Personality and Individual Differences 49 (2010) 175–180

Contents lists available at ScienceDirect

Personality and Individual Differences

journal homepage: www.elsevier.com/locate/paid

"I'll go to therapy, eventually": Procrastination, stress and mental health

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ARTICLE INFO

Article history:
Received 23 October 2009
Received in revised form 11 March 2010
Accepted 24 March 2010
Available online 24 April 2010

Keywords:
Procrastination
Stress
Mental health
Help-seeking
Treatment delay

ABSTRACT

Procrastination and stress are associated with poorer mental health, health problems, and treatment delay. We examine procrastination in the domain of mental health. Higher levels of procrastination and stress were predicted to correlate with poorer mental health status and fewer mental health help-seeking behaviours. Undergraduate participants (135 females, 65 males) completed online questionnaires on procrastination, stress, mental health issues, and mental health help-seeking behaviours. Three significant canonical correlations were obtained between the predictor variables of procrastination, stress, (with controls for age, gender, and social desirability) and the criterion mental health variables. The first canonical correlation supported the main hypothesis associating stress and procrastination with poorer mental health. The second suggested that greater age and female gender are positively correlated to mental health help-seeking. The third canonical correlation depicted reduced procrastination and reduced concern for social desirability as associated with a pattern of poorer mental health and increased mental health help-seeking behaviours. These findings are discussed with a view to addressing the discrepancy between the considerable extent of mental health suffering and the comparatively low levels of mental health help-seeking.

1. Introduction

A considerable gap exists between the extent of mental health suffering and the prevalence of help-seeking behaviour in many industrialized societies. For example, the United States' National Comorbidity Study (NCS) and the NCS Replication (NCS-R) determined the prevalence of any type of mental disorder was 29.4% and 30.5%, respectively, although among patients with a disorder, only 20.3% and 32.9% received treatment, respectively (Kessler et al., 2005). Furthermore, an international consortium (Bijl et al., 2003) examined the prevalence rates of treated and untreated mental disorders in five countries: Canada, Chile, Germany, the Netherlands and the United States. The largest discrepancies were found for Canada (19.9% of people diagnosed with a DSM-IV disorder and only 7% seeking treatment in the past year), the United States (29.1% and 10.9%) and the Netherlands (24.4% and 13.4%). Research on procrastination and physical health (Sirois, 2007; Sirois, Melia-Gordon, & Pychyl, 2003) suggests an investigation of procrastination as both a possible contributor to ailment and a behavioural barrier to treatment in the mental health domain.

1.1. Procrastination, stress and mental health

To procrastinate is to put off acting on one's intentions; for some individuals engaging in procrastinatory behaviour may become a habitual activity, labeled trait procrastination. Trait procrastination is the predisposition to postpone that which is necessary to reach some goal (Lay, 1986). The current study examines trait procrastination on academic and everyday tasks as it relates to mental health and help-seeking. Procrastination has been linked to many negative mental health states. Anxiety and depression are positively correlated with self-report and behavioural measures of procrastination (Beswick, Rothblum, & Mann, 1988; Martin, Flett, Hewitt, Krames, & Szanto, 1996).

Stress and mental health have been repeatedly found to vary inversely (e.g., DeLongis, Lazarus, & Folkman, 1988) and with likely reciprocal influence (Hammen, 2005). Defining stress as the organism's reaction to external survival-related demands (Lazarus & Folkman, 1984), and mental health as "... a state of well-being in which the individual ... can cope with the normal stresses of life ..." (World Health Organization, 2001), it is also clear that stress and mental health are linked by definition.

Procrastination and stress are positively correlated (Flett, Blankstein, & Martin, 1995). In a student sample, all participants reported experiencing stress resulting from procrastination (Schraw, Wadkins, & Olafson, 2007). Procrastinating online was also linked to perceived stress relief (Lavoie & Pychyl, 2001). The relation between procrastination and stress may vary depending on the urgency of the stressor. Tice and Baumeister (1997) found that students who procrastinated at the beginning of a semester experienced less stress and fewer illness symptoms. However, at the end of a semester, with deadlines and examinations looming, procrastinators tended to have greater stress, more illness symptoms, more

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doi:10.1016/j.paid.2010.03.028

health care visits, and poorer academic performance than nonprocrastinators.

1.2. Procrastination, stress and treatment delay

Individual differences in personality are related to help-seeking for emotional problems (Rickwood & Braithwaite, 1994). More specifically, procrastination acts as a barrier to help-seeking for drug abuse (McCoy, Metsch, Chitwood, & Miles, 2001) and gambling (Bellringer, Pulford, Abbott, DeSouza, & Clarke, 2008). Procrastination may thus be a barrier to help-seeking for other mental health concerns.

The present study extends into the mental health domain previous research (Sirois, 2007; Sirois et al., 2003) examining the relation between procrastination, stress, physical illness and the practice of wellness behaviours (i.e. seeing a physician or ensuring proper nutrition). Sirois and colleagues (2003) examined university students during a high stress period and measured their procrastination, physical health, treatment delay, stress, and wellness behaviours. Procrastinators experienced poorer health, treatment delay, stress, and fewer wellness behaviours. Stress was found to fully mediate the procrastination-illness relationship. Analyses in a subsequent replication generalized original findings to a community-dwelling adult sample (Sirois, 2007). Consistent with the previous findings, procrastination was associated with higher stress, more acute health problems, and the practice of fewer wellness behaviours. Procrastinators also reported less frequent household safety behaviours and dental and medical check-ups. In this study (Sirois, 2007), stress fully mediated the procrastination-health relationship. Initially, health behaviours also appeared to mediate the procrastination-health relationship. However, after considering the covariance with stress, health behaviours proved not to be a significant mediator (Sirois, 2007). In an effort to replicate Sirois' findings (2007) as applied to *mental* health, we used a similar array of measures, namely, measures of procrastination, stress, mental health, and mental health behaviours. Nevertheless, we designed our analysis to remain sensitive to the possibility that mental health distress might affect help-seeking behaviour in a different way than physical illness. Due to the nature of mental distress, the cognitive functioning required to seek help may be more impaired in this context than with physical ailments.

1.3. The current study

In this exploratory study we aimed to examine how procrastination and stress may both work to predict mental health and help-seeking. We predicted that the combination of procrastination tendencies and stress levels would affect mental health and help-seeking conjunctively. Consequently, we included both procrastination and stress as predictor variables of mental health and help-seeking. Due to the presence of multiple predictor and criterion variables we used a canonical correlation analysis. This analysis can also reveal more subtle associations between measured constructs if there are multiple canonical functions that satisfy a null-hypothesis approximate test of significance.

On the basis of previous findings, we predicted that participants who score high on procrastination and stress will have poorer mental health than participants who score low on procrastination and stress. In addition, we predicted that participants who score high on procrastination and stress measures will engage in fewer mental health help-seeking behaviours than participants who score low on procrastination and stress.

2. Methods

2.1. Participants

Undergraduate students (135 women, 65 men; age 17–22 years, $M = 18.42$, $SD = .75$) from the University of Western Ontario participated in this study through an online departmental portal for course credit. Self-assessed English proficiency was listed as a participation requirement to foster valid questionnaire responding.

2.2. Materials

2.2.1. Measures of procrastination

General procrastination scale (GP; Lay, 1986). The GP scale is composed of 20 items that measure trait procrastination on a variety of everyday activities (e.g. "I always seem to end up shopping for birthday gifts at the last moment"). Items are scored on a 5-point Likert scale ranging from 1 (False of me) to 5 (True of me). The mean of all items yields a composite score, with higher values indicating a higher tendency to procrastinate. The internal consistency has been shown to be .78 and the test–retest reliability .80 (Ferrari, Johnson, & McCown, 1995). The internal consistency for the present sample was $\alpha = .89$.

Procrastination Assessment Scale for Students (PASS; Solomon & Rothblum, 1984). The PASS measures trait procrastination on six varied academic task domains such as studying, writing, and attendance. While the PASS is specific to academic concerns, it measures procrastination as an academic disposition across situations, making it a plausible measure of academic procrastination as a trait. The PASS contains two questions for each of the six academic tasks: "To what degree do you procrastinate on this task?" and "To what degree is procrastination on this task a problem for you?" Each question is scored on a 5-point rating scale. Internal consistency for the first question (PASS-1) was .79 in past research (Shanahan & Pychyl, 2007) and .77 in the present sample. Internal consistency for the second question (PASS-2) was .72 in previous research (Shanahan & Pychyl, 2007) and .78 in the present sample.

2.2.2. Measure of stress

Daily Hassles Scale-Revised (*DHS-R*; Holm & Holroyd, 1992). The Daily Hassles Scale lists 61 "hassles", which are irritating or frustrating demands in one's life. Each hassle is rated on a 5-point rating scale, plus a "not applicable" option. Sample hassles are "concerns about owing money" and "physical appearance." The cumulative severity rating (sum of all items) was the stress measure used in our study (as per Holm & Holroyd, 1992). Internal consistencies of .80 and .88 are reported for overt and covert hassles, respectively (Holm & Holroyd, 1992).

2.2.3. Measures of mental health

Mental Health Inventory (MHI; Veit & Ware, 1983). The MHI measures general levels of psychological distress and well-being. The MHI consists of 38 items that are scored on a 6-point Likert scale according to the frequency of its occurrence over the past month. For example, "During the past month, how often did you feel isolated from others?" The MHI has elicited reliably strong internal consistencies ranging from .83 to .96 (Veit & Ware, 1983). The internal consistency for the present sample was .78. In the interest of isolating cognitive factors, MHI can be further divided into a 32-item Mental Health Index (MHI-32) and a 6-item Cognitive functioning subscale (CF-6). The CF-6 encompasses questions on concentration, memory, and problem-solving, among other daily cognitive skills. In the present sample, the internal consistency for the CF-6 is .78 and for the MHI-32, .66.