



Review article

The downside of tobacco control? Smoking and self-stigma: A systematic review



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ABSTRACT

Objective: Little is known about the consequences of tobacco smoking stigma on smokers and how smokers may internalize smoking-related stigma. This review summarizes existing literature on tobacco smoking self-stigma, investigating to what extent smokers are aware of negative stereotypes, agree with them and apply them to themselves.

Methods: We carried out a systematic search of Pubmed/Web of Science/PsycInfo databases for articles related to smoking self-stigma through June 2013. Reference lists and citations of included studies were also checked and experts were contacted. After screening articles for inclusion/exclusion criteria we performed a quality assessment and summarized findings according to the stages of self-stigma as conceptualized in Corrigan's progressive model of self-stigma (aware, agree, apply and harm). Initial searches yielded 570 articles.

Results: Thirty of these articles (18 qualitative and 12 quantitative studies) met criteria for our review. Awareness of smoking stigma was virtually universal across studies. Coping strategies for smoking stigma and the degree to which individuals who smoke internalized this stigma varied both within and across studies. There was considerable variation in positive, negative, and non-significant consequences associated with smoking self-stigma. Limited evidence was found for subgroup differences in smoking-related stigma.

Conclusion: While there is some evidence that smoking self-stigma leads to reductions in smoking, this review also identified significant negative consequences of smoking self-stigma. Future research should assess the factors related to differences in how individuals respond to smoking stigma. Public health strategies which limit the stigmatization of smokers may be warranted.

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1. Introduction

Tobacco smoking is, in many countries, subject to restrictive public health efforts, aimed at discouraging smoking and making it an unacceptable behavior. Many public health institutions including the [World Health Organization \(2012\)](#) and the [Centers for](#)

[Disease Control \(2014\)](#) advocate the denormalization of tobacco use and changing social norms around tobacco use to combat the negative health effects of tobacco. Approaches include smoke free air laws ([Tynan et al., 2011](#)), media campaigns ([Wakefield et al., 2010](#)), and pictorial health warnings on tobacco products ([Cameron et al., 2015](#); [Hammond, 2011](#); [Monarrez-Espino et al., 2014](#)). In addition, some organizations have instituted anti-smoking policies such as prohibiting the hiring of smokers ([Asch et al., 2013](#)) or requiring higher health insurance premiums for smokers ([Madison et al., 2013](#)). Alongside changes in social attitudes, these policies could contribute to the stigmatization of

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smokers (Bayer, 2008; Bell et al., 2010a). However, social control strategies, which are employed in an effort to reduce the prevalence and incidence of smoking and reduce exposure of non-smokers to second-hand (Baxi et al., 2014) and third-hand smoking (Ferrante et al., 2013), may actually further marginalize 'residual smokers' who may be more disadvantaged and have fewer resources to help them quit (Burns and Warner, 2003).

Comparative studies on the stigma of health conditions suggest a difference between uncontrollable conditions like schizophrenia, which the general public does not primarily associate with guilt (but with notions of unpredictability and dangerousness), and seemingly controllable conditions like alcohol use disorders (Schomerus et al., 2011). In the latter, stigma is hypothesized to carry a strong normative function: unacceptable behavior is stigmatized to clarify boundaries of acceptable, normal behavior (Phelan et al., 2008). Stigmatized persons are excluded and can only rejoin the group if they change their behavior. Goffman defines stigma as an attribute considered undesirable and unpleasant by society differentiating the person from other members of the community. He also refers to 'spoiled identity' but acknowledges there are different degrees to which stigma is experienced (1961). Presumably, the stigma of smoking, although certainly not as severe as the stigma of alcohol dependence, follows the same pattern. One main factor that distinguishes smoking stigma from other stigmatized conditions is its relative recency. While not always considered acceptable throughout history, a few decades ago, smokers were revered as "cool," and "mysterious" invoking images such as the Marlboro Man (Corrigan, 2004; Hafez and Ling, 2005). However, in recent decades the social status associated with being a smoker has diminished (Stuber et al., 2009). Other mental and physical health conditions have not seen this dramatic shift in status through the 20th century making smoking stigma an important and distinct area of research.

There is broad consensus regarding the impact of smoking on individual and public health (e.g., Mokdad et al., 2004; Oberg et al., 2011) and considerable research on the degree to which anti-smoking campaigns are successful in encouraging individuals to quit and in reducing overall smoking rates (Levy et al., 2004; Wakefield et al., 2010). Yet, little is known about how those who smoke cope with smoking-related stigma that may stem from these strategies and the negative consequences of smoking-related stigma on those who smoke. Of particular concern are the potential consequences of internalizing public stigma which is referred to as self-stigma or internalized stigma (Link and Phelan, 2001).

A prominent cognitive model of self-stigma, originally proposed by Corrigan et al. for mental illness (Corrigan and Watson, 2002), describes self-stigma as a process of four interrelated steps. According to this progressive model of self-stigma (Corrigan and Watson, 2002), a person is first aware of prevalent negative stereotypes and, second, personally agrees to some extent with the negative stereotypes. The person may then, thirdly, self-identify with the stigmatized group and apply negative stereotypes to himself/herself, which may finally result in negative consequences such as loss of self-esteem and reduced self-efficacy. This model has been validated for mental illness (e.g., Corrigan and Watson, 2002; Corrigan et al., 2011) and alcohol use disorder (Schomerus et al., 2011) but has not been examined in the context of tobacco use and dependence. A particular strength of this model is that it incorporates both perceived stigma (first stage) and internalized stigma (stages three and four) and thus provides a framework with which to explore the relationship between negative public attitudes and individual self-stigma. Because of the broad perspective of this model, describing different stages from stigma perception to self-stigma, it provides a useful framework to examine self-stigma-related findings.

We hypothesized that if the public stigma of tobacco smoking results in self-stigma and reduced self-efficacy among those who smoke, it could have detrimental effects. Intended to reduce smoking, it could instead undermine abilities of those affected to quit smoking. In this context, the aim of this review is to summarize existing literature on smoking self-stigma and the degree to which the current literature addresses the stages of self-stigma according to the progressive model of self-stigma. Moreover, we know that smoking rates differ greatly by gender, culture, SES, and age (e.g., Evans-Polce et al., 2015) and there may also be differences in self-stigma according to these characteristics, with certain groups being particularly vulnerable. Thus, we examine the degree to which current literature has examined differences in smoking self-stigma by the following subgroups: gender, SES, culture, and age.

2. Methods

2.1. Search strategy and study selection

We searched the following databases for articles related to tobacco smoking self-stigma: Pubmed, Web of Science, and PsycINFO through June 2013. Further articles were identified through hand-searching reference lists of retrieved articles. We also contacted expert stigma researchers for additional studies, including those not published in peer-reviewed journals. These methods identified 661 articles. We used the following search terms: internalized stigma OR felt stigma OR imagined stigma OR self-stigma OR shame OR blame OR hopelessness OR guilt OR fear of discrimination OR anticipated discrimination) AND (smok* OR tobacco OR nicotine OR cigarette). The review protocol was registered at PROSPERO International Prospective Register of Systematic Reviews (PROSPERO 2013:CRD42013005093).

One reviewer (JMCM) screened all titles and abstracts and a second reviewer (SEL) independently screened a random sample of 10% of selected studies. Both reviewers evaluated articles using the inclusion and exclusion criteria detailed below. Disagreements were resolved through discussion and consultation. Agreement for article exclusion was greater than 80%. A diagram of the study selection process is presented in Fig. 1.

A priori inclusion and exclusion criteria were set by the authors. The criteria were: (1) original data based articles (quantitative and qualitative), (2) articles published in English, German, Portuguese, or Spanish, (3) articles that dealt, totally or partially, with tobacco smokers' self-stigma, (3) articles which used the term stigma to refer to botanical elements, cellular biology, or stigmata) were excluded. Additional exclusion criteria were added after a pilot search of articles. These comprised articles which discussed stigma only in relation to: other types of substance use, general drug use (not just nicotine/tobacco use), other psychiatric disorders, other clinical diseases, socio-demographic characteristics, patients in treatment for diseases such as cancer, tuberculosis, or COPD due to past or current tobacco smoking.

2.2. Data extraction and quality assessment

One author (JMCM) tabulated data for all included studies using a pre-piloted form. Information was extracted on: (1) study characteristics, (2) participant characteristics, (3) results relevant to self-stigma (i.e., relationship between self-stigma and quit attempts, attitudes toward smoking/smokers, consequences of self-stigma), and other relevant information.

The quality assessment was performed separately for quantitative and qualitative studies. For quantitative studies, six criteria were used, adapted from the Evidence for Policy and Practice Information and Co-ordinating Centre (Oliver et al., 2005). These

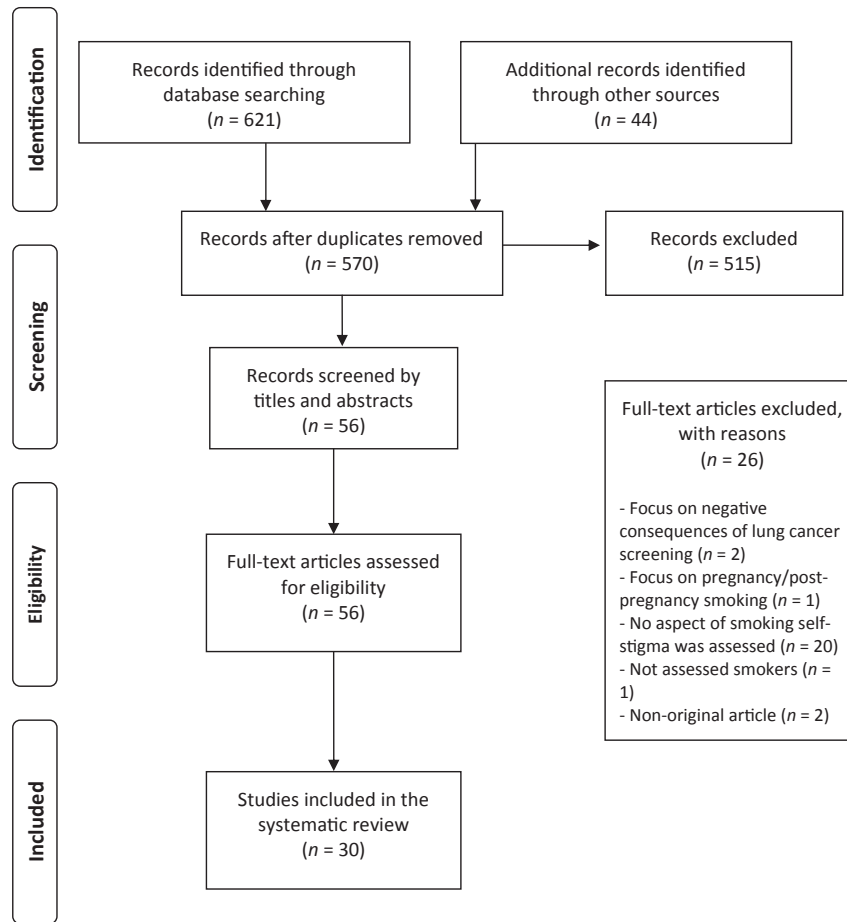


Fig. 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

were: (1) aims clearly stated, (2) design appropriate to the stated objectives, (3) justification for sample size, (4) evidence provided of reliability or validity of measures used, (5) statistics accurately reported, (6) sample selection relatively unbiased. For the 18 qualitative studies, seven criteria were used, adapted from the Critical Appraisal Skills Programme Qualitative Research Checklist [25]. These were: (1) aims clearly stated, (2) design appropriate for stated objectives, (3) study context described in detail, (4) data collection and sampling appropriate, justified, and clearly reported, (5) analysis was rigorous and clearly described, (6) a reflexive account of the researchers' influence was provided, and (7) a clear statement of the findings was provided. Because relatively little data exists on smoking self-stigma we used broad and not overly restrictive quality criteria in our assessments, including studies meeting at least four of the six criteria for quantitative studies and six of the seven criteria for qualitative studies, as reported in previous systematic reviews (Clement et al., 2014).

Results were synthesized using the Corrigan model as a framework. In our synthesis we examined three categories: (1) stereotype awareness ('aware'), (2) personal stereotype agreement ('agree'), and (3) applying stereotypes to oneself and experiencing consequences associated with self-stigmatization ('apply' and 'harm'). While the Corrigan Model has traditionally divided this third step into two separate processes, empirical studies have consistently found very high correlations between measures of 'apply' and 'harm' [20]. For our synthesis, we found it most appropriate to combine these two stages of internalized stigma into one.

3. Results

Our database searches identified 570 non-duplicate records. After reviewing titles and abstracts, 56 articles were identified as potentially relevant papers and these full papers were assessed against eligibility criteria during which approximately half (n = 26) were removed. The remaining 30 studies were included in the review. Eighteen of these studies were qualitative [26–41] and 13 were quantitative (one used mixed methods). This process, including reasons for article exclusion, is outlined in Fig. 1.

3.1. Quality assessment

Among quantitative studies, 10 of the 13 studies met at least five and 12 of 13 studies met at least four of the six quality criteria. One study used a mixed methods approach; however, only qualitative findings were included as the study's quantitative results only met three of the six criteria, and thus were excluded from subsequent analyses. The main methodological weakness identified by the quality assessment was lack of sample size justification (n = 13 studies).

In assessing qualitative studies, 15 of the 18 studies met at least six of the seven criteria. The remaining three studies met five of the seven criteria. The most frequently neglected criterion was having a reflexive account of the researchers' influence on the study (n = 12). Table 1 summarizes characteristics of included studies and additional details can be found in a supplementary table.

Table 1
Study Characteristics for included studies ($n = 27$).

Author and year	Country	Participants	Type of study	Design
Allan et al., 2012	Scotland	Smokers who dropped out of a smoking cessation program that had a final incentive ($n = 14$)	Qualitative	Unstructured interviews
Baer et al., 1989	USA	Smokers who had not resumed regular smoking 4 weeks post-treatment ($n = 102$)	Quantitative	Prospective, in context cessation intervention, followed up to 1 year post-treatment.
Bell et al., 2010a,b	Canada	Smokers and ex-smokers recruited from newspaper advertisements ($n = 25$)	Qualitative	Open-ended interviews
Bennasar Veny et al., 2011	Spain	Female nurses who had been habitual smokers for at least two years prior to the study ($n = 15$)	Qualitative	Semi-structured interviews
Berlin and Covey, 2006	USA	Smokers recruited for a smoking cessation trial ($n = 600$)	Quantitative	Prospective, in context of cessation intervention, followed through 3 months of treatment and 6 months post-treatment. Focus groups and in-depth interviews
Betzner et al., 2012	USA	Smokers and recent quitters who responded to a tobacco cessation program ($n = 166$)	Qualitative	
Bottorff et al., 2013	Canada	Mother and father dyads who were current and former smokers with a 1 year old child at baseline ($n = 28$)	Qualitative	In-depth interviews when child was 1 year, 20–35 months, and 36–48 months
Bush et al., 2003	England	Purposive sample of Bangladeshi and Pakistani smokers and nonsmokers in Newcastle ($n = 141$)	Qualitative	Semi-structured, in-depth interviews and focus groups
Copeland, 2003	Scotland	Female smokers, General Practitioners, and nursing staff recruited from a general practice ($n = 41$)	Qualitative /Quantitative	Observational cross-sectional quantitative survey and open-ended qualitative questionnaire
Farrimond and Joffe, 2006	UK	Smokers and non-smokers with diverse socio-economic statuses ($n = 40$)	Qualitative	Conceptual mapping, 'episodic' interviews, semi-structured interview
Fong et al., 2004	Australia, Canada, USA and UK	Participants from the International Tobacco Control Policy Evaluation Survey (Canada $n = 2193$; United States $n = 2115$; United Kingdom $n = 2344$; Australia $n = 2271$)	Quantitative	Observational cross-sectional survey
Frohlich et al., 2010	Canada	Current adult smokers recruited with purposive sampling ($n = 17$)	Qualitative	Semi-structured interviews
Gibbons et al., 1991	USA	Adult smokers responding to a smoking cessation program advertisement ($n = 120$)	Quantitative	Prospective, 16 weekly surveys in context of intervention and 6 month post-quit date follow up survey
Goldstein, 1991	Canada	Adult smokers and nonsmokers household level 1989 Winnipeg Area Study ($n = 521$)	Quantitative	Observational cross-sectional survey
Greaves et al., 2010	Canada	New fathers who continued to smoke during partner's pregnancy and/or post-partum ($n = 29$)	Qualitative	In-depth, semi-structured interviews
Grove, 1993	Australia	Smokers who had ever made a quit attempt ($n = 155$)	Quantitative	Observational cross-sectional survey
Holdsworth and Robinson, 2008	UK	Mothers with at least one smoking parent and a child under 5 ($n = 17$)	Qualitative	Interviews using the Bibliographic Narrative Interpretative Method
Kirchner et al., 2012	USA	Smokers enrolled in a research smoking cessation clinic who had experienced a lapse ($n = 203$)	Quantitative	Prospective, in the context of a cessation intervention, ecological momentary assessments collected during the first 6 weeks of a quit attempt
Lee and Paek, 2012	Korea	Male smokers ($n = 255$)	Quantitative	Quasi-experimental, survey pre and post one of 3 types of anti-smoking message conditions
Lee and Paek, 2014	Korea and USA	University student smokers ($n = 310$)	Quantitative	Quasi-experimental survey pre and post one of 3 types of anti-smoking message conditions
Louka et al., 2006	UK and Greece	Adult smokers ($n = 21$)	Qualitative	Semi-structured interviews and focus groups
McCarthy et al., 2010	USA	Adult daily smokers ($n = 463$)	Quantitative	Prospective, in the context of a cessation intervention, ecological momentary assessments pre- and post-quitting smoking
Oliffe et al., 2012	Canada	New fathers who smoked ($n = 24$)	Qualitative	Four audio-recorded group sessions
Ritchie et al., 2010	Scotland	Adult current smokers and recent ex-smokers ($n = 40$)	Qualitative	Three-wave longitudinal in-depth interviews
Scheffels, 2009	Norway	Established daily smokers sampled for diversity on gender and social class ($n = 21$)	Qualitative	Semi-structured interviews
Stuber et al., 2008	USA	Current and former smokers in New York City ($n = 816$)	Quantitative	Observational cross-sectional survey
Stuber and Galea, 2009	USA	Current New York City smokers ($n = 835$)	Quantitative	Observational cross-sectional survey
Supnick and Colletti, 1984	USA	Individuals who completed a smoking cessation program ($n = 33$)	Quantitative	Prospective, followed up after a cessation intervention monthly through 6 months post-treatment
Thompson et al., 2007	New Zealand	Smokers ($n = 17$) and ex-smokers ($n = 9$) living in a diverse, socioeconomically disadvantaged neighborhood	Qualitative	Semi-structured interviews
Van der Heiden et al., 2013	Netherlands	Lower-educated daily smokers ($n = 18$)	Qualitative	Structured in-depth interviews

3.2. Evidence of smoking self-stigma in the literature using the progressive model of self-stigma

We categorized findings of smoking-related self-stigma into three groups according to the stages represented in the progressive model of self-stigma (Corrigan and Watson, 2002): (1) Stereotype awareness, (2) stereotype agreement, and (3) applying stereotypes to oneself. Of the 30 studies assessed in the review, eight studies addressed all three stages within the Corrigan model. Table 2 shows the stages addressed in each of the studies.

3.3. Stage 1: stereotype awareness

The majority of studies addressed smoker's awareness of smoking-related stigma. The stereotypes that smokers reported to be associated with smoking were almost universally negative. Most of the studies that addressed this stage were qualitative studies ($n = 17$); however three quantitative studies addressed this stage as well. The first found that 30–40% of current smokers felt high levels of family disapproval and general social unacceptability of smoking and 27% perceived differential treatment due to their smoking status (Stuber et al., 2008). The remaining two studies which comprised both current and former smokers who recently quit found similarly high levels of awareness of social stigma with 39% reporting that people think less of a person who smokes (Stuber and Galea, 2009) and smokers to be rated less favorably than nonsmokers (Goldstein, 1991).

Within the qualitative studies, participants reported almost exclusively negative perceptions of smokers and smokers felt acutely aware of these negative stereotypes. Many smokers reported feeling stigmatized for their smoking status, including feeling ostracized or through perceptions of negative judgments,

stares, or nonverbal communication. However, some studies also reported more explicit experiences in the form of overtly negative comments or actions displayed by others (e.g., Bell et al., 2010a; Greaves et al., 2010). In the four studies in which parents were interviewed, participants reported feeling that stigma was particularly strong for parents. Stigmatizing perceptions were felt from many different social domains including: family members, co-workers, individuals encountered in public spaces, and even health care providers. In multiple studies participants reported avoiding smoking in public spaces due to fear of stigmatization. Thus, this increased awareness of stereotypes may lead to increased social distance between smokers and non-smokers (Thompson et al., 2007). One exception to these negative perceptions was a study of Pakistani and Bangladeshi immigrants in the UK in which some reported that for men cigarette smoking was seen as “macho” and fashionable (Bush et al., 2003).

3.4. Stage 2: personal stereotype agreement

While there was wide discussion and acknowledgment of the existence of social stigma around smoking, personal agreement with these perceptions and stereotypes was less frequently addressed. Only nine studies addressed this stage in some way—seven qualitative and two quantitative studies. All studies found that at least some participants agreed with the stereotypes. One study reported that while participants were aware of negative stereotypes, some disagreed and contested stereotypes and even medical advice, for example, denying that smoking around children was dangerous (Holdsworth and Robinson, 2008). However this was not the norm and all other studies that addressed this stage found exclusive agreement with negative stereotypes. Interestingly, a few studies found that smokers only applied negative

Table 2
Summary of the stages of the progressive model of self-stigma addressed in the studies.

Author and year	Type of study	Stage 1	Stage 2	Stage 3	
		Awareness	Agreement	Application	Consequences
Allan et al., 2012	Qualitative	X		X	–; guilt, smoking behavior
Baer et al., 1989	Quantitative				–; guilt, smoking behavior
Bell et al., 2010a,b	Qualitative	X	X	X	+/-; smoking behavior, concealment
Bennasar-Veny et al., 2011	Qualitative	X		X	+/-; smoking behavior, guilt
Berlin and Covey, 2006	Quantitative				n.s.; self-blame
Betzner et al., 2012	Qualitative	X		X	+/-; smoking behavior, self-efficacy
Bottorff et al., 2013	Qualitative	X	X		+/-; guilt
Bush et al., 2003	Qualitative	X			
Copeland, 2003	Qualitative/Quantitative	X		X	
Farrimond and Joffe, 2006	Qualitative	X	X	X	
Fong et al., 2004	Quantitative			X	
Frohlich et al., 2010	Qualitative	X		X	
Gibbons et al., 1991	Quantitative		X	X	n.s.; smoking behavior
Goldstein, 1991	Quantitative	X	X		
Greaves et al., 2010	Qualitative	X	X	X	–; stress, guilt
Grove, 1993	Quantitative				n.s.; self-efficacy
Holdsworth and Robinson, 2008	Qualitative	X	X	X	
Kirchner et al., 2012	Qualitative				+; guilt, self-blame
Lee and Paek, 2012	Quantitative				+; guilt
Lee and Paek, 2014	Quantitative			X	+; guilt
Louka et al., 2006	Qualitative	X	X	X	–; guilt, self-efficacy
McCarthy et al., 2010	Quantitative				n.s.; guilt
Olliffe et al., 2012	Qualitative	X		X	
Ritchie et al., 2010	Qualitative	X	X	X	–; concealment
Scheffels, 2009	Qualitative	X			–; smoking behavior
Stuber et al., 2008	Quantitative	X			
Stuber and Galea, 2009	Quantitative	X			–; concealment
Supnick and Colletti, 1984	Quantitative				+; smoking behavior, guilt
Thompson et al., 2007	Qualitative	X			
Van der Heiden et al., 2013	Qualitative	X		X	+/-; smoking behavior

Note: – = negative consequences, + = positive consequences, +/- = mix of positive and negative consequences, n.s. = non-significant.

stereotypes, or applied them more strongly, to a subset of smokers such as older and heavier smokers or those that smoked around children (Frohlich et al., 2010; Greaves et al., 2010; Ritchie et al., 2010; Louka et al., 2006). This “downward comparison” by smokers allowed them to agree with negative stereotypes but resist applying these stereotypes to themselves.

3.5. Stage 3: applying stereotypes to oneself and experiencing consequences associated with self-stigmatization

Almost all studies addressed the third stage of applying the stereotypes to one's self and the consequences associated with doing so. Sixteen were qualitative and 10 were quantitative.

Interestingly, the consequences reported were not always negative, nor were smoking stereotypes always personally applied to themselves even if it appeared that there was personal agreement with stereotypes generally. As discussed above in Stage 2, while some participants agreed with stigmatizing stereotypes, they only applied these stereotypes to a subset of smokers who they saw as worse off than them. Similarly, one study reported that participants in a smoking cessation program perceived themselves to have little in common with the “typical smoker.” Moreover, their image of a “typical smoker” became more negative over the course of the program, regardless of whether they were successful in quitting smoking (Gibbons et al., 1991). However, the vast majority of studies which addressed application of stereotypes to one's self overwhelmingly reported that participants felt shame, guilt, and embarrassment for their own smoking behavior. In multiple studies, participants applied words such as “leper,” “outcast,” “bad person,” “low-life,” and “pathetic” in reference to their own smoking behaviors. Some reported an increase in these feelings following a failed quit attempt (Bennasar-Veny et al., 2011; Copeland, 2003).

Table 2 shows whether consequences were positive, negative, mixed, or non-significant (e.g., stigma was not associated with relapse) for each study. In four studies, negative consequences of smoking self-stigma were exclusively reported. Negative consequences included relapse, increased resistance to smoking cessation or reduction, self-induced social isolation, increases in stress due to non-disclosure of smoking status to one's healthcare provider. Four studies exclusively reported positive consequences. Positive consequences included smoking cessation, decreased risk of lapse or relapse, and increased intentions to quit. Multiple studies ($n = 5$) reported a mix of positive and negative consequences from smoking stigma. The mix of positive and negative consequences related to smoking self-stigma may be partially due to subgroup differences. Five studies also reported non-significant findings in relation to consequences.

3.6. Group differences in self-stigma

Very few studies addressed population subgroup differences in smoking self-stigma. We summarize the findings from the small number examining these differences.

Two studies examined *gender differences* in smoking self-stigma (Bush et al., 2003; Fong et al., 2004). One study examined differences in awareness or perceptions of stigma towards smokers by both smokers and nonsmokers. This study was among Pakistani and Bangladeshi adults and found greater awareness of stigma for women compared to men. A woman who smoked was seen as shameful and “tainted” whereas smoking among men was seen as acceptable and “macho.” The second study examined differences in personal agreement and consequences and found women experienced more regret with regard to smoking compared to men (Fong et al., 2004).

Four studies examined differences in self-stigma by *socioeconomic status (SES)*, with conflicting results. Two studies found that

those with a higher SES (measured by income or education) experience more stigma, guilt, and embarrassment compared to those of lower SES (Frohlich et al., 2010; Stuber et al., 2008). However, the remaining studies found the opposite with one showing more regret among those with less than a university education. The other found that those of low SES were more aware of the “outcast” label of a smoker, more accepting of negative stereotypes, and more likely to internalize these stereotypes, while those of higher SES were better able to distance themselves from smoking stereotypes (Farrimond and Joffe, 2006).

Three studies addressed *cultural differences*. The first found that compared to those in the U.S., Korean smokers experienced more guilt following an anti-smoking message (Lee and Paek, 2014). Another study also examined racial/ethnic differences in the U.S. and found Whites to have more awareness of stereotypes (Stuber et al., 2008) compared to Blacks or Hispanics/Latinos. The third study examined differences between Greek and U.K. smokers finding heightened stereotype awareness and guilt among U.K. versus Greek smokers (Louka et al., 2006).

Two studies addressed *age differences*, both in terms of awareness of stereotypes. One study identified older smokers as being more aware of smoking stereotypes and how they have evolved and intensified over time (Betzner et al., 2012). The second study found that gender difference in stereotypes – specifically the stronger negative stereotypes for women – was stronger in older generations than younger ones.

3.7. Variations in coping with smoking stigma

We found considerable heterogeneity in whether individuals internalized stigma and the coping strategy they employed in reaction to smoking stigma. Strategies ranged from guilt and internalization of stigma to defensiveness and rejection of stereotypes. Defensive strategies comprised reports of a strengthening of resolve to continue smoking because of experienced stigma and a general anger and frustration with the restrictive policies around smoking and frank stigma they experienced.

4. Discussion

Overall, these findings provide tentative support for intended consequences of stigmatizing smoking/smokers (i.e., reducing smoking); but, also for unintended consequences (e.g., guilt, loss of self-esteem, defensiveness and resolve to continue smoking). There are several mechanisms upon which tobacco control programs could influence smoking including directly through an individual's decision to smoke or indirectly by facilitating discussion around smoking (and its potential harms) or through changing social norms which may lead to pressure to quit and influence policy-makers (Wakefield et al., 2010). In relation to the process of self-stigma and smoking, while our review found no studies that specifically used the Corrigan Model of Self Stigma, many studies addressed multiple components of the model within their findings. The vast majority of studies addressed both awareness of smoking stereotypes and the application and consequences of self-stigma. While findings regarding awareness were for the most part consistent across and within studies, the evidence regarding applying stereotypes and the consequences of self-stigma was much more heterogeneous. Personal agreement with stereotypes was assessed much less often. This stage appears to often be overlooked in the literature and it may be that this stage is often assumed or it is not considered an important intermediary step from stereotype awareness to consequences. While previous self-stigma research indicates that not all individuals who are aware of public stigma internalize it (Corrigan and Watson, 2002; Rusch

et al., 2005), in the case of smoking, negative stereotypes are so dominant throughout many communities that it may be inevitable that all smokers would agree with these stigmatizing views as well.

4.1. Variation in coping with smoking stigma

While we were not able to decipher the types of coping strategies from the studies we reviewed, it was evident that different strategies were used by smokers to deal with the stigma they experienced. Given the pervasiveness of smoking stigma awareness and the abundance of public health strategies and campaigns that aim to denormalize smoking (CDC, 2014; WHO, 2012; Bell et al., 2010a), a better understanding of the coping strategies used by individuals who smoke in the face of this stigma is warranted. In particular, there is little research on individuals who use a defensive coping strategy in response to smoking stigma or other strategies outside of the dominant strategy to internalize. This defensive strategy is also employed by other marginalized groups such as individuals with mental illness (Rusch et al., 2005) and individuals with weight difficulties (Puhl and Brownell, 2003). For smoking, defending one's self-esteem against the internalization of public stigma can result in maintaining smoking behavior and it thus poses a serious health risk to themselves, their families, and the broader community. However, why certain individuals are defensive or more resistant to public stigma compared to others and if health outcomes differ for these individuals is not well understood. More research is needed to understand the different smoking stigma coping strategies and if they are similar to those of other mental and physical health conditions (Link et al., 1991) as well as how different coping strategies may lead to different outcomes.

4.2. Self-stigma consequences

Consequences varied widely both across and within studies. Only four studies exclusively reported positive consequences as a result of smoking self-stigma. While this corroborates that there can in fact be positive consequences from self-stigma such as smoking cessation and reduction, these are far from universal. Many smokers also report negative consequences as a result of stigma and self-stigma. Additionally, negative consequences were even found in healthcare settings (Allan et al., 2012; Stuber and Galea, 2009). Other research has also suggested that fear of stigma can lead individuals to avoid treatment for a health condition (Rusch et al., 2005; Clement et al., 2014). It appears public stigma of smoking could result in four different individual outcomes. The desired outcome and the one often assumed by public health practitioners is that smokers will internalize the stigma and quit smoking in order to feel better. However, there are at least three other potential outcomes: (1) the smoker internalizes the smoking stigma, loses self-esteem and self-efficacy, and fails to quit smoking, (2) the smoker resists internalizing the smoking stigma remaining indifferent and fails to quit smoking, or (3) the smoker resists smoking stigma internalization, may become angry and defensive at the public for stigmatizing smoking, fails to quit smoking and may even increase their self-esteem and self-efficacy regarding smoking. In severe mental illness, severity of stigma-related outcomes such as low self-esteem and hopelessness may be determined by personal stress appraisal, coping resources and individual emotional and cognitive stress reactions (Rusch et al., 2009a, 2009b). The role of individual coping resources for outcomes of smoking stigma has not yet been investigated; but, understanding these mechanisms could help tailor anti-smoking programs to be more effective, particularly for vulnerable groups with few coping resources.

To date, much of the public health and psychology literature emphasizes the positive consequences of smoking stigma. This study sheds light on potential negative consequences when this stigma is internalized into smoking self-stigma. There is not enough understanding of potential unintended negative consequences that can result from anti-smoking policies. Research in other areas of mental health and public health tend to agree that stigmatization strategies are not effective and lead to more negative consequences than positive ones (Bayer, 2008). Other research has also shown that stigmatizing attitudes are complex and that different types of stigma are associated with varied consequences (Castaldelli-Maia et al., 2011; Evans-Lacko et al., 2012). More attention should be given to negative consequences given the large portion of public health interventions to reduce smoking that make use of socially stigmatizing strategies.

4.3. Group differences

Only a few studies examined group differences, most often qualitatively. However, there were not able differences in terms of gender, culture, SES, and age. Additionally, two studies, highlighted potential cultural differences in the awareness of stigma. A study of a Pakistani and Bangladeshi sample in the U.K. was unique in that it was the only study to identify positive stereotypes associated with smoking (Bush et al., 2003). Additionally, smokers in Greece rarely reported experiencing stigma and disapproval with regard to their smoking (Louka et al., 2006). This suggests these stereotypes are dependent on cultural context. While there seems to be broad consensus in most mainstream Western culture that smoking is "bad," there are other cultures which have managed to evade negative stereotypes that appear dominant in much of the Western world. Further research should explore cultural differences in awareness and whether this leads to differential smoking outcomes. Additionally, it may be beneficial to track changes in stereotypes among different cultures across historical time. Two of the studies that examined cultural differences occurred almost a decade or more ago. Given the pace at which smoking stigma has emerged in Western culture, there may be significant changes in awareness of smoking stigma even in the span of 10 years.

Group differences in self-stigma are not well understood. More research is needed that examines group differences at each of the three self-stigma stages and the extent to which negative and positive consequences and differences in coping strategies are distributed throughout the population. An uneven distribution of consequences may help explain health disparities related to smoking. Additionally, other potential group differences should be explored such as differences in family structure and family support or regional differences based on smoking policies.

4.4. Limitations

The limitations of our study need to be acknowledged. Using the Corrigan model of self-stigma, we tried to distinguish findings on perceived stigma, personal attitudes of the smokers and internalized stigma. Because none of the studies tested a theoretical model of self-stigma, we can only assume that the Corrigan model captures the most relevant aspects of smoking self-stigma. Due to the vague conceptualizations of stigma and self-stigma in many studies, it remains unclear whether the consequences discussed in these studies were a result of self-stigma or of overall smoking stigma. The heterogeneity of studies and the high number of qualitative studies prevented conducting any meta-analysis of findings. Additionally, although we defined cigarette smokers broadly and did not exclude studies based on where individuals fell on the smoking continuum, smoking levels varied across

participants and studies and there may be differences in self-stigmatization depending on an individual's smoking behavior which we are not able to determine. Another limitation is that the search terms emphasized negative factors such as stigma and discrimination and have the potential to bias our findings; however, more neutral terms such as attitudes, beliefs and perceptions are overly general and thus difficult to include while maintaining a reasonable scope to the study. It is also possible that some articles were missed that do not explicitly use the terms we have selected but have relevant information relating to smoking self-stigma. We attempted to mitigate this by contacting experts in the field to suggest any crucial articles we may have missed. The individual studies varied in methodological quality; however, we assessed this and to some degree excluded those that were of poor quality. In addition, as only one author performed data extraction and quality assessment for all of the articles, we were not able to determine inter-rater reliability. However, there were extensive discussions among authors throughout the review process and all authors discussed any articles that appeared unclear.

4.5. Implications

While there is evidence that internalizing smoking stigma may prompt some individuals to quit smoking, this review also suggests that smoking self-stigma can have profoundly negative consequences for some smokers and may make quitting more difficult. We do not suggest that internalization of smoking stigma has universally negative consequences; however, it is important to highlight the potential for negative consequences in response to the substantial research and public health effort focused on the positive consequences of smoking stigma. Public health policies aimed at smoking reduction, thus, might also, alongside current strategies, consider increasing the self-efficacy of smokers and avoiding messages that trigger potentially harmful defensive coping strategies and consequences. Instead of reiterating negative stereotypes about smokers or smoking, health policies could rely more on positive strategies. Currently, there may be an overreliance on strategies which focus on negative reinforcement including both strategies to change smoking norms and increase smoke-free public spaces as well as more structurally stigmatizing policies such as basing hiring decisions and health insurance costs on smoking status. Public health smoking prevention and cessation strategies might instead benefit from a greater inclusion of interventions and policies that focus on positive reinforcement and treatment in order to reduce smoking prevalence while avoiding the stigmatization of smokers.

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Conflict of interest

SEL and GS have received consulting fees from Lundbeck unrelated to the current study.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.socscimed.2015.09.026>.

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