DISSERTATION IN BRIEF

Boredom Proneness: Its Relationship to Psychological- and Physical-Health Symptoms

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The relationship between boredom proneness and health-symptom reporting was examined. Undergraduate students ($N = 200$) completed the Boredom Proneness Scale and the Hopkins Symptom Checklist. A multiple analysis of covariance indicated that individuals with high boredom-proneness total scores reported significantly higher ratings on all five subscales of the Hopkins Symptom Checklist (Obsessive–Compulsive, Somatization, Anxiety, Interpersonal Sensitivity, and Depression). The results suggest that boredom proneness may be an important element to consider when assessing symptom reporting. Implications for determining the effects of boredom proneness on psychological- and physical-health symptoms, as well as the application in clinical settings, are discussed. J Clin Psychol 56: 149–155, 2000.

To date, the work on boredom proneness has focused on its association with negative affect, as well as problems in academic and work settings. For instance, significant positive relationships have been found between the tendency to experience boredom and depression, anxiety, hostility, anger, loneliness, and hopelessness (e.g., Ahmed, 1990; Farmer & Sundberg, 1986; Rupp & Vodanovich, 1997; Vodanovich, Verner, & Gilbride, 1991; Watt & Davis, 1991). Other researchers have reported boredom proneness to be related significantly to lower educational achievement, truancy rate, and poor work performance (e.g., Branton, 1970; Drory, 1982; Gardell, 1971; Maroldo, 1986; O'Hanlon, 1981; Robinson, 1975; Smith, 1981).

Limited work, however, has been devoted to investigating the association between boredom and psychological- and physical-health symptoms. Evidence for such a relationship can be inferred from studies reporting significant, positive correlations between boredom and substance abuse and eating disorders (e.g., Abramson & Stinson, 1977;

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Ganley, 1989; Johnston & O'Malley, 1986; Martin, 1989; Pascale & Sylvester, 1988). Other researchers have established a connection between boredom and detrimental health effects in organizational settings. For instance, Smith, Cohen, and Stammerjohn (1981) found that workers in monotonous jobs reported more visual, musculoskeletal, and emotional-health complaints than those performing non-monotonous work. Samilova (1971) found that female Russian workers employed in repetitive tasks experienced higher incidence of health problems, including gastritis, peripheral neurological disorders, and joint, tendon, muscle, and cardiovascular disease, than workers in less-repetitive jobs. Ferguson (1973) found that telegraphists who complained of task monotony indicated a greater occurrence of physical-health problems, such as asthma, bronchitis, trunk myalgia, and hand tremors, as compared to other workers in less-monotonous positions.

A shortcoming of much of the research investigating the relationship between boredom and health problems is the manner in which boredom has been measured. For instance, prior studies typically assessed boredom using a single-item self-report measure or equated boredom with repetitious and monotonous work. Consequently, the purpose of this research was to investigate the relationship between boredom proneness and self-reported health symptoms using psychometrically sound instruments. Specifically, the study examined the relationship between scores on the Boredom Proneness Scale (Farmer & Sundberg, 1986) and subscale scores of the Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). Given the previous review, it was anticipated that high boredom proneness would be associated with significantly greater reports of psychological- and physical-health symptoms.

Method

Participants

The sample consisted of undergraduate students ($N = 200$) at a public university in the southeastern United States. The average age of the sample was 19.9 years, and 63.7% of the participants were female.

Procedure

The participants completed a packet containing the Boredom Proneness Scale, the Hopkins Symptom Checklist, and a short demographic sheet (e.g., age, gender, race) during regular class periods. Participation in the study was voluntary, and all responses were anonymous.

Instruments

Boredom Proneness Scale (BPS). The 7-point Likert version of the Boredom Proneness Scale (BPS, Farmer & Sundberg, 1986) was employed in the present study as compared to its original true–false format. The scale consists of 28 items that range from "1" (highly disagree) to "7" (highly agree). A high score across the scale's items (e.g., "It takes a lot of change and variety to get me going," "Much of the time I just sit around doing nothing") is indicative of high boredom proneness.

Test–retest reliability of the original true–false version of the BPS was found to be .83 after a one-week interval (Farmer & Sundberg, 1986) and .79 after a two-week time frame (McGiboney & Carter, 1988). Internal consistency estimates for the 7-point scale have ranged between .79 to .84 across a wide range of studies (e.g., McLeod & Vodano-

vich, 1991; Polly, Vodanovich, Watt, & Blanchard, 1993; Seib & Vodanovich, 1998; Vodanovich & Kass, 1990; Watt & Blanchard, 1994; Watt & Ewing, 1996; Watt & Vodanovich, 1992a).

Construct validity of the scale has been determined through significant, positive correlations with negative affect, such as anxiety, depression, anger, hostility, hopelessness, and life dissatisfaction (e.g., Ahmed, 1990; Farmer & Sundberg, 1986; Rupp & Vodanovich, 1997; Vodanovich et al., 1991; Watt & Davis, 1991). BPS scores also have been shown to be significantly related to impulsivity (e.g., Watt & Vodanovich, 1992b), procrastination (Vodanovich & Rupp, 1999), poor psychosocial development (Watt & Vodanovich, 1999) narcissism (Wink & Donahue, 1997), and alienation (Tolor, 1989).

Hopkins Symptom Checklist (HSCL). The HSCL is a 58-item self-report scale that asks respondents to report how much a given problem distressed or bothered them during the past seven days, including the present day (Derogatis et al., 1974). The items are arranged on a 4-point scale ranging from "1" (not at all) to "4" (extremely).

The HSCL yields scores on the following subscales: somatization (e.g., "headaches"), obsessive–compulsive (e.g., "having to check and double check what you do"), interpersonal sensitivity (e.g., "feeling critical of others"), depression (e.g., "thoughts of ending your life"), and anxiety (e.g., "nervousness or shakiness inside"). These five underlying symptom constructs were determined through clinical–rational clustering and empirical–analytic factor analysis (e.g., Derogatis, Lipman, Covi, & Rickels, 1971; Williams, Lipman, Rickels, Covi, Uhlenhuth, & Mattsson, 1968).

The HSCL has been shown to possess high reliability for each of the dimensions with a sample of anxious neurotics ($N = 1435$). For example, coefficient alphas computed for each of the dimensions ranged from .84 to .87 (Derogatis et al., 1974).

Construct validity of the scale has been established through significant positive correlations with self-handicapping strategies (Organista & Miranda, 1991), bulimia (Kent & Clopton, 1988), measures of anxiety and depression (Kellner et al., 1985; Mavissakalian, Hamann, Haidar, & de Groot, 1995; Stein, Downing, & Rickels, 1978) and decreased immunity (Linn, Linn, & Jenson, 1981). A revised version of the scale also has reported a significant association with depression, which was significantly correlated with substance abuse (e.g., alcohol, tobacco, and marijuana)(Johnson, Hyler, Skodol, Bornstein, & Sherman, 1995).

Results

A median split was used to divide participants into low ($M = 81.3$) and high ($M = 112.2$) boredom-proneness groups. Preliminary analyses indicated that significant correlations existed between gender (dummy coded) and all five of the HSCL subscales. Consequently, a multiple analysis of covariance (using gender as a covariate) indicated that individuals with high boredom-proneness levels possessed significantly greater HSCL scores; $F(5, 187) = 4.2$, $p < .001$. Specifically, univariate F-tests indicated that greater boredom proneness was associated significantly with higher scores on all five HSCL subscales.

Discussion

The results of the present study provide empirical evidence that high levels of boredom proneness are related to a greater frequency of symptom reporting. Specifically, the findings support prior researchers who have found a significant association between BPS

Table 1
Means and Standard Deviations of HSCL Subscales by Boredom Proneness Group

	Boredom Group				
	Low		High		
HSCL Subscales	*M*	(SD)	*M*	(SD)	*F*
Obsessive–Compulsive	16.4	(6.0)	20.2	(6.0)	18.9***
Somatization	21.0	(7.2)	24.2	(7.5)	8.7**
Interpersonal Sensitivity	13.9	(4.8)	15.9	(5.5)	5.9*
Anxiety	9.2	(3.8)	10.4	(3.9)	3.9*
Depression	19.8	(7.0)	23.4	(8.5)	9.5**

Note. Standard deviations of HSCL subscales are in parentheses.
*$p < .05$; **$p < .01$; ***$p < .001$.

scores and anxiety and depression (e.g., Farmer & Sundberg, 1986; Vodanovich et al, 1991). The results also indicate a significant relationship between boredom proneness and a negative social orientation, as described by the HSCL interpersonal sensitivity subscale (e.g., "feeling that people are unfriendly or dislike you," "Your feelings being easily hurt"). This adds tangential support to the findings of Leong and Schneller (1993), Maroldo (1986), and Tolor (1989), who reported boredom proneness to be significantly associated with alienation, low sociability, and shyness, respectively.

The significant relationship between BPS scores and the HSCL obsessive–compulsive (OC) subscale appears somewhat surprising at first glance. However, many of the OC subscale items consist of statements regarding difficulty with attentional deficits (e.g, "trouble concentrating," "Your mind going blank," "trouble remembering things"). When discussing the construct of boredom (or the boredom-prone individual), several authors have stated that boredom is connected with distractibility, low attentional control, and concentration difficulties (Damrad-Frye & Laird, 1989; Farmer & Sundberg, 1986; Hamilton, 1981; Hamilton, Haier, & Buchsbaum, 1984). For instance, Fisher (1993) stated, when bored, an individual ". . . feels a pervasive lack of interest in and difficulty concentrating on the current activity" (p. 396).

Finally, our finding that high boredom-proneness scores are related to greater somatization complaints adds empirical support to previous work that reported negative associations between boredom and eating behaviors (e.g., Martin, 1989; Pascale & Sylvester, 1988) and physical-health symptoms (e.g., Ferguson, 1973; Smith et al., 1981). It should be noted, however, that this prior work did not assess boredom levels using psychometrically sound instrumentation.

Perhaps one reason for the relationship between boredom proneness and greater symptom reporting is that individuals with high BPS scores may be overly focused on themselves (or their internal states) and therefore be more likely to perceive that problems may exist. For instance, many authors (e.g., Eisnitz, 1974; Weinberger & Muller, 1975) have discussed the connection between boredom and the tendency to dwell on oneself (e.g., narcissism). Recently, Wink and Donahue (1997) found greater BPS scores to be related to high narcissism scores. In a related vein, Spacks (1995) argued that the focus on oneself is a primary reason for the increased incidence in reports of boredom in society. As she has stated, "The inner life comes to be seen as consequential, therefore its

inadequacies invite attention" (1995, p. 23). Finally, Seib and Vodanovich (1998) found that individuals with high BPS total scores had greater scores indicative of "maladaptive" self-awareness, as indicated by greater scores on the Self-Reflectivity subscale of the Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975).

It should be noted that the present research possesses some shortcomings that limit the generalizability of the results. For instance, the study measured boredom proneness and health symptoms using single, self-report devices within a college-student sample. Consequently, it may be beneficial for future researchers to employ multiple measures of boredom and health (e.g., medical examinations, clinical interview ratings, physiological indices, and other self-report instruments) in applied settings. Also, the research is confined by the correlational nature of the findings. Therefore, it is conceivable that the direction of the relationship between the variables in this study may be reversed. That is, perhaps greater health complaints are related to higher boredom rather than vice versa. Also, congruent with past research, other variables not included in this study (e.g., anger, sensation seeking, Type A behavior) may moderate the influence of boredom proneness (Kass & Vodanovich, 1990; Rupp & Vodanovich, 1997) and deserve attention in subsequent research in this area.

In conclusion, the results of this study indicate that it may be beneficial for future researchers to devote more attention to the multimodal assessment of boredom across a variety of contexts. This approach may yield a more precise identification of the boredom-prone individual, enable a better understanding of the relationship between boredom and other physical and psychological constructs, and be useful for practitioners. For example, Schubert (1978) has asserted that ". . . if the psychiatrist can identify the boredom prone patient early enough, he can be on guard for the reactions he can expect from such a patient during treatment" (p. 46–47).

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