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A Phenomenological Exploration of Challenges Faced by Nicotine Dependent Working Women Undergoing Mindfulness-Based Relapse Prevention

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Abstract

Objective

The objective of the study was to understand the challenges faced by nicotine-dependent working women who were undergoing mindfulness-based relapse prevention (MBRP) for smoking relapse prevention.

Method

In this qualitative study, recruitment, and screening of participants were done to meet inclusion criteria. The final sample consisted of eight working women who underwent eight weeks of MBRP. Interviews were conducted post-intervention, and challenges captured. Thematic analysis was conducted to analyze data.

Results

The themes that emerged as challenges within the session were transitioning through the program, challenges in the practice of mindfulness, and homework. Challenges outside the session included identifying, and coping with triggers, and cravings, and being mindful through them.

Conclusion

Though MBRP has seen benefits its does not come without challenges. These challenges can be overcome if practitioners address such within their sessions with the clients. These findings give scope for greater research in the area to showcase the best possible results in the space of smoking relapse prevention.

Keywords: Mindfulness-based relapse prevention, nicotine dependence, working women.

1. Introduction

Smoking is the highest cause of preventable deaths in the world **(World Health Organization, 2015)**. Tobacco is said to kill up to half of its users. The most widely

prevalent and most studied form of tobacco use globally, is cigarette smoking. Cigarettes kill one in two consumers prematurely, half of these deaths occurring during middle age (35 to 69 years) **(GATS,2010)**. Premature deaths due to tobacco addiction take place at alarming rates where one person is seen to die every six seconds **(WHO, 2010)**. Though the numbers are reducing, there is still a large smoking population **(WHO, 2017)**.

According to WHO, over 1.1 billion people were recorded as employees with nicotine dependence in the year 2015 **(WHO, 2015)**. As of 2013, an estimated 17.3 percent of working women were seen to be active cigarette smokers. The results showed varying smoking prevalence levels depending on the occupation and Industry **(Mazurek & England, 2016).**

Researches show that only 33 percent of self-quitters can stay off cigarettes for two days and less than five percent can quit cigarettes **(APA,1996).** Many management techniques have been suggested to work for relief from nicotine dependence. This ranges from behavior therapy, education/support groups, exercise, hypnosis, nicotine fading, nicotine replacement therapy, and so on **(APA,1996).**

Nicotine is seen to have properties that are similar to those seen which culminates in the abuse of drugs. It is seen to stimulate and give rewarding experiences. Depending on how the substance is taken, the effects differ. Nicotine that can be seen in varying levels in tobacco has addictive properties that are as addictive as heroin or cocaine. The physiological andbehavioral changes that lead to tobacco addiction are similar to those of heroin or cocaine addictions **(WHO, 2010)**. The other rules of addiction that it adheres to include the physiological withdrawal when cessation takes place, a tolerance that is seen to increase with continuous intake, and the substance which becomes a consuming necessity **(Spitzer, 2006).**

Smoking among women

Six percent of the world's female population smoke cigarettes (Ritchie, 2019). Currently, two percent of Indian women smoke **(GATS, 2018).** India is said to have the second- highest number of female smokers globally after the US **(Sinha, TOI, 2014).** There is an increase in the number of female smokers in India despite a global decrease in smoking behaviour**(Ng, Freeman, Fleming, Robinson, Dwyer-Lindgren, Thomson, et al., 2014).**Overall smoking among women is seen to have doubled in India from 2005 **(Roy & Goel, 2015).** 17.3 % of working women were reported to be active cigarette smokers in India **(National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014)**. The results showed varying levels of smoking prevalence depending on occupation and industry **(Mazurek & Engl, and, 2016).**

More working women are smoking due to peer pressure and stress **(Rawat, Times, 2018).** Women employees under stress are prone to addictions. Levels of stress and personality make them more susceptible to develop smoking habits**(Mishra, Majmudar, Gupta, Rane, Hardikar & Shastri, 2010; Mohanty & Madhumita, 2014).** The levels of stressand their personality makes them more susceptible to taking to smoking**(Mishra, Majmudar, Gupta,**

Rane, Hardikar & Shastri, 2010; Mohanty & Madhumita, 2014). Addictions are seen to develop in such a population, where there are high disposable incomes at a very young age, and smoking is looked at by them as a quick-fix solution to their stress problems. Young women professionals living away from family, pop culture, newfound freedom, and high stress jobs are seen to make working women take to smoking in Bangalore **(Anien, DH News, 2018).**If this trend is not sustained smoking is likely to rise by 20% by 2025 **(Mackay & Amos, 2003).**

Effects of smoking among women.

Smoking affects menand women differently. The reinforcing effects of the nicotine urge men to smoke whereas women smoke to regulate mood or in response to cigarette-related cues **(National Institute of Drug Abuse (NIDA), 2020).**

There are various negative effects of smoking on women. Women may be more susceptible to smoking-related morbidity and mortality **(Allen, Oncken, & Hatsukami, 2014).**The risk of lung cancer is 20 times higher in women who are heavy smokers **(National Jewish Health (NJH), 2020).** Women who smoke have higher rates of asthma **(Chen Y, Mai X-M, 2011).** Smoking is directly linked to 80 % of Chronic Obstructive Pulmonary Disease (COPD) deaths in women each year and has a greater risk of strokes **(NJH, 2020).** Smoking also ages women. Smokers have more facial wrinkles, gum disease, dental decay, and halitosis (bad breath) **(NJH, 2020).** Women smokers are more likely to be depressed than non-smokers**(NJH, 2020).**Cigarette smoking has many adverse reproductive and early childhood effects, including an increased risk for infertility, preterm delivery, stillbirth, low birth weight,, and sudden infant death syndrome (SIDS)**(NJH, 2020).** Changes have also been seen in the sex hormones in women who smoke **(Bjarnason, Jorgensen, Christiansen, 2012).**Women smokers often have symptoms of menopause about three years earlier than non-smokers**(NJH, 2020).**Postmenopausal women who smoke have lower bone density than women who never smoked **(NJH, 2020).**

Quitting and relapse among women

35.5% of the smoking women population in India have attempted to quit out of 46.4% who were contemplating doing so (GATS, 2018). Only 16.8% of women daily smokers have quit **(GATS, 2018).**Relapse rates are said to be between 60% to 90% within the first year, but drop significantly post the second year **(Schayck, Tuithof, Otten, Engels, Kleinjan, 2019).**Relapse rates are higher in women due to high cortisol levels which are predictive of relapse **(al'Absi, Nakajima, Allen, Lemieux, Hatsukami, 2015).**Research suggests that women experience stronger cravings than men in response to stress **(Wray, Gray, McClure, Carpenter, Tiffany, Saladin, 2015)**. Causes for relapse among women vary from that of men, and include stress, weight control, and negative emotions**(NJH, 2020).** Evidence suggests a conducive work environment is positively associated with cessation, and negatively with relapse **(Albersten, Borg & Oldenburg, 2006).**

Mindfulness

Mindfulness is the art of being in the present. “Knowing what you are doing while you are doing it is the essence of Mindfulness practice” **(Kabat-Zinn, 1990).** Mindfulness has been developed from the meditative technique Vipassana, which is an established Buddhist meditative practice **(Kabat-Zinn, 1990).** Mindfulness helps bring awareness to one's thoughts, emotions, and sensations **(Kabat-Zinn, 1990).** Mindfulness helps the practitioner to attend to their bodily sensations, and allows them to pass non-judgmentally, and objectively **(Kabat-Zinn, 1990).** Practitioners attend to their sensations at the present moment. Mindful living will lead an individual to live a life where stress can be managed, and life can be more peaceful (**Sathiyaseelan & Sathiyaseelan, 2014)**especially for working women**(Soumya& Sathiyaseelan,2021).** Mindfulness is being used as a therapeutic intervention to reduce symptoms of various disorders, and in turn, increase functionality **(Langer & Moldoveanu, 2000).** Research shows mindfulness is needed more in women than in men due to the stress they incur from multitasking **(Cabrera, 2016).** Research shows that mindfulness practise has helped reduce nicotine intake considerably by reducing craving, and withdrawal **(Cropley, Ussher, & Charitou, 2007)**

Mindfulness- based relapse prevention

Mindfulness-based relapse prevention (MBRP) has been developed by Bowen, Chawla, Marlatt at the Addictive Behavioral Research Center, by integrating three different therapies, Mindfulness-based stress reduction by Kabat-Zinn, mindfulness-based cognitive therapy by Segal, Williams, and Teasdale, and the relapse protocol by Daley, and Marlatt. It has been seen to have greater success in relapse prevention than other forms of treatment **(Bowen, Chawla & Marlatt, 2008).** MBRP helps in bringing mindful awareness to individuals suffering from addictions. Such awareness is brought by being aware of triggers, destructive habitual patterns, and automatic reactions that take control. The exercises integrated into MBRP help the practitioner pause, observe the present experience, and bring awareness to the range of choices available, before acting on the same. Such choices make one respond in ways that are better for the individual rather than ways that are detrimental by nature. MBRP helps the individual become free from addictive bondages. These skills are combined with traditional relapse prevention practices to develop effective coping mechanisms, increasing self-efficacy, and being able to recognize triggers, and antecedents to abuse of the substance **(Marlatt et al, 2008).** The focus is not on doing what is right or making better decisions but rather is on ‘just being in the moment' **(Segal, et al, 2002).** The treatment mainly revolves around identifying the individual's high-risk situations where relapse is more prone to occur. This is done by being able to recognize early warning signs for relapse, and increase awareness of triggers such as people or places that relate the individual to the substance use. The practice of mindfulness provides practitioners with new ways of processing risky situations, and environmental cues **(Marlatt, Bowen, Chawla & Witkiewitz, 2008).** MBRP is used in various forms of addiction, and shows positive results for long- term relapse prevention **(A.Vadivale & A. Sathiyaseelan, 2018).**

The primary goals of MBRP are to become aware of personal triggers, and spontaneous reactions, and create ways to pause before following automaticity, have a better understanding of discomfort, and recognizing difficult emotions or sensations, and responding to them with more skill, learn to be non-judgmentalandcompassionate to oneself, and build a lifestyle that supports both mindfulness practiceand recovery **(Marlatt, 2002).**

The MBRP program is an eight-week closed group intervention program. The size of the group can vary from six to twelve participants. Each session is timed for two hours where a new part of mindfulness is introduced, andpracticed, and homework is discussed, and given. Several research studies on different groups prove the eight-week MBRP program beneficial for relapse prevention in addictive behavior. Each session of MBRP is developed in progression, and has a specific purpose, and outcome.

2. Need and objective of the study.

Nicotine dependence is seen to be the highest amongst all other substance dependencies. Working individuals are seen to be more prone to substance dependence, and statistics show that working women have higher rates of cigarette consumption **(The Indian Express, 2009).** Though various techniques have been established for helping people who have quit smoking especially on their own, relapse rates amongst such self-quitters are still seen to be very high with a meager five percent of the population being able to abstain without any intervention **(WHO, 2015).** Such high relapse rates especially amongst self-quite attempts show the need for relapse prevention treatments. MBRP is seen to show results when it comes to the prevention of relapses with different types of addiction **(Bowen, Chawla, Marlatt, 2008).** Such relapse prevention interventions though have seen benefits do not come without challenges. This paper looks at the challenges faced by nicotine-dependent women who have quit on their own and have gone through an eight-week MBRP intervention to prevent relapse.

The primary objective of the qualitative study is to gain an in-depth understanding of the challenges faced by the participants undergoing MBRP therapy thus helping the intervention providers to be aware of such challenges, and work with their clients on the sameand gain effective results.

3. Material and Method

Aim

The main aim of the study was to understand the participants' challenges through the eight-week program and how these challenges may influence relapse prevention among working women who smoke.

Sampling technique, screening, and sample.

Purposive sampling was carried out on the population that consisted of working women between the age of 25 to 45 years who consumed between 10 and 20 cigarettes a day and indulged in the habit for at least one year.

Sampling procedure. Recruitment of participants was undertaken by advertising

information about the research on social media. Information on the study was also sent out through the companies' Human Resources department. In addition to these methods, the researcher also shared information on the study for recruitment through WhatsApp with personal and professional contacts.

Participants. 33 individuals contacted the researcher stating that they were willing to participate in the study. 12 Participants did not meet inclusion criteria. The fourteen participants who fit the inclusion criteria and appeared interested were then screened. This included the provision of an informed consent form. The screening also included an assessment of the individual's general health and levels of nicotine dependence. The final sample consisted of eight working women. Participants were asked to quit smoking at set their own quit date before the start of the intervention. All participants quit within one week before the start of the intervention.

Screening tools

The following tools were used for screening the participants.

- *General Health Questionnaire, 28 item version* **(Goldberg, 1978)**
- *The Fagerstrom Test for Nicotine Dependence (*FTND) **(Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991).**

Tools

Data for the qualitative analysis was collected through semi-structured interviews. Interviews were conducted on the completion of the intervention.

Data analysis

Thematic analysis was conducted to analyze data. All interviews were recorded with the permission of the participants. Each interview was and coded to elicit themes.

Ethical Considerations.

The research was granted clearance from the university and all ethical guidelines for safe research duly followed. Informed consent was received from all participants

4. Results and discussion

Post data analysis it was noticed that though MBRP proved to have benefits on smoking relapse prevention, undergoing this form of alternate intervention did come with its set of challenges. Challenges were seen to be 1) smoking-related challenges, 2) session related challenges, and 3) practice related challenges. These challenges were under the broader spectrum of challenges within and outside of the session.

Challenges within MBRP session.

The challenges that emerged through the program sessions were seen to be as follows.

Transition through the program concerning personal and professional life. A challenge that was identified by the participants was the transition through the program both personally and professionally. The transition was not seen to be easy in other studies where there was seen to be resistance to change and inconsistency within the group which developed into a challenge for the program **(Haig, 2017).** Though the overall transition was not seen to be overwhelming certain triggers were difficult to pass through. As narrated by one participant "only those times when I had triggers like the end of long meetings and all where I felt like actually smoking. But I was able to stay away." The participant went on to say that the journey was difficult and a lot of work had to be put in.

Mindfulness practice. Apart from not falling into the cycle of relapse being a challenge, the program itself had its own set of challenges as stated by the participants. The practice of mindfulness was seen to be a challenge by all participants. Having never experienced any form of meditation in the past, concentrating on bodily sensations and breath was seen to be most challenging. Daily practice was seen to be a challenge. Setting aside a scheduled amount of time every day to practice mindfulness had emerged as being difficult. Participants found it challenging to sit and concentrate on the body and breath for longer periods without getting bored or distracted. Falling asleep during practice was another challenge with practice. The process of meditation was not found to be easy by the participants and as stated by them needed effort. Participants felt that meditation could be altered to suit their needs and timings, instead of having long sessions of daily mindfulness there could be smaller practice sessions over different periods during the day.

Home-work. The next challenge that emerged through the program was keeping up with the homework. There were mixed opinions about home worksheets where half the participants felt they found out more about their cravings and triggers while filling in tracking sheets and doing homework sheets. Other participants found it difficult to keep up with the homework and missed out on filling in data that could help identify and overcome triggers and help in altering thoughts about smoking.

Challenges outside of MBRP session.

The sessions alone did not come with challenges. Participants did find challenges outside of the sessions as well.

Identification of cravings and triggers. Having identified what influenced the participants to stick to the habit, identification of cravings at the beginning of the program was a challenge. It was seen that at the start of the program the participants had trouble identifying what their triggers were. The main triggers were identified as stress and any other negative emotional state. This identification became easier by the end of the eight weeks where individual participants found their understanding of cravings and hence its identification becomes easier.

Coping with triggers and cravings. It was seen that participants did not find quitting as hard as staying away from cigarettes. Participants stated that quitting was not the difficult part but keeping away from cigarettes was difficult. Though trigger identification was made possible through MBRP, such became a challenge for the participants. Trigger identification and craving were part of the intervention which was looked at and overcome with great difficulty. Participants stated that stress and peers were the most difficult triggers to get past and cravings that arose out of these situations were the most difficult to pass. The next on the list of challenges was seen to be social events. When it came to triggers to do with smoking social events where alcohol consumption was involved triggers were high. Research showed that when at social events especially at bars where there is alcohol involved there are higher chances of individuals wanting to smoke **(Milton, Woods, Dugdill, Porcellato, & Springett, 2008)** this is mostly because alcohol increases impulsive behaviorand increases levels of socialization thus making individuals who watch friends smoke also want to smoke.

Being mindful through the triggers and cravings. MBRP equips individuals to be mindful once they can identify what their triggers are, what craving feels like and what are their automatic responses. It also helps them to understand these responses and alter such negative responses by being mindful of such triggers and cravings and not reacting in autopilot mode. Being mindful helps the individual by teaching them to pause, using observation of bodily sensations rather than reacting in autopilot mode. This though practiced during a session was seen to be a challenge to practice outside the session. It took participants some time to get used to the practice and was seen to be most difficult during high- risk situations. Certain participants felt that though they were able to go through the exercise like urge-surfing during the session it was difficult to put it in practice outside when they were in an actual high-risk situation.

5. Conclusion

Individuals who go through MBRP for smoking relapse prevention do see positive results, but these results do not come without their set of challenges. Individuals do find challenges that are within the sessions as well as outside the sessions. Though MBRP was seen to have various positive results on nicotine-dependent working women, challenges that are faced by the population could deter the progress made and there could be a failure in achieving the ultimate goal of relapse prevention. Understanding challenges would help practitioners structure treatment plans and prepare clients. Overcoming such challenges would help see better results in treatment. Continued follow up yield better results. Overall, if strategies to overcome these challenges are put in place MBRP could be more successful as a non-invasive alternative form of treatment that could help individuals who quit smoking on their own and want to avoid a relapse.

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