task, and how available or rewarding was it?
Immediate consequence	Did distress fall, uncertainty close, or autonomy feel restored?
Delayed consequence	What happened to time, quality, sleep, trust, money, health, or self-evaluation?
Exceptions	When has a similar task begun more easily? Which cues, people, skills, or consequences differed?
Capacity and context	Are diagnosis, sleep, illness, disability, safety, workload, or resources limiting action?

IX. MEASUREMENT

Self-report scales can characterize trait-like procrastination, but treatment needs behavioral indicators. Measures might include latency between scheduled and actual start, number of task switches, minutes of focused work, proportion of planned first actions completed, submission timing, and distress before and after starting. Quality and health should be monitored so that earlier starting is not purchased with compulsive overwork.

Baseline monitoring should be brief. Detailed logging can become another delay. One week of recording the cue, alternative behavior, and immediate effect may be sufficient to identify a pattern. Digital activity data can help if consented to and interpreted cautiously; screen time alone does not reveal function.

X. EVIDENCE FOR TREATMENT

Direct treatment research is smaller and more heterogeneous than popular advice suggests. Rozental et al. (2018) reviewed psychological treatments and found an overall small benefit, with larger effects in some cognitive-behavioral interventions; studies varied in quality, sample, guidance, and outcome. In a randomized trial of internet-based cognitive-behavioral treatment, both guided and unguided formats reduced procrastination, with different patterns of support and completion (Rozental et al., 2015). A 2023 systematic review of academic interventions likewise found diverse approaches and a gap between proposed models and the components actually targeted, reinforcing the need to identify active ingredients rather than treat every student program as equivalent (Salguero-Pazos & Reyes-de-Cózar, 2023). These findings are encouraging, not proof that one protocol fits every patient.

Treatment components commonly include psychoeducation, goal specification, time estimation, task decomposition, stimulus control, cognitive restructuring, behavioral experiments, reward planning, and relapse prevention. Acceptance- and values-based elements can address unwillingness to experience task-related discomfort. When a diagnosable disorder is primary, treatment should include or coordinate evidence-based care for that disorder rather than treating procrastination in isolation.

XI. AN INTERVENTION SEQUENCE

A. *Choose one delayed behavior*

Beginning with every area of delay reproduces overload. Select a behavior that matters, recurs, and is safe to change. Describe the next complete action: “open the portal and enter contact details,” not “sort out my career.” State how completion will be observed and what would count as a legitimate obstacle.

The goal must belong at least partly to the person. If the task is solely an external demand, intervention may focus on negotiation, refusal, or an informed choice to accept the consequence. Values-consistent action is not compliance by another name.

B. *Form an implementation intention*

Implementation intentions link a cue to a response in an if-then form: “If it is 09:00 and I have placed coffee on the desk, then I will open the methods file and work on the first table for fifteen minutes.” Meta-analytic evidence indicates that such plans can improve goal attainment across contexts (Gollwitzer & Sheeran, 2006). Specificity helps transfer control from repeated deliberation to a prepared cue.

The plan should include likely obstacles. “If I notice myself opening news, then I will close it and write one sentence

before deciding what to do.” It should not multiply into a complex rule system. One visible cue and one response are enough for an initial test.

C. *Use a bounded start*

A bounded start changes the expected cost. The person commits to five, ten, or twenty-five minutes and retains permission to stop at the boundary. The interval should be long enough to engage the task and short enough to be credible. Success is starting at the cue, not completing the entire project.

The permission to stop is important. If every “ten-minute start” covertly becomes a demand for hours, the person learns not to trust the technique. After the interval, continuation is a new decision. Over time, duration can be shaped from data rather than optimism.

D. *Reduce environmental friction*

Prepare materials, keep the next step visible, close unrelated applications, and move high-reward alternatives out of reach during the interval. This is not a test of willpower. Digital products are designed to capture attention, and changing access alters the choice architecture.

Friction can also be social. A task that requires locating a contact, requesting permission, or risking an interaction may appear administrative but be primarily relational. Write the question, rehearse it once, and send it through the agreed channel. If another person's delay is the blockage, set a follow-up date and continue independent components.

E. *Estimate, then compare*

People often underestimate complex work and overestimate the aversiveness of starting. Before a task, estimate duration, difficulty, and distress. Afterward, record the actual values. Repeated calibration improves planning and weakens global predictions. The exercise is informative even when the estimate was correct.

For large projects, estimate at the component level and include coordination, revision, and recovery. Optimistic schedules create repeated “failure” even when work rate is reasonable. A buffer is not procrastination; it is planning under uncertainty.

F. *Bring reward closer*

Distant outcomes compete poorly with immediate alternatives. Visible progress, a brief chosen reward, social acknowledgement, or linking the task to a valued person can bring consequence closer. Rewards should not require completing an unrealistic amount, and they should not undermine the goal. The strongest reinforcement may be reduced ambiguity and evidence of competence after starting.

Temptation bundling—pairing a mildly aversive task with an enjoyable but compatible stimulus—can help with routine

behavior, though it is unsuitable for tasks requiring full concentration. The person should test effects on quality rather than assume benefit.

G. *Use precommitment carefully*

Precommitment changes future choice before temptation arises. Examples include a scheduled co-working session, an earlier external checkpoint, automatic transfer, or software that limits access. Ariely and Wertenbroch (2002) showed that deadlines can act as commitment devices, although externally structured deadlines may be more effective than self-selected ones.

Punitive commitments can increase shame or create financial harm. The consequence should be proportionate, reversible where possible, and chosen without coercion. Accountability works best when it elicits accurate reporting rather than concealment. Meaning and psychological-flexibility measures can help connect a small action to a chosen direction, but they are aids to collaborative formulation rather than objective arbiters of value (Steger et al., 2006; Levin et al., 2012).

A seven-day behavioral experiment

- Select one recurring, safe, delayed action and record its usual cue.
- Define a specific if-then start and a credible time boundary.
- Prepare the workspace and remove one high-probability competing cue.
- Estimate distress, difficulty, and duration before starting.
- Begin at the cue while allowing discomfort; do not wait for motivation.
- Record actual start, duration, distress, and one thing learned.
- Review the pattern after seven days and change one variable at a time.

XII. COGNITIVE AND EMOTIONAL INTERVENTIONS

A. *Test predictions rather than offer slogans*

Common predictions include “I cannot tolerate boredom,” “If the first draft is poor, I am incapable,” “Once I begin I will be trapped,” and “I need the right mood.” The therapist asks what evidence would count and designs a test. A timed stop examines entrapment; an intentionally provisional paragraph examines perfection; work completed during low motivation tests the mood rule.

Positive affirmations that ignore evidence may be unconvincing. Balanced statements acknowledge cost and capacity: “The task is tedious and twenty minutes is tolerable,” or “Criticism is possible and revision is part of the process.” The objective is behavior under realistic beliefs, not forced optimism.

B. *Tolerate the opening emotion*

The first minutes may contain the strongest aversion. The person can name the emotion, rate its intensity, locate bodily sensations, and continue one chosen action without making reduction a prerequisite. This is a small exposure to boredom,

uncertainty, shame, or frustration. If distress indicates actual danger or overwhelming trauma, the plan changes.

Urge surfing can be used for task switching. When the urge to check or escape appears, the person observes its rise and fall for a brief interval while keeping the task open. The aim is not never to take a break. It is to choose the break rather than enact the first urge automatically.

C. *Correct shame after a lapse*

A lapse review has four parts: describe what happened without identity language; identify cue and function; repair any consequence; modify the next plan. "I missed two sessions because I opened messages when confused by the analysis. I will ask the question today and block messages for the first interval." This is more actionable than either condemnation or reassurance that the delay did not matter.

Self-forgiveness may reduce avoidance when it permits re-engagement, but it should not become absolution without repair. Compassion and consequence can coexist. Uncertainty, experiential avoidance, and repetitive negative thinking may maintain delay, so intervention can test feared predictions and increase willingness while distinguishing productive planning from rumination (Carleton, 2016; Hayes et al., 1996; Nolen-Hoeksema et al., 2008; Watkins, 2008).

XIII. WORKING WITH UNDERLYING CONDITIONS

A. *Anxiety disorders*

When delay protects against feared evaluation, uncertainty, bodily sensations, or panic, disorder-specific CBT and exposure may be central. The procrastination plan becomes an exposure hierarchy with response prevention: send the message without repeated checking, attend the appointment without excessive reassurance, or submit at the agreed quality threshold. Haverkamp (2017a) emphasized the communication and meaning of anxious responses; this may supplement an exposure formulation, not replace it.

B. *Depression*

Behavioral activation can schedule small, values-linked actions and monitor the relation between activity and mood. Severe depression requires assessment of suicidal thinking, psychomotor change, sleep, appetite, and bipolar history. The expectation that motivation must precede action can be tested, but low capacity should not be moralized.

C. *ADHD and executive dysfunction*

External cues, visible time, body doubling, immediate feedback, reduced step count, and medication where clinically indicated can address executive barriers. Diagnosis requires developmental and cross-context assessment. A person whose difficulty began after sleep loss or depression should not be given a neurodevelopmental label from procrastination alone.

D. *OCD*

Repeated checking, arranging, rereading, or certainty seeking can delay completion. Exposure and response prevention targets the compulsive rule. A generic productivity technique may increase ritual efficiency without treating OCD. The quality threshold and number of reviews can be agreed in advance, with specialist care for severe symptoms.

E. *Sleep, substance use, and health*

Chronic insomnia, obstructive sleep apnea, pain, medication effects, and substance use can impair attention and energy. The intervention includes appropriate medical or sleep assessment. Stimulants, sedatives, alcohol, and cannabis can alter both performance and sleep; abrupt medication changes should not be made from general advice.

XIV. COMMUNICATION AND PROCRASTINATION

Delay has interpersonal meaning. It can communicate resistance, fear, uncertainty, resentment, or a boundary that has not been stated. Others may receive it as indifference or disrespect. Repeated concealment then damages trust beyond the missed task. The correct interpretation cannot be assumed; it must be explored.

Communication-Focused Therapy is an author-developed framework described in prior JPPC work (Haverkamp, 2017a). Applied here, it asks which message is difficult to formulate or transmit. "I cannot start the report" may contain "I do not understand the criterion," "I fear your evaluation," "I cannot meet both deadlines," or "I do not consent to this workload." Each message implies a different action.

Clear communication uses an observable status, responsibility, impact, and request: "I have not completed the analysis; I underestimated the cleaning step. I can send the verified table on Thursday, or we can reduce scope. Which serves the project?" This does not erase the delay. It replaces concealment with information and permits coordination.

Internal communication also matters. An intention stated abstractly may never become a concrete cue. Translating "work on health" into "at 08:30, call the clinic number saved on the calendar" converts value into action. In therapy, patient and clinician can use the relationship as a place to notice concealment, anticipated criticism, or unclear expectations, then test a more accurate message. With a partner or colleague, the aim is clearer coordination and repair, not surveillance. The framework is useful only when it improves observable choice and is not a validated stand-alone treatment for procrastination.

Table 3. Matching intervention to mechanism

Maintaining process	Intervention	What to measure
Immediate mood repair	Bounded start, urge tolerance, nearer reward	Start latency and task-switch urges

Maintaining process	Intervention	What to measure
Ambiguity	Define deliverable and next complete action	Time spent before first relevant action
Evaluation fear	Graded submission and safety-behavior reduction	Prediction versus observed response
Perfectionism	Fit-for-purpose criteria and limited review passes	Completion and quality at agreed threshold
Temporal discounting	Immediate cue, progress signal, precommitment	Adherence before deadline pressure rises
Executive load	External checklist, visible time, body doubling	Steps completed with and without support
Low reinforcement or depression	Behavioral activation and disorder treatment	Activity, mood, and functioning
Value conflict or resentment	Clarify ownership, negotiate, decline, or recommit	Congruence and communicated decision
Environmental constraint	Resource, workload, disability, or safeguarding intervention	Feasibility and burden, not just output

XV. PROCRASTINATION IN HEALTH BEHAVIOR

Delay of appointments, screening, medication collection, or symptom evaluation can be driven by fear of diagnosis, needles, cost, stigma, prior mistreatment, or practical access. Calling it procrastination should not obscure these barriers. The clinical response may include accurate information, graded exposure, advocacy, transport, or assistance with booking.

Health anxiety creates a paradox: some people seek repeated urgent reassurance, while others avoid evaluation for fear of confirmation. The same person may alternate. A plan defines which symptoms require care, which channel to use, and how internet checking will be limited. New or severe symptoms are not a self-help experiment.

Medication adherence can involve delay through adverse effects, ambivalence, cognitive load, or fear. The clinician asks what the patient actually does and what outcome is feared. Pill organizers and reminders help memory; shared decision making addresses objection. Covertly pressuring adherence without discussing harms damages trust.

Lifestyle advice can become an overloaded moral project. "Improve diet, exercise, sleep, mindfulness, and social life" supplies too many starting points. Select one behavior linked to a meaningful outcome and current capacity. Chronic illness and disability require adaptation rather than generic activation.

XVI. CREATIVE AND SCHOLARLY WORK

Creative work requires uncertainty and repeated imperfect output. The product cannot be fully specified before it exists. This makes it vulnerable to perfectionistic procrastination. Separate exploratory generation, evidence checking, structural revision, and final editing. Each phase uses a different quality criterion.

Research can become avoidance when every new paper delays a question. Define the review's scope, evidence hierarchy, cutoff, and stopping rule. Record unresolved uncertainty transparently. Scholarly integrity requires enough research, not infinite research.

Feedback should arrive before the work is polished enough to protect identity. A provisional outline or sample can reveal whether the direction fits. The recipient and question are chosen carefully: "Does the argument follow?" is more useful than "Is this good?"

Authorship and collaboration require explicit handoffs. A team can wait because everyone assumes another person owns the next step. Meeting notes should name deliverable, owner, date, and decision authority. This is organizational design, not individual therapy.

XVII. GROUP AND ORGANIZATIONAL INTERVENTIONS

Group treatment can normalize the process, provide structured practice, and reduce shame. It should not become a forum for competitive productivity. Members can report one cue, action, obstacle, and learning while protecting privacy. Guided intervention may support adherence better than information alone for some patients, consistent with variation seen in treatment research (Rozenal et al., 2015).

Organizations can establish intermediate milestones, rapid clarification, protected focus time, and realistic workload. These measures reduce ambiguity for everyone and should not require a diagnosis. Managers also need to distinguish accountability from public humiliation.

Deadlines should correspond to actual coordination needs. Artificial urgency across every task destroys prioritization and can reproduce crisis dependence. A transparent queue and escalation rule make priorities and consequences explicit.

XVIII. DECIDING WHEN TO SEEK CLINICAL CARE

Self-directed strategies may be reasonable for circumscribed delay with preserved function. Professional assessment is indicated when procrastination is pervasive, produces major health, financial, academic, or occupational harm, or co-occurs with severe anxiety, depression, suspected ADHD or OCD, substance use, insomnia, or medical symptoms.

Care is also indicated when repeated technique failure intensifies shame. The question is no longer which application or timer to try. A clinician can reassess diagnosis, capacity, treatment history, and context. Practical specialists—occupational health, disability services, debt advice, legal support—may be more relevant for part of the problem.

XIX. EMOTION-SPECIFIC ACTION PLANS

A. *Boredom*

Boredom often predicts that reward is distant and stimulation low. The response can shorten the work interval, increase visible progress, alternate compatible task types, or add a modest immediate reward. The person still practices contact with some boredom; a plan that eliminates every low-stimulation moment is fragile.

B. *Anxiety*

Anxiety requires a specific feared outcome. If starting means discovering incompetence, the experiment produces a limited draft. If submission means criticism, the experiment includes actual submission at a fit-for-purpose threshold. Safety behaviors such as repeated review, reassurance, or alcohol are identified. The outcome is not anxiety reduction alone but whether the prediction and coping were tested.

C. *Shame*

Shame encourages concealment. The action plan includes one accurate disclosure to an appropriate person, repair of the consequence, and a next step small enough to occur before self-attack resumes. The person uses descriptive language—"I did not send the form"—rather than identity language. Privacy remains legitimate; disclosure is selective, not compulsory.

D. *Resentment*

Resentment may signal that the task is imposed, unfairly distributed, or inconsistent with role. The person identifies ownership and consequence. Options include negotiation, delegation, refusal, or recommitment for a chosen reason. A timer cannot resolve an exploitative workload.

E. *Confusion*

Confusion calls for information or skill. The next action is a focused question, example, or tutorial, with a stopping rule for research. If asking is delayed through social anxiety, the question itself becomes the exposure. Confusion should not be treated as evidence of low ability before instruction is tested.

F. *Fatigue*

Fatigue requires capacity and safety assessment. A shorter interval, different time, rest, or medical evaluation may be appropriate. Using crisis pressure to override fatigue can deepen sleep and health problems. The person records whether rest restores function and whether symptoms are disproportionate or new.

Table 4. Match the opening emotion to the first intervention

Opening state	First hypothesis	Initial action	What would disconfirm it?
Boredom	Reward is too distant relative to alternatives	Short interval plus visible progress or modest reward	Delay persists despite engagement once started
Anxiety	Action exposes a feared outcome	Graded behavioral experiment with reduced safety behavior	Fear is low but sequencing still fails
Shame	Global self-judgment and concealment make contact aversive	Descriptive repair and selective disclosure	Delay occurs before any evaluative meaning appears
Resentment	Goal ownership or workload is disputed	Clarify responsibility, negotiate, or deliberately recommit	Task is endorsed but remains ambiguous
Confusion	Information, instruction, or criterion is missing	Ask one focused question or inspect one model	Sufficient clarity exists but perfectionism blocks output
Fatigue	Capacity is temporarily or medically reduced	Adapt demand and assess sleep, health, medication, and substance factors	Energy is adequate in the same period for comparable tasks

XX. DELAY, REFUSAL, AND INFORMED CHOICE

An important endpoint of treatment is an explicit no. Procrastination sometimes performs a refusal the person does not feel permitted to state. Work remains technically accepted while never beginning; an invitation remains unanswered; a commitment is allowed to expire. This protects against immediate conflict and creates later damage.

The clinician asks what would happen if the person declined directly. The feared consequence may be realistic—loss of income, family conflict, retaliation—or exaggerated. Risk and power shape the response. A safe boundary may be communicated, while a dangerous hierarchy may require documentation, advocacy, or another route.

Informed choice includes accepting a cost. A person may decide to complete an unwanted task because the financial consequence matters, or decline a valued opportunity because health cannot sustain it. The decision is not judged by enthusiasm. It is judged by awareness, ownership, and alignment with current priorities.

A deliberate deferment states why, until when, and what information will trigger review. This differs from an open loop. "I will reconsider the course after the medical

appointment on 14 March” preserves a decision point. The date is recorded, and no further analysis is required before it.

XXI. RELAPSE PREVENTION

Procrastination is likely to recur when tasks are novel, evaluative, ambiguous, distant, or imposed; when sleep and mood deteriorate; and when external structure disappears. A relapse plan identifies the earliest sign, such as repeated planning without a first action or increased concealment. The response is to restore the smallest proven cue–action pair and review the functional formulation.

Maintenance should include periodic workload pruning. An overfull system makes every choice a failure to do something else. Deliberate deletion, delegation, or renegotiation is part of self-regulation. A person who completes everything only through chronic overwork has not necessarily solved the problem.

XXII. SAFETY AND LIMITS OF SELF-HELP

Delay of urgent medical care, essential medication, legal deadlines, housing action, or safety planning can have serious consequences. If anxiety or shame prevents action, professional or practical support may be needed promptly. Suicidal thinking, severe depression, mania, psychosis, dangerous substance use, inability to meet basic needs, or abrupt cognitive change requires clinical assessment.

Self-help techniques should not be used to override pain, disability, coercion, or unsafe work. Nor should financial penalties be adopted where they threaten basic needs. General strategies cannot determine whether an individual has ADHD, depression, OCD, or another condition.

XXIII. LIMITATIONS AND RESEARCH NEEDS

Procrastination definitions and measures vary, samples are often young and educated, and many interventions use wait-list comparators or brief follow-up. Self-report improvement may not equal earlier completion or better health. Treatment packages contain multiple components, making mechanisms difficult to isolate. More research is needed in clinical populations, diverse cultures, workplaces, chronic illness, and long-term outcome.

The communication-oriented account is a supplementary clinical synthesis, not direct evidence of efficacy. Future studies could test whether identifying unexpressed uncertainty, resentment, or evaluative fear improves engagement beyond standard behavioral components.

XXIV. CONCLUSION

Procrastination is best understood as costly delay maintained by immediate consequences, not as a defect of character. Task aversiveness, temporal discounting, anxiety,

perfectionism, shame, executive load, and context can all contribute. Assessment defines the delayed action and its function and rules out conditions or constraints that require different care. Effective change combines a concrete cue, bounded start, environmental design, realistic standards, emotional willingness, feedback, and repair. Evidence supports psychological treatment, particularly cognitive-behavioral approaches, while remaining heterogeneous. The aim is neither constant work nor perfect self-control. It is greater freedom to act—or deliberately not act—according to chosen priorities rather than the shortest route away from discomfort.

XXV. 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 cognitive-behavioral treatment. No other conflicts were reported.

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XXVI. REFERENCES

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