**ABSTRACT**

Boredom is a problem in forensic mental health settings, and is believed to increase levels of violence and be detrimental to health and recovery. Eight men in a forensic unit, all with a psychotic disorder, were interviewed regarding their experiences of boredom. A thematic analysis was used to identify emergent themes. These included: Mental health and motivation; Restrictive environment; Responsibilities; and Nothing to do. These findings provide a greater understanding of factors which may contribute to boredom within forensic settings and can guide occupational therapy interventions to address them.

**KEYWORDS**

Boredom, forensic, mental health, psychosis, occupational therapy

**Introduction**

The majority of studies into the causes of boredom are dated and have been conducted in industry or education. They suggest that boredom is subjective, and due to a variety of reasons which include: a perception that time passes slowly (Vodanovich, Verner, & Gilbride, 1991); situations perceived as monotonous (Eastwood, Frischen, Fenske, & Smilek, 2012); not reaching the right level of arousal (Vodanovich et al., 1991) or engagement (Harris, 2000); and lacking goals, purpose and meaning (Eakman, 2011; Van Tilburg & Igou, 2011). The literature also suggests that boredom is not typically about the lack of something to do (Mann, 2007), a common misconception, but instead is about lacking the necessary skills to address boredom (Long, 2004) by occupying oneself successfully (Kass & Vodanovich, 1990). A study by Chin, Markey, Bhargava, Kassam, and Loewenstein, (2017) found that men are significantly more likely to experience boredom than women, and that there is a positive link between very low educational attainment and boredom. Furthermore, that social environment, activity, and the time of day (afternoons) increased propensity for boredom, whereas sports, spending time with friends and family, and mornings and evenings reduced propensity to boredom. Boredom has also been found to have negative consequences such as depression and anxiety (Sommers & Vodanovich, 2000), gambling (Elpidorou, 2014) and substance misuse (Iso-Ahola & Crowley, 1991). Dahlen, Martin, Ragan, and Kuhlman (2004) found that boredom, due to a lack of external stimulation, predicted propensity to experience anger, maladaptive anger expression, aggression and deficits in anger control.

 Within mental health wards boredom has been identified as a problem (National Institute for Clinical Excellence [NICE], 2005, 2011) and it is believed to be detrimental to patients’ recovery (Royal College of Psychiatrists, 2011) as well as reducing the safety of wards due to increasing levels of violence and aggression (Healthcare Commission, 2007; NICE, 2005). Although it has been highlighted as a problem, research has shown that occupational therapists do not always prioritize requests from from patients or the multi-disciplinary team to address boredom perceiving them to be requests for ‘entertainment’ (Newell, 2009).

A National Audit of Violence (Healthcare Commission, 2007 found that some violence reported in mental health services was a result of patients becoming frustrated, due to a lack of activities. A decrease in perceived boredom has been shown to correlate with a decrease in violence (Janner, 2007). Furthermore, increased levels of activity on wards have also been shown to reduce levels of violence and aggression ([Antonysamy](http://qir.bmj.com/search?author1=Arokia+Antonysamy&sortspec=date&submit=Submit), 2013), However, there is a lack of research which has examined the experiences of boredom for people in mental health services, and particularly in forensic settings where increased restrictions could lead to increased levels of boredom. Findings of studies that have explored this field can be broadly summarised into four categories; diagnosis, meaningful activity, absconding and environment..

***Literature Review***

***Diagnosis***

Correlations have been found between boredom and various psychiatric conditions including personality disorder, emotional maladjustment (Sommers and Vodanovich, 2000) and males with schizophrenia or psychosis (Todman, 2003; Watt & Vodanovich, 1999). Newell, Harries, and Ayers, (2012) conducted a quantitative, cross sectional study to investigate the prevalence of boredom in a psychiatric inpatient unit. Using the Boredom Proneness Scale (Framer & Sundberg, 1986) they established significant correlations between boredom and diagnosis. Based on mean scores those patients with personality disorder were found to be the most prone to boredom and those with psychotic disorders the least. Significant relationships were also found between boredom proneness, depression and anxiety. Patients who were detained in hospital against their will were found to be less likely to be boredom prone. The researchers consider that this may be because a large proportion of the voluntary patients had depression, which they had already established increases the likelihood of being boredom prone. The results need to be treated with caution due to the untested reliability of the Boredom Proneness Scale on a mental health population. In addition, causality of relationship cannot be established with this methodology.

 Gerritsen, Goldberg, and Eastwood (2015) conducted a study to measure boredom proneness among 38 outpatients diagnosed with schizophrenia in Canada. Each participant completed the Boredom Proneness Scale (Framer & Sundberg, 1986)). This data was compared to a database of findings from other studies. A single-sample t test was used to determine whether the measured mean BPS level in the clinical sample (X=99.1) deviated significantly. This indicated that boredom proneness in the clinical sample was significantly elevated (mean difference=13.2, t(36)=3.24, p=.003). Participants were also asked to complete a Lehman’s Quality of Life Interview (Lehman, 1988) and the researchers found a correlation between boredom proneness and reduced quality of life, specifically with leisure activity dissatisfaction.

***Meaningful Activity***

Some patients in mental health services have excessive amounts of unoccupied time (Janner & Delaney, 2012). Morrison, Burnard, and Philips,(1996) conducted a satisfaction survey of patients within a forensic unit. They used a questionnaire with 12 patients, 6 of whom also engaged in a semi-structured interview. Content analysis was used to examine the data. They found that the majority of patients experienced boredom during the day despite the availability of occupational therapy. This was worse at weekends when there was no occupational therapy. Farnworth, Nikitin, and Fossey (2004) studied patients’ use of time in a secure unit and found they frequently experienced boredom, often due to a lack of meaningful, challenging activity. They established that patients spent the majority of their time (90-96%) engaged in passive activities such as sleeping, smoking, talking and watching television. It could be argued that the results of Newell et al. (2012) also support these findings, as they found a negative correlation between boredom proneness and self-directed activities, the more activities engaged in, the less boredom prone they were. Also, they found that there was no correlation between the amount of organised activities patients participated in and boredom proneness, suggesting that activities need to be meaningful to the individual.

 Meehan, McIntosh, and Brgen (2006) conducted a qualitative study in a high secure unit to explore factors which contributed to levels of aggression. Twenty seven participants, 85% of whom had a diagnosis of schizophrenia, participated in focus groups. Content analysis was used to identify themes. Almost all of the participants discussed ‘empty days’, a lack of meaningful activities and enforced idleness which they believed increased incidents of aggression. They also expressed frustration regarding activities being cancelled due to staff shortages.

***Absconding***

Absconding generally refers to ‘breaking the conditions of regulated authorised absences from the psychiatric unit’ (Exworthy & Wilson, 2010 p81). Wilkie, Penney, Fernane, and Simpson (2014) examined the reasons why inpatients absconded from a forensic hospital in Canada. They investigated 101 incidents of absconding by 57 inpatients over a two year period. They examined clinical information documented in progress notes which related to the reasons patients had given for absconding. A thematic analysis of this data identified that the most commonly reported reason was that patients were bored or frustrated. Simpson, .Penney, Fernane, and Wilkie, (2015) conducted a further study in the same unit to examine the effect of a new policy regarding privileges on the rate of absconding. They reviewed documented clinical information regarding the incidents 18 months prior to and 18 months following the policy implementation. Undertaking a thematic analysis they also found that as in the previous study boredom was one of the main reasons given for absconding.

***Environment***

The correlates between mental health problems and boredom were found within the community (Johns, Sellwood, Mcgovern,, & Haddock, 2002; Corvinelli 2005), inpatient services (Shattell, 2007) and particularly within constrained environments (Corvinelli, 2010). Shattell, Andes, and Thomas (2008) conducted a qualitative study to explore patients’ lived experiences of a locked environment. They found that restrictions created barriers to engaging in valued and meaningful occupations; limited choices and satisfaction in occupations; and hindered the development of meaningful roles. Patients experienced boredom as time passed slowly, and much of the day was spent ‘killing time’. Farnworth et al. (2004) had similar findings, although they need to be treated with caution as the unit was closing due to substandard facilities.

 Tetley,Evershed, and Krishnan(2011) studied the transition of patients from high secure to medium secure services by interviewing 16 patients who had gone through this process. A thematic analysis was used to identify emergent themes, one of which was related to boredom. The patients reported that there were less facilities (education, sports and work) in the medium secure units in comparison to high secure. This led to feelings of boredom, loss of confidence and motivation and frequently a desire to return to high secure. This factor, along with the others identified, was believed to be detrimental to the patient’s successful transition. The authors suggest that patients need to be better prepared for transition.

***Research Question***

Although the small body of research exploring the impact of boredom in mental health settings provides some insight, there has been limited research specifically exploring the issue in a forensic setting and for people with psychosis. This research aims to explore the causes of boredom for people in a forensic setting, which will inform healthcare staff in its prevention and management. The research question is ‘What causes boredom from the perspectives of men aged 20-50, with a psychosis, in a forensic setting?’

 **Method**

A qualitative study involving semi-structured interviews that were analysed using thematic analysis. A group of service users were consulted about the design of the study. . An interpretative approach was used which aims to understand the world from the participant’s point of view (Green & Thorogood, 2009). Approval from NHS Ethics Committee (12/SC/0396) was granted for the study.

Reflexivity was an essential aspect of this qualitative research as it was important that the researchers recognised that their social identity and backgrounds may have an impact on the research process (Lathlean, 2013).This was particularly important as the principal researcher was also the study unit’s Head Occupational Therapist.

***Participants***

Participants were recruited from a single sex (male) medium secure forensic unit in the South of England, therefore all participants were male inpatients detained under the Mental Health Act (1983). The inclusion criteria included age range of 20 – 50 years as this was known to be the largest age group in the unit; and a diagnosis of psychosis as the literature suggests this group to be the most prone to boredom (Todman, 2003). Exclusion criteria included those awaiting trial or sentencing as information provided during the interview process may prejudice legal proceedings.

Participants meeting study criteria (N=22) were approached by a unit psychologist, not directly involved in the study, who provided a Participant Information Sheet, explaining the purpose of the study and how confidentiality would be maintained. Those who agreed to participate were approached by the lead researcher to clarify any concerns, arrange an interview and to sign a consent form. Confidentiality was adhered to by ensuring that only the research team had access to the research data, which was stored securely. Anonymity was maintained by assigning each person a participant number and a pseudonym for the purposes of this paper. The recruitment process was carried out in referral order, some patients were too unwell or decided not to participate, so the procedure was continued until saturation was achieved and participants were not adding new perspectives on boredom. A total of eight participants were interviewed. Their mean age was 35 with an age range of 27 years.

***Data collection***

In 2014, three researchers collected data from participants during single in depth semi- structured interviews lasting 45 – 60 minutes. Two of the researchers had previously worked in the study unit, and the third continued to work there. Therefore, to reduce bias, participants were allocated to a researcher who was not known to them. Interviews were audio recorded and transcribed verbatim for analysis. A topic guide was developed by the research team, which included open questions and prompts relating to the themes identified in the literature review (see Appendix 1). These included environment; use of time/routine; volition; skills; diagnosis/illness; and roles.

***Data Analysis***

The lead researcher conducted a thematic analysis of the data which followed the stages outlined by Braun and Clarke (2006). An initial reading of all the transcripts ensured familiarisation with the data. Initial codes were assigned during the second reading to information relevant to the research question. Once this had been completed for all eight transcripts the codes were reviewed together to identify the emergent themes. These themes were then reviewed with the research team where they were refined by examining them in relation to the research question, breaking some down further and combining or discarding others. A definition of each theme was written to complete the audit trail. The themes were analysed by re-reading and cross referencing the transcripts, comparing similarities and differences between participants to identify patterns and explore meanings.

**Results**

Four main themes relating to the causes of boredom emerged from analysis of the participants’ transcripts; 1) Mental health and motivation, the relationships between boredom and psychosis, aggression, sleep and motivation; 2) Nothing to do the lack of meaningful activities, and how participants try to fill their time; 3) Restrictive environment, environmental restrictions that have an impact on boredom; and 4) Responsibilities,, participants views that boredom is exacerbated by basic responsibilities being taken away from them.

All participants have been given pseudonyms.

***Theme1: Mental health and motivation***

All participants discussed the relationship between boredom and their mental health. Some reported that boredom affected their psychosis because it gave them time to focus on thoughts and delusions, whereas engaging in activities provided a distraction. This is described by Peter:

*‘...because when you become bored you become unsettled. I start getting, I start going into deeper delusions. And I start thinking persecuting ideas and persecuting thoughts and beliefs.....I need to always be doing something to distract myself from the voices in my head because if I listen to ‘em and react to ‘em then I’m going to be here longer and it’s going to set me back’. Peter (Lines 92 – 98)*

Negative symptoms of psychosis such as lack of motivation resulted in less engagement in activities and subsequently increased boredom. In contrast positive symptoms, such as thought disorder and delusions preoccupied participants so they did not feel bored.

‘*I don’t think I had time to be actually bored because I just had so many thoughts whizzing around my head, I wasn’t really, you know, with it.* *If I was em, stable at that point I probably would have been bored yeah, because after I got better and I was still on that ward I did eventually get bored because there was nothing for me to do.  But when I was unwell I wasn’t really focused on em, you know, doing anything, I was just in my own little world really’. Harry (Lines 390 – 392)*

The majority of participants reported problems with their sleep patterns. Some slept more because medication caused drowsiness, whereas others used sleep to get respite from distressing thoughts or boredom. Lack of motivation to do anything led to some participants staying in bed during the day, several of whom recognised that this was detrimental to their mental health.

 *‘Well I just don’t want to do anything you know I just lay in bed all day. You know until hopefully it passes’. Clifford (Lines 197 – 201)*

All of the participants said that they felt frustrated, angry or irritable when they were bored. Several thought that boredom was often the precursor for aggression, particularly between patients. Harry talked about how this could be prevented:

*‘I think that em if there were more activities for patients to do, I think there would be less play fighting and ultimately less fracas between patients because, you know, if you’re both in an irritable state where you’re bored and there’s nothing else to think about you, you’re bound to rub each other the wrong way, it happens you know, I think that if people were distracted a bit more it would prevent assaults on the ward as well…. if you’ve got nothing to do em, then, and you are bored then it heightens your irritability may be’. Harry (Lines 70.1 – 70.9)*

Participants reported that when they have hope they are more motivated to set goals and engage in activities, thus reducing boredom and improving mood. Those who were less engaged had more time to think about why they were in hospital which contributed to low self-esteem and depression.

*‘I think because, not having hope and not having faith and like, not having the inspiration, it can, it can delude you. It can knock you off track. And you think what is there, there is nothing, my life is a mess. I’m stuck here, I’m not going anywhere, and I’m not going forward. You start thinking all depressed and unmanageable and hostile and agitated, and then you, it’s just the boredom that does it’. Peter (Lines 290.1-290.7)*

***Theme 2: Nothing to do***

All of the participants felt that there was ‘nothing to do’ in the unit and therefore no reason to get up in the mornings. Routine activities such as smoking breaks, meal times andoccupational therapy sessions helped some participants to cope by providing structure to the day.

*‘.. if I’ve got something to do then I’ll get up at nine just, just to make sure that I’m up and sort of able to do whatever task I’ve got to do. I think what’s the point, you know, why, why get up when you’ve nothing to do so I’d sleep all the time you know, which is not healthy. Luke (Lines 38 – 42)*

The weekend was reported by the majority of participants to be the most boring time of the week as there was no occupational therapy and less staff on duty. This resulted in fewer opportunities to get off the ward and access ground and community leave. Recreational ward activities were viewed as positive, particularly by Ben, but did not happen regularly as staff were busy.

*‘There’s literally nothing to do on a weekend. Yeah, there’s not even things like OT and stuff in here for the weekends’. Richard (Lines 82 – 84)*

*‘ Ward activities, I think really important.... the staff do try but I think because they’re so busy half the time with their own paperwork, writing up on the computer, it’s very difficult for them to facilitate it at times’. Ben (Lines 261 – 262)*

The majority of participants tried to pass time by smoking, watching television, sleeping or listening to music. Although other activities were available they needed to be meaningful, with the right level of challenge to engage the participants and maintain their interest. If they were too easy, too difficult, or repetitive then they were perceived as boring.

*‘I think, I’m not saying I’m really clever or anything but all, some of the stuff they do on the ward is like, a bit sort, like quizzes and the bingo and stuff like that, and I’m thinking that’s not really for me you know, it’s not really, it doesn’t really challenge me enough’. Luke (Lines 90.1 – 90.5)*

Therapy groups or activities were also perceived as boring if participants could not see their relevance to treatment. Those which related to discharge or the future were seen as more relevant and therefore meaningful.

*‘Like therapy groups. Yeah like I’ve been sat there bored thinking, is this doing ought for me, is it, is it gonna get me anywhere, is it, am I really learning anything. You know. I’m, I’m pretty bored here. I’m listening to stuff I’ve already learnt’. Peter (Lines 330.1 – 330.3)*

Some participants thought that the unit’s resources were good although others felt they were limited due to security reasons or lack of funding. This had an impact on boredom as some participants were not able to access their hobbies. There were also waiting lists for some activities such as internet sessions due to limited resources which was frustrating for some of the participants, in particular for Samuel:

*‘Well it’s like, when I get bored I get frustrated, I pace up and down. You know when I’m bored and I get angry because, you know, the things I want to do I can’t do it. And they haven’t, they haven’t got the facility for it. And they say they can’t facilitate it because they’ve got no funding.... They do education but it’s like, you know, like, one hour a subject, three subjects only. You can’t, you know, they can’t fund more than that, they’ve got no money to pay for it’. Samuel (Lines 13 – 22 and 36 – 38)*

Some participants had made friends in the unit, so spent time with them playing games such as pool, which appeared to reduce boredom. However, the majority felt that they had been ‘thrown together’ with people that they had nothing in common with, as they came from a variety of backgrounds and cultures.

*‘I wouldn’t say that I’ve built up any close friendships since I’ve been in [name of unit], but I’ve sort of em, in a way kept myself to myself in some respects, but I know that everyone comes from quite different backgrounds’. Ben (Lines 337.1 – 337.5)*

***Theme 3: Restrictive environment***

The environment was described as restrictive, dull or claustrophobic, exacerbated for some by the lack of personal belongings.

*‘..the ward isn’t particularly open, em it’s quite a, they’re quite narrow corridors em and quite low ceilings which just exacerbates feelings of claustrophobia..... I think that not only does the environment make you feel bored but also because you’re bored you’re, you’re making note of what the environment is as well so it kinda comes hand in hand’. Harry (Lines 192. 29 – 34)*

Most participants were frustrated that smoking had been restricted to every two hours and banned in the grounds. This had reduced the amount of ground leave being taken which had been use to socialise with peers and reduce boredom.

*‘No, you’re not allowed to smoke on ground leave anymore.  It’s a terrible thing, I used to meet people off other wards to socialise with people, talk about stuff, but em it aint sort of, different environment and stuff like that.  I think it’s a terrible thing what they’ve done. I used to go on ground leave but now you’re not allowed to smoke I don’t go out anymore because it just seems pointless’. Luke (Lines 246.1 – 246.6)*

A few participants had Ministry of Justice permission to access community leave. This significantly reduced boredom, so they were frustrated that it was limited due to staff shortages.

*‘It’s just lucky I’ve got community leave ‘cause if I didn’t have that I wouldn’t be able to cope with it, you know’. Richard (Line 48)*

Most participants spent a lot of time with family and friends in the community, which prevented boredom. Maintaining this contact in hospital was important to them but was restricted to visiting times or telephone calls.

 *‘..or I’d be able to spend time with friends and family or my girlfriend em which means that I’m occupied, and my family do tend to visit me as often as they can but the visiting hour windows are fairly narrow here em, so they can’t always see me when they want, em and the other thing  that frustrates me is that you’re only allowed an hours visit and em when I’m with my girlfriend or a member of my family and we’re chatting the time does tend to fly by and an hour just doesn’t seem like enough’.* *Harry (Lines 186.1 – 186.7)*

***Theme 4: Responsibilities***

Several of the participants felt that a lot of day to day responsibilities had been taken away from them, resulting in less to do and increased boredom. Lack of responsibility contributed to some participants developing a passive role following admission, expecting staff to direct them or do things for them.

*‘Because you’ve got everything done for you. You don’t really have to do anything Well, you’ve got 3 meals a day. Em, you get your benefits money. All your washing and like bed linen and stuff is always clean. You only have to put it on your bed’. Clifford (Lines 63 – 72)*

Many participants described their frustration about the lack of control they had over their lives, often having to wait for clinical staff to make decisions. Some felt that gaining responsibility related to trust. Engaging in treatment such as occupational therapy was viewed as an important way to earn the trust of staff. This led to more responsibility and access to activities which helped them progress towards discharge, also reducing boredom.

*‘I’ve been recently granted em unescorted leave into the community and that’s works out better for me ‘cause I’m more relaxed. Yeah. Freedom. Yeah Well I think freedom, to my my view that is linked freedom to trust. If you’re trusted then you can get more freedom if there’s no trust then there’s no freedom then it can go downhill.... Yeah ‘cause you get more things to do if you’re trusted and you get more privileges and em you feel more happy within yourself’. Trevor (Lines 198 – 204))*

Taking on more responsibility by attending education sessions, therapy or participating in vocational rehabilitation helped participants to improve their self-identity. Most had been employed in unit jobs, although Richard, for example, worked in a charity shop in the community. All participants enjoyed the work, felt a sense of achievement, and saw it as a way to occupy their time, get off the ward and earn money. They were positive about the role and identity they had gained, viewing the experience as important for their future employment. Clifford describes how important his car washing job is to him:

*‘ Doing that makes me feel good. Yeah I get off the ward and em I don’t think too much I just do what I’ve got to do. I feel quite good about it. You know so staff will like it, you know, and so they’ll come back again. And another thing I’m kinda being paid for it as well so I purposively do it good just so they will come back and say, you know, it’s good like, you know… a bit of em responsibility And it’s a bit like, em well I suppose being grown up’. Clifford (Lines 111 – 132)*

Summary of findings

Participants have described how boredom can have a negative impact on their mental health and motivation. They have highlighted concern about the lack of meaningful activities available to them, particularly at weekends. Boredom is further exacerbated by basic responsibilities being taken away and restricted access to the community and their family and friends.

**Discussion**

This study illustrated some of the complex problems associated with boredom which are potentially detrimental to health and recovery. Although there is limited research in this area, the findings appear to support some of the previous research available. For example, Farnworth et al. (2004) and Shattell et al. (2008) also found that the restrictions of a secure environment created barriers to engaging in valued and meaningful occupations, limited choices and opportunities to develop roles. Additionally, participants’ experiences concur with the literature, that boredom can increase frustration and the likelihood of violence and aggression (Healthcare Commission, 2007; NICE, 2005).Further research is needed to explore this relationship, by measuring levels of boredom in relation to incidents of violence.

The instillation of hope was also important as this motivated participants to engage in activities. Lack of hope resulted in less participation in activities which for some led to non-productive hostile behavior. It is possible that this is why groups that were related to discharge or the future were perceived as more meaningful, and less boring by patients. This is an important finding for occupational therapists who are the primary providers of group work on inpatient/outpatient units.

Although the reasons are not clear, previous research has found that people with depression (Newell et al., 2012) or psychotic disorder (Watt & Vodanovich, 1999; Todman, 2003) are more boredom prone. This may be explained by the findings of this study, which suggest that lack of motivation, a symptom of depression and psychotic disorder is significant in increasing levels of boredom.. In this study it appeared to increase participants’ levels of sleep, and reduce their inclination to engage in activities. Furthermore, participants found that when bored they had more time to think, and this reportedly increased psychotic symptoms or feelings of depression. In contrast, some participants reported that during psychotic episodes they were not bored as the psychosis preoccupied them. These different perceptions of boredom between participants with positive and negative symptoms of psychosis would benefit from further research.

It is concerning that participants reported that roles and responsibilities are unnecessarily taken away from them, thus increasing their levels of boredom. For example, staff undertaking domestic activities of daily living for patients. This led to some participants becoming passive and unmotivated to initiate activities for themselves. However, a positive finding of this study is that participants found the vocational rehabilitation an effective way to reduce boredom, by providing them with meaningful roles and responsibilities.

The strongest theme that emerged from the data was a perception that there was ‘nothing to do’ in the unit, particularly at weekends. Similar to the findings of other studies (Farnworth et al., 2004; Shattell et al., 2008, Newell et al., 2012) it was evident that activities were available to participants, but they were either not meaningful, or did not have the right level of challenge leading to participants not wanting to engage in them. The importance of selecting and grading activities that are at the right level of challenge for patients is identified in the Vona du Toit Model of Creative Ability (De Witt, 2005). This occupational therapy model was developed in South Africa and is becoming increasingly popular in the UK. It provides a framework to evaluate a patient’s occupational performance and then guides the selection of treatment interventions with characteristics that are at the right level of challenge. Similarly, the Cognitive Disability Theory (Allen, 1992) which is often used with patients who have schizophrenia can guide selection of interventions at the right level of challenge. The model has a classification system which identifies what activities people are capable of at different levels, and the amount of support and assistance required in order to perform the activity.

 It could be argued that the theme ‘nothing to do’ is actually a combination of the other three emergent themes. For example, a restrictive environment, and reduced levels of responsibility, results in less for people to do. This finding is supported by the Model of Human Occupation (Keilhofner, 2008) which describes a dynamic process in which clients are motivated to engage in various occupations which are transformed into routines and habits, and performed capably within given social and physical environments. The environment interacts with these factors and should ideally include physical and social facilitators. Another environmental factor identified by participants was lack of access to family and friends, and lack of friends within the unit. There has been much research into the benefits of social skills training with people with schizophrenia. Although not established as effective within forensic settings the research has established that when the right training is linked to the phase of the disorder patients can learn social and independent living skills which can be generalized into everyday life if patients have the opportunities (Kopelowicz, Liberman & Zarate, 2006). An additional factor which had an impact on the social inclusion of the patients was that smoking had been banned within the unit and this had been a time which provided routine and social contact.

Conducting in-depth interviews was a useful way in which to develop a deeper understanding of the participants’ experiences of boredom. However, this method also presented challenges. For example, some of the participants were less articulate than others, so ensuring that their quotes were included in this paper was difficult. Furthermore, as clinicians, one of whom was working in the research unit, it was important to use reflexivity to minimise researcher bias, and potential blurring of therapist and researcher roles. During the research interviews, and later when transcribing and analysing data, it became evident that at times researchers had unintentionally reverted to a ‘therapist’ role, focused on the need of the ‘patient’ and not the ‘participant’. Arber (2006) also experienced the challenges of working as a practitioner and researcher, concluding that reflexive accounting is important for the credibility of the study. Tod (2010) suggests that it is difficult to avoid role conflict when conducting research interviews, particularly for clinicians. It is possible that the actions of the researchers may have changed the direction of the interviews, potentially losing valuable information. It is also important to consider the sociological context of this study. The power relations between the researcher and participants may have affected the interviews. Unit staff maintain security, whereas patients are detained, usually against their will. This has significant implications for power relations. Furthermore, Lykkeslet and Gjengedal (2007) argue that the relationship between researcher and researched is unequal, as the researcher has the power to use the information as she or he sees fit. These power relations may have affected both researcher and the participants’ actionsThe findings of this study suggest that a restrictive environment is a key factor which contributes towards levels of boredom. Although the study was undertaken in one of the most restrictive healthcare settings, it is possible that some of the restrictions will be evident in other clinical areas. For example, people in all inpatient services (physical and mental health) are likely to have limited access to meaningful occupations, roles and responsibilities. Further research is needed to find out the impact of boredom on health and recovery in all settings.

***Implications for occupational therapy practice***

Changing occupational therapists’ attitudes towards boredom will be challenging. It is important that they learn more about this complex issue through education or training. As this study was conducted in a forensic setting the findings may be discounted by occupational therapists working in different areas of mental health. Although the environment does demand a balance between therapy and security, the role has many similarities with occupational therapists in other inpatient settings. Duncan (2008) defines forensic occupational therapy as assisting people to develop their interpersonal capacity, pro-social values, their personal identity and skills for life participation. The prevention and management of boredom needs to be a priority for occupational therapists as they have unique, specialist skills in adapting and grading activities to meet the needs of individuals. They are also experts in supporting people to maximise their independent living skills, develop meaningful roles and responsibilities, all of which will prevent or reduce boredom.

The lack of a structured routine at weekends is a problem which needs to be addressed, as it is linked to an increase in boredom. The practice guideline *‘*Occupational therapists' use of occupation-focused practice in secure hospitals’ (College of Occupational Therapists, 2012) recommends that occupational therapy provide services seven days a week. This is not currently provided in all forensic services, and will have resource and cost implications. Services need to consider how to make the most effective use of the resources available.

This study has highlighted how important it is for patients to be able to access their hobbies and interests and maintain regular contact with family and friends. Doing so has a positive impact on reducing levels of boredom. Working in forensic services, with their security restrictions, will always present challenges for occupational therapists, however, they need to consider the creative ways in which they can support patients to do this.

***Limitations of study***

This study only involved one single forensic unit and therefore participant experiences may be specific to that unit. Furthermore, the study involved a small sample size and contained relatively specific inclusion criteria. Therefore, caution should be taken when relating these experiences to patients in other medium secure settings.

***Conclusion***

There is a paucity of research into the causes of boredom for patients in mental health services, and even less in secure settings. This study provides a valuable insight into the experiences of boredom from the perspectives of eight men with psychosis, detained in a secure unit. They described the negative effect boredom had on their mental health and believed that it exacerbated violence and aggression. A restrictive environment was found to limit access to meaningful occupations, roles and responsibilities which increased levels of boredom. It is possible that some of these factors may apply to any inpatient healthcare setting, where people are removed from their everyday lives, roles and responsibilities. Occupational therapists have the skills to prevent or manage boredom and should view this as an important aspect of their work which contributes to patients’ recovery and wellbeing.

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**Appendix 1**

**Boredom Study: Interview Questions**

|  |
| --- |
| **Guidance for Interviewer**: As this is a semi-structured interview, not all of the following questions have to be asked. However, you do need to check that by the end of the interview each of the ‘themes’ in Section B have been covered. Therefore, if these areas have not arisen during the board questions you can use the ‘themed’ questions as prompts. You can also spend longer on the sections that are most meaningful to the participant.  |

|  |
| --- |
| **State for the Tape**:*a. Today is DAY XX of MONTH, 2010 and the time is XXXX.**b. This is NAME speaking with research participant ID number XXXX.***Rewind tape back and play to ensure recording equipment is working correctly. Record ward of participant on interview notes.** |

|  |
| --- |
| **Introductory Prompt Script** Before we start I would like to thank you for your time and recap on why we are here today, and to answer any questions you may have. You have agreed to take part in a research project we are doing here looking at boredom. We would like to find out more about your experience of boredom, for example: how often you feel bored; what boredom feels like to you and what causes you to feel bored. I have some set questions I would like to work through with you but want to reassure you that there are no right or wrong answers – I would just like to hear what you have to say. I would also like to reassure you that what you tell me today will be treated in the strictest of confidence. However, if you tell me something that causes me to worry about you, or the wellbeing of someone else on the unit, I have a duty of care to discuss this with your multidisciplinary team. I will let you know if this is the case.We have set aside an hour to work through these questions but if you would like to stop at any point we can arrange another time to finish off. I would just like to find out about your experience of boredom and what you feel causes your boredom.I am going to be recording our conversation today but no one other than those involved in carrying out this project will have access to the tape recording or any information you provide. After we finish this session the tape will be typed up by Donna, who is our research assistant, but no one from your multidisciplinary team or nursing staff will know what you have said. The tapes will be kept locked away in a secure filing cabinet within the occupational therapy department. Once the research is completed the tapes will be destroyed in confidential waste. Also when we write up or talk about the findings of the study no one will be able to tell that you took part – your name will not be used.Please tell me if there is anything you do not understand or you want me to explain further. So before we begin are you still happy to take part in this research?  |

**Section A: Background Information**

**1). How old are you?**

**2). What ward are you on?**

**3). Approximately how long have you been here?**

**Section B: Broad Questions**

**1). How do you feel when you are bored?**

Prompt: i) Thoughts: what is going through your mind?

ii) Physical feelings: how does your body feel?

iii) Behaviours: what do you do? e.g. do you: fidget; pace; sleep; stare out the window; eat; drink; doodle; bite your nails.

Volition Questions: v2). If you are feeling bored, what do you do?

 v3). What have you tried to stop feeling bored?

 v4). What has and has not worked? Why do you think this is?

 v5). Does anything work? Why?

(Note: questions v2 – v5 are also under volition questions, Section B)

**2). How often do you feel bored?**

Prompt: if answer is vague try to establish daily/ weekly/ monthly. If still struggle to answer, start with question 7 below.

**3). When was the last time you felt bored?**

Prompt: can you remember a time when you did not feel bored?

**4). Can you describe where you were and what was going on the last time you were bored?**

**5). What time of day was it?**

**6). What else had you done that day?**

**7). What was your mental health/ mood/ feeling like at that time?**

|  |  |
| --- | --- |
| **General Prompt Questions** *(to be used at any point in interview)* |  |
|  Can you tell me/say a little more about that?  |  Why do you think this is? |

**Section C: Themed Questions**

|  |
| --- |
| **6 Main Themes**: ***Environment (e)*** ❑ ***Routine (r)*** ❑ ***Volition (v)*** ❑***Skills (s)*** ❑ ***Illness (i)*** ❑ ***Roles (r)*** ❑ |

***Environment*** *(2 questions)* ❑

**e1). Can you tell me a little bit about what it is like to live here.**

Prompt: physical environment on ward/unit; social aspect; living with other patients; staff; facilities available; room.

**e2). Do any of those things make you feel more or less bored?**

***Routine*** *(4 questions)* ❑

**r1). Can you describe a normal weekday and a Saturday or Sunday to me?**

**r2). Is there a day or time in the week that you experience boredom more frequently?**

Prompt: explore in more detail – why is this?

Linking Volition and Routine:

*Answer suggests no apparent routine:*

**r3). It sounds as if you don’t have much of a routine, why do you think this is?**

**How does this affect your boredom?**

**Have you had a routine in the past?**

*Answer suggests a structured routine*:

**r4). Have you ever experienced a lack of routine in your life?**

**If yes, how did this affect your boredom?**

**Have you had a routine in the past?**

***Skills*** *(4 questions)* ❑

**s1) What are your interests?**

**s2) Are you able to do them here? ->** *if answers ‘no’* **-> Why do you think that is?**

**s3) Do you ever experience boredom when you are involved in some kind of activity?**

**s4) Why do you think this is?**

Prompt: i) Speed of gratification: how quickly achieve outcome/satisfaction

ii) Level of mastery: mismatch - demand of activity and skill level i.e. too difficult/too easy.

iii) Flow: able to immerse oneself in the task

***Volition*** *(5 questions)* ❑

**v1). Do you have any goals for the next week / 3 months / year?**

Prompt: is there anything you want to get done or achieve this week/ within the next 3 months/ this year?

**v2). If you are feeling bored, what do you do?**

**v3). What have you tried to stop feeling bored?**

**v4). What has and has not worked? Why do you think this is?**

**v5). Does anything work? Why?**

(Note: questions v2 – v5 may have been covered under question 7, Section A)

***Illness*** *(3 questions)* ❑

**i1) When you are feeling (mentally) unwell what do you experience/ what are your symptoms?**

**i2) When feeling unwell do you feel more or less bored?**

**i3) Why do you think this is so?**

***Roles*** *(1 question)* ❑

Prompt: there are various roles people have in life, for example, father, son, brother, manager, worker, volunteer, carer, ward rep, patient, friend librarian, ward gardener.

**r1). Do you have any roles here?**

**END of INTERVIEW**: *Right that was our last question. Is there anything else you would like to say or add about what boredom means to you?*

|  |
| --- |
| **State for the Tape** *End of session with research participant ID number XX on DAY DATE MONTH, 2013.* |

|  |
| --- |
| **Reminder! Tape Change during Interview – State for the Tape** *This is tape 2 of the session with research participant ID number XX on DAY DATE MONTH, 2013 with researcher NAME.***Rewind tape back and play to ensure recording equipment is working correctly.**  |