PSYCHOLOGICAL TREATMENT OF TOBACCO ADDICTION IN SMOKERS WITH PERSONALITY DISORDERS

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In this paper we analyze some basic characteristics of personality disorders and look at how to approach psychological treatment for smoking cessation in these individuals. The main general objectives are: the establishment of an adequate therapeutic climate in accordance with some of the traits typical of each disorder, such as suspicion or impulsivity; the management of negative emotions associated with smoking, such as anger or anxiety; training in relapse prevention, focusing on ineffective coping strategies and lack of social support; and the improvement of treatment adherence in these smokers. We conclude that the presence of a personality disorder need not be a reason for the failure of psychological treatment for tobacco addiction.
Key words: Personality disorders, Smoking cessation, Psychological treatment.

En el presente artículo se analizan algunas características básicas de los trastornos de la personalidad y de cómo enfocar el tratamiento psicológico para dejar de fumar de las personas que los tienen. En líneas generales, los objetivos básicos serían: el establecimiento de un adecuado clima terapéutico asumiendo algunos de los rasgos típicos de cada trastorno, como la desconfianza o la impulsividad; el manejo de emociones negativas asociadas al consumo de tabaco, como la ira o la ansiedad; el entrenamiento en prevención de la recaída, centrado en estrategias de afrontamiento ineficaces y la falta de apoyo social; y la mejora de la adherencia al tratamiento de estos fumadores. Se concluye que la presencia de un trastorno de personalidad no tiene por qué ser sinónimo de fracaso del tratamiento psicológico de la adicción al tabaco.
Palabras clave: Trastornos de la personalidad, Dejar de fumar, Tratamiento psicológico.

Cigarette smoking is one of the most significant health problems today, responsible for millions of deaths worldwide each year. Fortunately, efficient treatments, both psychological and pharmacological, are available, enabling all smokers to receive help for giving up (Comité Nacional para la Prevención del Tabaquismo, 2008; Fiore et al., 2008).

Within psychological treatments for smoking cessation, those that have proved most effective are multicomponent psychological treatments (Becoña, 2003, 2004). These would include motivational techniques, specific techniques for giving up smoking and techniques focused on the prevention of relapse (Agencia de Evaluación de Tecnologías Sanitarias, 2003; Becoña et al., 2001; Fiore et al., 2008). According to the latest clinical guide published in our country, based on the scientific evidence for the treatment of smoking addiction (Pereiro, Becoña,

Córdoba, Martínez, & Pinet, 2008), the psychological treatment of choice would be one which covered these three basic areas, applied in individual or group format.

In recent years, a large part of the research into smoking cessation has focused on determining which variables are most relevant for predicting short and long-term abstinence. Notable among these are the presence of associated psychopathologies such as anxiety and depression (Becoña & Míguez, 2004; Fiore et al., 2008) and, more recently, personality disorders (Fernández del Río & Becoña, 2010). In general terms, it appears that smokers with psychopathology are more likely to initiate and maintain the smoking habit, and also find it more difficult to give up. Various explanatory models have been proposed to identify the causes of the relationship between tobacco dependence and other mental disorders. The first hypothesis is that smoking constitutes a risk factor for the development of other mental disorders. Secondly, nicotine could be used as self-medication for the symptoms characteristic of Axis I and Axis II disorders. Finally, there may be a common factor (e.g., genetic

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vulnerability) contributing to tobacco dependence and the appearance of other mental disorders (Kalman, Baker, & George, 2005).

Although research on the relationship between personality disorders and smoking is relatively recent, results published to date with respect to the prevalence of these disorders in smokers are highly inconsistent, with figures ranging from 9% (Black, Zimmerman, & Coryell, 1999) to 45% (Lasser et al., 2000). This enormous variation may be due in part to the methodology used in these studies (e.g., different assessment instruments, extremely heterogeneous samples, differences in the consideration of smoker status, or differentiation between smokers according to nicotine dependence). Although there is no agreement with respect to the most frequent type of personality disorder in smokers, the majority of studies agree that Cluster C disorders would be the most common, followed by those of Cluster B (Grant, Hasin, Chou, Stinson, & Dawson, 2004; Moran, Coffey, Mann, Carlin, & Patton, 2006). As to the influence of personality disorders on smoking cessation, the results are far from conclusive (Covey, Hughes, Glassman, Blazer, & George, 1994; Fernández del Río, López, & Becoña, 2010a; Perea, Oña, & Ortiz, 2009). While Covey et al. (1994), for example, found no significant relationship between smoking and attempts to give up and antisocial personality disorder, other more recent studies have found that at least certain disorders, such as avoidant, self-destructive, passive-aggressive, schizotypal and borderline (Perea et al., 2009), and dependent (Fernández del Río et al., 2010a), have a significant effect on therapeutic intervention when these individuals decide to stop smoking.

Despite the complexity involved in the diagnosis and treatment of personality disorders, we should not ignore it when dealing with someone who needs treatment for addictive behaviour, of which smoking addiction is an example. We should also take into account that although psychological treatment for smoking addiction have a common denominator, each personality disorder is characterized by a series of traits that should guide our intervention. The final goal is undoubtedly to improve the efficacy of treatment, raising the percentages of abstinence in the short and long term and increasing patients' adherence to treatment.

In this article we analyze the principal characteristics of Cluster A, B and C personality disorders, and how the different stages of psychological smoking cessation treatment (preparation, quitting and maintenance) need to be adapted to these characteristics, in line with research and with our clinical experience with these disorders.

THERAPEUTIC APPROACH TO SMOKERS WITH CLUSTER A PERSONALITY DISORDERS

Cluster A personality disorders include paranoid, schizoid and schizotypal disorders, The individuals in question would be described as "strange" or eccentric (American Psychiatric Association [APA], 2002). In general, these smokers need a suitable therapeutic environment, in which their initial distrust or suspicion is accepted (Millon & Davis, 1998), as well as a certain level of initiative on their part (which, in principle, they lack) to analyze the behaviours and beliefs that are keeping them smoking.

Paranoid personality disorder

This disorder is characterized by a pattern of permanent distrust and suspicion in which the person interprets the intentions of others as malevolent (APA, 2002). These individuals tend to distort events in an irrational manner, and actively resist external influences (Belloch & Fernández-Álvarez, 2002). Given their exaggerated concern about the confidentiality of the data they are providing (Oldham, Skodol, & Bender, 2007), it will be necessary to stress that this is guaranteed, and in writing (e.g., in a contract signed by both parties).

Working with smokers who have a paranoid disorder is similar to working with any other patient in the precontemplation stage of change (e.g., encouraging individuals to reflect rather than to discuss or increasing their doubts or worries about smoking, using the motivational interview for this purpose; Rollnick, Miller & Butler, 2008).

In the event that we decide to include smokers with these characteristics in group treatment, it is essential to make them see that, despite the group format, their treatment is individualized. If the smoker understands that others have failed he/she may think that it is not worth continuing with the treatment and will drop out prematurely. We should also take into account their inherent tendency towards a polarized view of the world (all or nothing) and work on this aspect from the outset (Millon, 2006). It is important to make the smoker understand that many concepts are best seen as a continuum rather than in black and white terms, and that one failure does not mean that everything is bad (e.g., "if I feel the urge to smoke at the end of the treatment, it means I have failed").

Other basic components of their treatment are successive approximation to achievement of specific goals (e.g., clear and attainable objectives from session to session) and exploration of their irrational beliefs and their self-efficacy, given that they are prone to seeing themselves as incapable of achieving self-control, attributing behaviour they cannot control to external causes (e.g. "I can't control the desire to smoke when a colleague at work makes me angry") (Beck, Freeman, & Davis, 2005).

Finally, we need to be careful with reinforcement of achievement, since this can be misinterpreted as false or ill-intentioned, leading to rejection of the therapist (Martínez & Trujillo, 2003). In principle, these smokers should only be praised, in contingent fashion, for real progress (e.g., in the case of a reduction in carbon monoxide levels relative to the previous session).

Schizoid personality disorder

This personality disorder is characterized by a general pattern of lack of interest in social relationships and restricted emotional expression. It is uncommon in clinical practice (Millon, 2006; Roca, 2004).

First of all, we need to consider that this type of smoker may be using nicotine as an escape route when faced with a problem, given its highly reinforcing effects. Furthermore, it is possible that for them social dependence on nicotine is less important, and that they prefer to smoke alone. Taking these aspects into account, during treatment we should encourage activities they can do alone and which are incompatible with smoking (e.g., going to the cinema, walking). As in the case of paranoid disorder, we need to avoid early confrontations and to improve the individual's perception of self-efficacy from the very first treatment session (Millon & Davis, 1998). This can be achieved by showing them explicitly how each task they do and each goal they achieve refutes their notions of their own inadequacy.

It should also be borne in mind that, in these smokers, relapses are likely to be triggered by internal variables of an emotional nature (e.g., distress, worry, stress), rather than external variables (e.g., being surrounded by other smokers) (Beck et al., 2005). It follows that self-control training should focus less on skills of rejecting offers, for example, than on emotions and cognitions (especially negative ones) that have helped maintain their smoking over time (e.g., "smoking relaxes me"). Likewise, special care must be taken with depressive symptomatology after cessation, since it could trigger relapse (Hughes, 2007).

Schizotypal personality disorder

This disorder is marked by a limited capacity to establish close personal relations, as well as by the presence of cognitive or perceptual distortions and eccentric behaviours (Oldham et al., 2007).

As regards treatment, it should be taken into account that the tendency of these individuals to suspect everyone and everything may extend to the therapist. Therefore, the first step, in the initial assessment, is to determine whether or not one has the patient's trust (Caballo, López-Gollonet, & Bautista, 2004a). If we do not develop strategies to ensure their cooperation (e.g., accepting their affective inadequacies, strange beliefs or suspicions as normal), it is quite likely that they will not even attend the first treatment session (Martínez & Trujillo, 2003).

The setting of objectives must be negotiated with the smoker and, as in the case of other Cluster A disorders, these must be realistic, attainable, and with clearly defined deadlines (e.g., in six sessions you will stop smoking) (Millon & Everly, 1994).

Their dysfunctional beliefs about their own worth or self-efficacy can be modified through "behavioural experiments" (e.g., if individuals maintain that they will not be capable of delaying the first cigarette of the day, they are encouraged to try by preparing the situation: leaving the cigarettes far away from the bedroom, for example in the letterbox at the front door, going straight into the shower after getting up, etc.) (Beck et al., 2005; Becoña, 2007).

THERAPEUTIC APPROACH TO SMOKERS WITH CLUSTER B PERSONALITY DISORDERS

This cluster includes the antisocial, borderline, histrionic, and narcissistic disorders. These are individuals who would be considered erratic, dramatic and unstable (APA, 2002). In general terms, smokers with this kind of personality disorder will need to acquire strategies for controlling negative emotions such as aggression or anger, strongly associated with smoking (Kahler et al., 2009).

Antisocial personality disorder

Although this diagnostic category includes a quite heterogeneous group of patients, this disorder is characterized by a behavioural pattern based on contempt for others and the violation of their rights (Millon & Davis, 1998; Roca, 2004). Together with borderline disorder, it is clearly one of the Axis II disorders with the

most negative implications and which is most difficult to treat.

The treatment of antisocial smokers must begin by underlining the limits and the behaviour expected of the patient and the therapist. For this purpose, an acceptable behaviour contract can be drawn up, clearly delimiting the roles and commitment of both parties (Becoña, 2004).

These individuals tend to be quite impatient to achieve results (Caballo & López-Torrecillas, 2004), which means that they need training in planning for the short term (e.g., carrying out first-session tasks) and long-term (e.g. achieving abstinence).

Equally important is the behaviour of the therapist, who at no point should allow him/herself to feel manipulated or attacked (Millon, 2006). It is not unusual for the antisocial smoker to challenge and question the efficacy of treatment. Reacting in an authoritarian, rigid or demanding manner will give the patient the perfect excuse to discontinue the treatment.

We should emphasize the control of impulses, as well as the management of negative emotions such as aggression and anger, through training in specific approaches (identification of factors or events that can trigger aggression or anger, problem solving, etc.) (Becoña, 2007). These individuals tend to have a low frustration threshold and a high degree of impulsivity, so that they react in a disproportionate manner to certain situations (people laughing at them when they say they are going to quit smoking, suffering a relapse because of a trivial argument, etc.).

Finally, the use of alcohol should be noted as an important risk factor for relapse, given that antisocial disorder is strongly linked to substances like alcohol (Echeburúa, Bravo de Medina, & Aizpiri, 2007; Goldstein, Dawson & Grant, 2010). If this variable is not taken into account before starting the treatment and throughout its duration, relapse into smoking is highly likely to occur.

Borderline personality disorder

This is characterized by a marked instability that affects practically all aspects of functioning in those who present it (interpersonal relationships, self-image, feelings, behaviour, etc.). It is one of the diagnostic categories that has given rise to most conceptual problems and research (Caballo, Gracia, López-Gollonet, & Bautista, 2004; Millon & Davis, 1998). Together with antisocial disorder, it is one of the most prevalent in addictive behaviours

(Martínez & Trujillo, 2003; Tenorio & Marcos, 2000). Nevertheless, it should be borne in mind that there are different profiles of borderline disorder, and that, for example, not all of them are equally impulsive (Fernández del Río, López, & Becoña, 2010b).

With cases of borderline personality disorder, the patient-therapist relationship is fundamental. It is necessary to consolidate cooperation from the outset, so that smokers do not feel the threat of abandonment if they fail to meet the therapeutic objectives (Millon & Everly, 1994). To capture their attention and trust, we might describe our experience in the psychological treatment of smokers, thus reinforcing their positive expectations toward the treatment. Nevertheless, we must always remember that the patient is responsible for his or her treatment, as well as guarding against excessive familiarity.

With regard to treatment, there are various key aspects that will help us with smokers with borderline disorder. Their tendency to think in terms of "all or nothing" may lead them to express beliefs of the type "I will never quit smoking" or "I will always have an irresistible craving for cigarettes." This, together with the strong impulsivity that characterizes them, can make it difficult to achieve abstinence (Perry & Carroll, 2008). Our task will be to show them that this way of thinking will not only make them feel worse about themselves, but may also lead them to what they most fear: relapse (Millon, 2006).

It is useful to employ strategies that involve action, such as tasks to carry out at home (e.g., quitting smoking in one room of the house or keeping a record of one's cigarette consumption), strategies involving imagination (e.g., working on their image as a non-smoker) and strategies of information encoding and processing (e.g., training in problem-solving) (Becoña, 2007). In patients that present a deficit in control of impulsivity, the control of impulses should also be worked upon, previous research having shown that impulsivity is a key variable in predicting relapse (VanderVeen, Cohen, Cukrowicz, & Trotter, 2008).

We should also work with these patients on their "fear of change," since moving from smoker to non-smoker would mean the end of the treatment, which is terrifying for many of them (Beck et al., 2005; Becoña, 2007). Patients with borderline disorder may start smoking again after achieving abstinence not only because of the craving for tobacco, but in an attempt to show that the problem has not been solved and that they need more help. Finally, it

is necessary to take into account the feeling of emptiness typical of this personality disorder as a risk factor for relapse (Millon, 2006). To address this it may be helpful to include in the treatment guidelines for dealing with negative affect (e.g., detection of events or facts that trigger negative emotions such as anxiety or sadness; doing pleasant activities).

Histrionic personality disorder

This disorder is characterized by excessive emotionality and a pronounced need to be the centre of attention (APA, 2002; Roca, 2004). These individuals tend to come across as dramatic and unstable, rambling and with difficulties for focusing their attention. Given that the task of keeping self-registers may seem to them boring and absurd, they will need to be made aware its potential benefits (e.g., the self-observation process helps to control their impulsivity). It is very important to praise them so as to reinforce their achievements from session to session.

Since it is important to these individuals to receive approval and attention from others (Caballo, Bautista, & López-Gollonet, 2004a), group treatment may be a particularly effective format. If their contributions are too long, interrupting and hindering the participation of others (Beck et al., 2005), the therapist may need to insist on keeping to the rules according to which this kind of treatment functions (Becoña & Míguez, 2008).

Finding out about their personal relationships is also recommended, as these can influence their ability to maintain cessation. If we detect that people in their environment encourage them to smoke, offering them cigarettes, for example, or belittle their efforts, we will need to work on their assertiveness (e.g., learning to say no, transmitting to the other party that they understand why they might question their ability to quit smoking but without renouncing their own decision to try and quit).

Equally important are the mistaken beliefs of these smokers regarding the social image of smoking. They may well believe that "smoking makes them look good," giving them a sophisticated image which is important to them (particularly in the case of women smokers). If this erroneous belief is not addressed, it is possible that they will fail to achieve abstinence or to maintain it. This can be worked on, for example, by highlighting the fact that smoking causes premature ageing, yellowing of the teeth and fingers, body odour, and so on (Becoña, 2007).

Finally, regarding relapse, two aspects should be mentioned. First, these individuals tend to lose interest rapidly, which may lead them to drop out of the treatment before significant changes are achieved (e.g., leaving the programme after quitting, without attending the sessions reinforcing abstinence). To prevent this we should work on goals that are really important for them that allow them to obtain short and long-term benefits (Millon & Davis, 1998). And second, given their tendency to dramatize (Oldham et al., 2007), they may exaggerate withdrawal syndrome symptoms and thereby justify taking up smoking again, or, having quit, exaggerate the benefits obtained through the treatment, which would lead them to underestimate the subsequent temptation to smoke and how to deal with it.

Narcissistic personality disorder

A general pattern of grandiosity and the constant need for admiration, as well as a marked lack of empathy and an arrogant and superior attitude, are characteristics of this personality disorder (Caballo, Bautista, & López-Gollonet, 2004b).

These individuals usually begin treatment at a stage called "anti-contemplation," whereby they are openly opposed to change (e.g., "nobody can get me to stop smoking") (Beck et al., 2005). Avoiding direct confrontation, their ambivalence should be accepted as normal, and we should explore with them the balance of pros and cons (e.g., pros and cons of smoking or of being a non-smoker) (Becoña, 2007).

Given their low tolerance to frustration, it may be more necessary than in other disorders to assess these patients' expectations prior to treatment (Witkiewitz & Marlatt, 2007). Goal-setting should be realistic, and there should be an analysis of their beliefs about the success of the treatment. Their tendency to compare themselves with others, to underestimate the need for effort and to overlook the importance of small achievements may lead them drop out of the treatment prematurely.

As in the case of histrionic disorder, these individuals give great importance to their own image because it is, so to speak, the "protective armour" of their self-esteem (Beck et al., 2005). This aspect can be exploited by emphasizing how much their physical appearance will improve once they stop smoking. Another key aspect is that they think of themselves as "special", quite different from "ordinary people". We can use this as a therapeutic tool by stressing the social success they will have when they quit smoking, and how good they will feel about themselves (e.g., especially if someone close to them has

cast doubt over their ability to quit). They need to see that giving up smoking and changing their lifestyle is a decision which "only intelligent people like themselves take" (Fernández del Río, López, & Becoña, 2010c).

Many individuals with narcissistic personality disorder have problems managing their anger appropriately, and this can lead to setbacks in their treatment or, in the worst case, relapse. Training in basic anger management strategies (e.g., identification of factors that can trigger anger, problem-solving, deep breathing) can help to alleviate this aspect (Becoña, 2007).

Reinforcement of small achievements, from the therapist and the family, is very important in the treatment of smokers with narcissistic personality disorder. If, however, we criticize errors (e.g., accepting an offer of cigarettes), the patient will take it as a personal attack, which will increase the likelihood of premature dropout. A good therapeutic strategy is to make them see that they are clever people capable of learning from their mistakes, so that they will do everything they can to avoid a relapse (Millon & Everly, 1994).

Finally, with regard to risk factors for relapse, the most notable are as follows: their own self-image (e.g., do they really see themselves as non-smokers?), the importance they give to how those around them perceive smoking (e.g., the probability of quitting rises if these patients view giving up smoking as "cool") and group pressure (e.g., if they are surrounded by other smokers who encourage or pressurize them to smoke, particularly if such people are admired by the patient and say that they have no problem with smoking) (Marlatt & Donovan, 2005).

THERAPEUTIC APPROACHES IN SMOKERS WITH CLUSTER C PERSONALITY DISORDERS

Cluster C includes the avoidant, dependent and obsessive-compulsive personality disorders. In general terms, this group would be made up of individuals considered anxious and fearful. Recent studies have shown that smokers with these disorders use smoking as self-medication to calm their anxiety symptoms (Pomerleau, Marks, & Pomerleau, 2000; Pulay et al., 2010).

Avoidant personality disorder

Despite the scarcity of research on this disorder, it is considered one of the most prevalent in the general as well as the clinical population. It is characterized by a pattern of permanent social inhibition, feelings of incompetence and hypersensitivity to negative feedback (APA, 2002; Caballo, Bautista, López-Gollonet, & Prieto, 2004).

During treatment it is essential to accept their fear of rejection and distrust of expressions of friendliness and warmth on the part of others (the therapist and other members of the group, where applicable). If they reject group treatment, they should not be forced into it, and should receive individual treatment instead.

If we find that they are using nicotine to calm their anxiety symptoms (Pomerleau et al., 2000), we should show them how to manage anxiety through relaxation or deep breathing (Becoña, 2007). We should also be alert to avoidant smokers who abuse alcohol for the same reason, since this may interfere with their achieving and maintaining abstinence from smoking.

With these smokers, the most important therapeutic strategies will be aimed at identifying stimuli for their smoking, the way they smoke, and the consequences of their smoking. This approach, together with the reinforcement of any progress, however slight (e.g., not smoking while driving, a reduction in the number of cigarettes since the last session), is crucial in the treatment of smokers with avoidant personality disorder.

Fear of rejection by others, as well as fear of negative feedback, may have held them back from attempting to quit smoking or seeking treatment in the past. The therapist, therefore, needs to review with the smokers their perceived self-efficacy and convince them that if they do not try to quit because of fear of failure, they will never know whether or not they are really capable of doing so. Going over those situations in the past in which they experienced great anxiety and did not turn to smoking could be a good starting point. If they have failed in previous attempts to quit smoking, the explanation could focus on aspects such as the wheel of change (Rollnick et al., 2008) and the learning opportunity that relapse can provide (Brandon, 2000).

Dependent personality disorder

This is characterized by an excessive dependence on others, which leads to submissive behaviour and great fear of separation (APA, 2000; Caballo, López-Gollonet, & Bautista, 2004b). Compared to other types of personality disorder, these cases may appear "easy to treat," because from the outset patients pay close attention to the therapist's instructions, commit themselves easily to the treatment, and behave very cooperatively (Millon,

2006). Nevertheless, as soon as the therapist tries to get them to act independently (e.g., asking them to set the day on which they will give up smoking), they may show resistance (Beck et al., 2005).

As in other personality disorders, dichotomous thinking is common (Millon & Davis, 1998). In these cases, their thinking fluctuates between the idea that they are able to do things "well" or "completely badly", and this may lead them to drop out of the treatment if they feel they are not making progress, or to a belief, having quit smoking, that they will not manage to maintain abstinence. It is important to address such mistaken beliefs from the beginning of the treatment until the end of the follow-up. In addition to dichotomous thinking, these individuals present automatic thoughts about their lack of self-efficacy (e.g. "I can't", "I won't be able to", "I'm too weak" or "I have no willpower"), which we need to detect and help to control. Finding exceptions in their lives that have nothing to do with quitting smoking, but in which they have exercised self-control, can help counter such polarized thinking.

The influence of other smokers on their behaviour should also be analyzed, especially in cases of people who are important for the patients. If they do not explicitly support the patient's decision to quit smoking their behaviour may interfere in the process of treatment or even in the maintenance of abstinence (e.g., offering the person cigarettes when he/she is unable to refuse).

Catastrophic thinking (Beck et al., 2005) is another characteristic of these individuals that can contribute to relapse. This cognitive distortion can lead smokers who have managed to quit to see a lapse, or an occasional cigarette, as a catastrophic event that confirms their inadequacy. The follow-up phase is therefore very important in these patients. Knowing that they can come back, regardless of whether they are abstinent, will help them not to worry.

Obsessive-compulsive personality disorder
This disorder is characterized by a general pattern of preoccupation with order, perfectionism and control (APA, 2002; Oldham et al., 2007).

On treating smokers with this personality disorder, two fundamental aspects should be taken into account: the balance of polarities (why they think and act in terms of "all or nothing"), and reduction of the rigidity that governs their lives (excessive preoccupation with rules, guilt feelings if they do not meet established goals, etc.) (Millon

& Everly, 1994). Nevertheless, with respect to the cases of other types of disorder, these smokers have fewer difficulties, in general, for following the therapist's recommendations, above all those which have to do with controlling the desire to smoke (use of self-registers, stimulus control, etc.).

These individuals do not easily tolerate emotional proximity (Millon, 2006), especially at first, so that group treatment may cause them anxiety or discomfort. Assuring them that they can contribute whenever they wish, and that the treatment is individualized despite taking place in a group, may contribute positively to resolving this aspect. Multicomponent treatments for smoking cessation are very well accepted by these smokers, since the instructions given in each session are quite specific, and they involve the progressive attainment of goals (Becoña, 2007). One of the most important principles with these smokers is precisely to set realistic objectives, avoiding targets that are too ambitious, because if they start failing to reach them they may drop out of the treatment before achieving abstinence.

Finally, given their tendency to think in terms of "all or nothing," it is important to work with these patients on the abstinence violation effect (AVE) (Witkiewitz & Marlatt, 2004), so as to avoid a momentary lapse turning inevitably into relapse. Throughout their treatment, they need to be shown that there is an intermediate point between all or nothing (Beck et al., 2005); furthermore, it will be necessary to assess variables that may lead them to smoke again (e.g., work stress or marital/partner problems) and to train them in strategies for coping with anxiety or stress (López, Fernández del Río, & Becoña, 2011).

CONCLUSION
Despite a growing interest in the study of personality disorders in smokers, the research published to date has not been able to conclude that the presence of an Axis II disorder will inevitably lead to the failure of treatment for tobacco dependence. Unfortunately, the dearth of published work on this issue and the enormous variability in the prevalence of these disorders in smokers (Fernández del Río & Becoña, 2010) makes the job of those professionals applying psychological treatment to smokers with personality disorders more difficult.

Independently of the complexity involved in the conceptualization and diagnosis of personality disorders, their presence must be taken into account on dealing with

individuals who wish to give up smoking, taking on board the particularities of each disorder during clinical intervention.

In this article, several fundamental aspects of psychological treatment of smokers with personality disorders have been reviewed. Firstly, it is necessary to achieve a suitable therapeutic climate, taking into account some of the attitudes typical of each disorder, such as suspicion in paranoid disorder or defiance in the antisocial type. Adapting to the particular characteristics of each personality disorder will help to establish an appropriate therapeutic relationship. Secondly, it is essential to show these individuals how to identify and manage negative emotions (e.g., anger, aggression, stress), since these are directly linked to smoking relapse (Kahler et al., 2009). Thirdly, given that these individuals tend to have problems in their interpersonal relationships, we need to determine from the outset their level of social support, as this is a key variable in the achievement and maintenance of smoking abstinence (Becoña, 2004). With a view to preventing relapse it is also important to train these patients in effective coping strategies. When faced with situations that cause stress or negative affect, they tend to use inadequate coping strategies (e.g. aggressive or avoidance behaviours), and this can significantly increase the likelihood of their starting smoking again. If we can ensure that over the course of the treatment they acquire appropriate coping strategies, their self-efficacy will increase, reducing the probability of relapse (López-Torrecillas, Salvador, Verdejo, & Cobo, 2002).

Previous studies have noted that the presence of a personality disorder has a negative effect on the patient's adherence to treatment (Fernández-Montalvo, López, Landa, Illescas, Lorea, & Zarzuela, 2004). We currently know that the efficacy of psychological treatment increases the more the contact time with the smoker (Fiore et al., 2008), and smokers with a personality disorder tend to attend fewer than half of the sessions, which makes it difficult for them to achieve abstinence (Fernández del Río, López, & Becoña, 2010d). If a smoker with a personality disorder decides to drop out of treatment prematurely, the therapist should never display a critical or disciplinary attitude (e.g., refusing to allow the person back into treatment), as in that case we would be failing to fulfil the ultimate aim of health professionals, which is to promote the well-being of the individual. There is no doubt that the person's well-being will improve

through giving up smoking, *whenever* that occurs. Showing an interest in the fact of an individual's absence from one of the sessions or carrying out regular follow-ups once the treatment is over may be helpful approaches in the treatment of these smokers.

We also need to take particular care with those smokers who present more than one personality disorder, an all-too-frequent phenomenon due to the categorical classification and diagnostic system currently in use (Widiger & Trull, 2007). Comorbidity of two or more disorders tends to complicate the process of quitting smoking and facilitate relapse (Martínez & Trujillo, 2003).

The presence of a personality disorder need not imply the failure of psychological treatment for smoking cessation (López et al., 2011). Certainly, the mere use of this diagnostic label can condition the therapist's attitude and involvement and the way the treatment programme develops (Pedrero & Segura, 2003). However, to try to avoid this, we need to understand personality disorders in depth, to take into account their presence in people requesting psychological treatment for smoking cessation, and to eradicate any prejudices we may have as therapists when we encounter such cases.

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