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The Influence of Social Identity and Attitudes Toward Anti-Smoking Campaigns on Smokers' Self-stigma

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Abstract

Purpose: This study aims to determine the influence of Social Identity and Attitudes towards the Anti-Smoking Campaign on Smoker Self-stigma.

Methodology: The research was conducted using a quantitative approach with the population in this study being smokers. The sampling technique used was Quota Sampling with the sample in this study amounting to 320 respondents with the main criteria being 18-40. The data analysis technique used is multiple linear regression analysis.

Results: The analysis results show the calculated F value is 24,706 with a probability of 0.000 ($p < 0.01$). Next, in the first minor hypothesis, the value is $p = 0.000$ ($p < 0.01$). In the second minor hypothesis, the results of multiple linear regression analysis obtained a value of $p = 0.001$ ($p < 0.01$).

Conclusion: In conclusion, social identity and attitudes towards anti-smoking campaigns together have an influence on self-stigma. In the first minor hypothesis, there is a very significant negative influence (in the opposite direction) between self-stigma and social identity. In the second minor hypothesis, there is a very significant negative influence (in the opposite direction) between self-stigma and attitudes towards anti-smoking campaigns.

Limitations: Anti-smoking campaigns and social identities may differentially contribute to each dimension of stigma, which in turn leads to different consequences.

Contribution: The finding that social identity actually has a negative relationship with self-stigma adds to the literature by suggesting that group identification can serve as a protective mechanism that reduces feelings of shame and alienation, particularly in collectivistic societies that emphasize values of togetherness and social solidarity.

Keywords: *Attitudes Towards Anti-Smoking Campaigns, Self Stigma, Smoking, Social Identity.*

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1. Introduction

Smoking was initially associated with masculinity, courage, and a luxurious lifestyle, frequently portrayed in films. However, this perception has shifted as awareness of the negative health impacts of smoking has increased over time. The WHO (2022) states that the tobacco epidemic is one of the world's biggest public health threats, causing more than eight million deaths annually. In Indonesia, the number of adult smokers rose from 60.3 million in 2011 to 69.1 million in 2021 (Badan Pusat Statistik, 2022), indicating that smoking behavior remains a serious issue despite ongoing anti smoking campaigns.

Social changes and tobacco control policies have created a new social climate that increasingly stigmatizes smoking (Graham, 2012; Putri & Hamdan, 2021). This stigmatization can reduce smoking

behavior but may also lead to negative psychological consequences such as guilt, shame, and low self-esteem (Evans-Polce et al., 2015). When external stigma is internalized by individuals, it forms self-stigma (Major, Dovidio, & Link, 2018), which can lower self-esteem and hinder help-seeking behaviors (Bottorff et al., 2013; Haighton et al., 2016). Previous studies have extensively discussed self-stigma in the context of mental disorders and chronic diseases (e.g., HIV/AIDS and obesity). However, research on self-stigma among smokers, particularly in collectivist cultures such as Indonesia, remains limited. Moreover, few studies have examined how social identity and attitudes toward anti-smoking campaigns contribute to the development of self-stigma among young smokers (Ristianto & Jatnika, 2023; Ulfa, Agustiani, Qodariah, & Jatnika, 2023).

Therefore, this study aimed to analyze the influence of social identity and attitudes toward anti-smoking campaigns on self-stigma among young adult smokers in Yogyakarta. Specifically, this study seeks to answer the following questions: Does social identity affect the level of self-stigma among young adult smokers? Do attitudes toward anti-smoking campaigns shape smokers'self-stigma? How do these two variables interact to explain variations in self-stigma among young smokers? This study contributes to the literature by highlighting self-stigma in the context of behaviors that are still socially accepted by some groups while expanding the understanding of the social-psychological factors influencing the internalization of stigma in Indonesian society.

2. Literature Review

Stigma is one of the key concepts for understanding how individuals are treated and how they perceive themselves in a social context. Goffman (1968) defined stigma as a social mark that discredits an individual and hinders normal social interactions. This perspective later evolved through the labeling theory, in which Scheff (1974) explained that stigma can arise as a consequence of the labeling process imposed on an individual. Link dkk. (1989) further emphasized that stigma is not merely about social labels but also involves how individuals respond to them. In the field of health, stigma has been widely studied, such as in individuals with HIV/AIDS (Bennett, 1990; Crandall & Coleman, 1992; Weitz, 1990) and mental disorders (Rössler, 2016). Findings from these studies show that stigma can worsen an individual's condition by adding psychological and social pressure. Recent studies have also affirmed that health-related stigma can reduce the motivation to seek help and deteriorate mental health (Hatzenbuehler *et al.*, 2024; Hatzenbuehler *et al.*, 2013).

The social stigma attached to an individual does not stop at societal perceptions but can be internalized as self-stigma. Vogel *dkk*. (2013) explained that self-stigma arises when individuals lower their self-worth by accepting the belief that they are socially unacceptable. Similarly, Lucksted and Drapalski (2015) defined self-stigma as the internalization of negative stereotypes, causing individuals to believe others' prejudices about themselves. This condition leads to feelings of shame, guilt, or helplessness and, in the long term, can hinder the achievement of personal goals (Link, 1987; Major, Dovidio, & Link, 2018). Contemporary research shows that self-stigma is significantly associated with increased depression and stress and reduced subjective well-being (Lu *dkk*., 2025).

The phenomenon of self-stigma is also found in the context of smoking behavior. Smokers are often negatively perceived by society, for example, as unethical, unhealthy, or lacking self-control. Anggarianto (2018) found that stigma toward female smokers is particularly strong and often associated with negative moral judgments. Similar findings were reported by Triandafilidis *et al.*. (2017), who found that female smokers experience greater discrimination than male smokers. A recent study in Korea also revealed that perceived smoker stigma is positively correlated with smoking cessation intention but simultaneously increases social stress and feelings of shame (Lee *et al.*, 2021).

This stigma has various psychological effects. Evans-Polce *dkk*. (2015) found that stigma can reduce smoking behavior but also triggers guilt, loss of self-esteem, and the emergence of self-defensive mechanisms. Haighton *dkk*. (2016) that self-stigma can be a major barrier preventing smokers from seeking professional help due to shame and fear of losing the social aspects of smoking. Psychological impacts such as depression and anxiety also increase among smokers experiencing self-stigma (Bottorff

et al., 2013; Bovin *et al.*, 2016). These findings show that self-stigma among smokers is not merely a matter of physical health but is also closely related to their mental health and social wellbeing.

Understanding the factors that shape self-stigma is essential to comprehend how the internalization of stigma occurs. Berger dkk. (2001) developed four dimensions of self-stigma: personalized stigma, disclosure concerns, negative self-image, and concern with public attitudes. Although the instrument was originally used to study stigma among people with HIV, its conceptual framework remains relevant to smokers, as these dimensions reflect similar social and psychological experiences (Pramesti & Arianti, 2023; Putri & Nurhuda, 2023).

Theoretically, Social Identity Theory (Tajfel & Turner, 2019) explains that individuals tend to evaluate themselves based on their membership in social groups. Negative attitudes toward anti-smoking campaigns may decrease resistance to social stigma and increase self-stigmatization (Rose et al., 2022). Therefore, both variables, social identity and attitudes toward anti-smoking campaigns, are considered influential in determining the level of self-stigma among smokers.
Based on the theoretical and empirical explanations above, the proposed hypotheses are as follows:
H1: Social identity negatively affects self-stigma among young adult smokers.
H2: Attitudes toward anti-smoking campaigns positively affect self-stigma among young adult smokers.
H3: Social identity and attitudes toward anti-smoking campaigns simultaneously have a significant effect on self-stigma among young adult smokers.

3. Methodology Research

This study employed a quantitative approach using a survey design. The participants were university students in the early adulthood stage (Santrock, 2023) who had smoking experience and resided in the Special Region of Yogyakarta, Indonesia. The participants were selected using a quota sampling technique, a sampling method which determines the number of respondents beforehand (Sugiyono, 2013). The quota sampling technique was chosen because the population of student smokers is relatively heterogeneous and difficult to access randomly, particularly because smoking behavior is often personal and not always openly disclosed. This method allows researchers to ensure the proportional representation of respondents who meet specific criteria (e.g., gender or university), thereby maintaining the representativeness of the target group. Moreover, this technique is efficient for social research involving populations with specific characteristics, such as student smokers (Etikan, 2017).

According to data from the Central Bureau of Statistics in 2022, the percentage of smokers aged over 15 years in Indonesia was 23.97% in 2022, totaling 1,928,058 individuals. The sample size was determined using the Isaac and Michael table with a 5% margin of error (Sugiyono, 2013). For populations exceeding one million or of unknown size, the table recommends a sample of 350 respondents. This age group was selected because young adults are in the process of forming their self-identity and are vulnerable to social pressures (Arnett, 2023). The study obtained informed consent and ensured data confidentiality in accordance with the ethics of psychological research.

The research instruments consisted of three scales adapted from prior studies. The Self-Stigma Scale was developed by Berger *et al.*. (2001) and comprises four dimensions: *personalized stigma*, *disclosure concerns*, *negative self-image*, and *concern about public attitudes*. This instrument, originally known as the Berger HIV Stigma Scale, was modified by Reinius et al.. (2017) into a 12-item version from the original 40 items, with prior validity coefficients ranging from 0.73 to 0.93. After a content validity test using professional judgment (expert raters), the items scored between 0.80 and 0.85, indicating that the scale was valid. The researcher further adapted the items to fit the context of smoking behavior and translated the English items into Indonesian. A pilot test showed item validity correlations ranging from 0.587 to 0.820, with a Cronbach's alpha of 0.918, confirming that the self-stigma scale was both valid and reliable.

The Social Identity Scale was based on Cameron 's(2004) Three-Component Model of Social Identity, which includes three aspects: *ingroup ties*, *centrality*, and *ingroup affect*. This 12-item scale had initial item validity coefficients ranging from 0.76 to 0.84. After translation and contextual adaptation to smoking behavior, a content validity test with professional judgment yielded scores ranging from 0.85–0.95. Subsequent pilot testing showed item validity correlations between 0.642 and 0.862, with a Cronbach's alpha of 0.906, indicating that the social identity scale was valid and reliable.

Meanwhile, the Attitude Toward Anti-Smoking Campaigns Scale was developed by the researcher based on the tripartite attitude model proposed by Rosenberg and Hovland (1960), which includes *cognitive*, *affective*, and *behavioral* dimensions. This scale consists of 18 items, with content validity scores ranging from 0.80 to 0.95 based on expert judgment. The pilot test produced item validity correlations ranging from 0.425 to 0.872, with a Cronbach's alpha of 0.857, demonstrating that the attitude scale was valid and reliable. The collected data were analyzed using IBM SPSS Statistics (version 25). The analysis included instrument validity and reliability testing, descriptive statistical analysis to describe the respondents' characteristics, and correlation and regression analyses to examine the relationships between social identity, attitudes toward anti-smoking campaigns, and stigma. This analysis enabled the researcher to determine the contribution of each variable to the formation of self-stigma among smokers (Hadi, 2024).

4. Results and Discussion

4.1 Result

The research scales were distributed online by sharing a Google Form link via social media and WhatsApp groups over 30 days. After the data were collected, further analysis was performed. Three types of analyses were performed in this study. First, a descriptive analysis was used to examine the mean scores, high and low values, and percentage distributions of the data, which facilitated a general understanding of the issues being analyzed in this study. Second, a classical assumption test was conducted, which included tests of normality, linearity, and multicollinearity, to ensure that the data met the assumptions required for further statistical testing. Third, multiple linear regression analysis was used to determine the effect of the independent variables on the dependent variable and to identify whether the influence was positive or negative for each independent variable. As noted earlier, the assumption tests were performed before conducting the regression analysis.

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The results of the normality test using the Kolmogorov–Smirnov test showed a significance value of 0.131 ($p > 0.05$), indicating that the data were normally distributed. The results of the linearity test showed that the relationship between self-stigma and social identity had a linearity value of 0.000 ($p < 0.05$) and a deviation from linearity value of 0.127 ($p > 0.05$), indicating that the two variables were linearly correlated. Similarly, the relationship between self-stigma and attitudes toward anti-smoking campaigns produced a linearity value of 0.030 ($p < 0.05$) and a deviation from linearity value of 0.72 ($p > 0.05$), indicating a linear correlation between these two variables. The multicollinearity test results showed a tolerance value of 0.745 ($T > 0.1$) and a Variance Inflation Factor (VIF) value of 1.342 ($VIF < 10$) for both social identity and attitudes toward anti-smoking campaigns. These results indicate that no multicollinearity was present, that is, there was no high intercorrelation among the independent variables. Therefore, the predictive power of the model is reliable and stable.

Table 1. Multiple Linear Regression Test (F-test)

F	**R**	**R *square***	***Sig* (*p*)**	**Description**
24.706	0.367	0.135	.000	Highly significant

Source: Data processed using SPSS (2021)

The analysis results above indicate that social identity and attitudes toward anti-smoking campaigns, when considered together, have a highly significant influence on the self-stigma of smokers in Yogyakarta, as shown by an R-squared value of 0.135. This means that 13.5% of the variance in self-stigma can be explained by social identity and attitudes toward anti-smoking campaigns, while the

remaining variance is explained by other factors. The calculated F-value was 24.706 with a probability of 0.000 ($p < 0.01$), indicating that the regression model was statistically significant and could be used to predict self-stigma. Thus, it can be concluded that social identity and attitudes toward anti-smoking campaigns jointly influence self-stigma, meaning that the main hypothesis is accepted.

The t-test in the multiple linear regression analysis was used to determine the partial effect of each independent variable on the dependent variable. A significance value of $p < 0.05$ indicates a partial influence of the independent variable on the dependent variable; otherwise, no significant effect is present. The results of the multiple linear regression analysis with the t-test are presented in the following table.

Table 2. Multiple Linear Regression Test (t-test)

Variable	Beta	T	Sig (*p*)	Description
Self-stigma with Social Identity	-0.425	-7.028	0.000	Highly significant
Self-stigma with attitude toward anti-smoking campaign	-0.206	-3.410	0.001	Highly significant

Source: Data processed using SPSS (2021)

The analysis results show a significance value of $p = 0.000$ ($p < 0.01$), indicating a highly significant negative (inverse) relationship between social identity and self-stigma. In other words, social identity had a strong and significant partial effect on self-stigma. This means that when an individual identifies themselves as a smoker, their level of self-stigma tends to decrease. Thus, the first minor hypothesis was accepted. Furthermore, the results of the multiple linear regression analysis showed a significance value of $p = 0.001$ ($p < 0.01$), indicating a highly significant negative (inverse) relationship between attitudes toward anti-smoking campaigns and self-stigma. This finding confirms that the second minor hypothesis is accepted.

Table 3. Contribution Value of Independent Variables to the Dependent Variable

Variabel	Beta	Zero Order	Beta x Zero Order x 100%	Keterangan
Self-stigma with social identity	-0.425	-0.321	-0.425 x -0.321 x 100% = 13.642 %	Highly significant
Self-stigma with attitude toward anti-smoking campaign	-0.206	0.008	-0.206 x 0.008 x 100% =-0.001 %	Highly significant

Source: Data processed using SPSS (2021)

Based on the results above, it can be seen that the effective contribution of the social identity variable (X1) to self-stigma (Y) is 13.642%, while the effective contribution of the attitude toward anti-smoking campaigns variable (X2) to self-stigma (Y) is -0.001%. This indicates that social identity has a more dominant influence on self-stigma than attitudes toward anti-smoking campaigns. The total effective contribution of both variables was 13.64%.

4.2 Discussion

The findings of this study show that social identity and attitudes toward anti-smoking campaigns jointly influence smokers' self-stigmatization. This result is consistent with Goffman's (1968) theory of stigma and the concept of stigma internalization proposed by Link and Phelan (2001), which explains that individuals tend to internalize the negative labels society attaches to their group. In this context, anti-smoking campaigns that highlight the negative image of smokers can strengthen the process of stigma internalization and lower self-esteem (Evans-Polce et al., 2015).

Social identity and attitudes toward anti-smoking campaigns strongly affect smokers' self-stigma because social identity refers to the process through which individuals identify themselves as members of a particular group, feeling emotionally attached to and a sense of belonging to that group. Similarly, attitudes toward anti-smoking campaigns reflect awareness of and beliefs about the health consequences of smoking. Thus, when smokers identify themselves as "smokers," develop emotional bonds with other smokers, and support anti-smoking campaigns while understanding that smoking is not a socially normal behavior, they tend to experience self-stigma. This finding supports Haighton *et al.* 's (2016) found that social pressure and public attitudes toward smokers contribute to feelings of shame and social avoidance. However, unlike previous studies, this study found that the influence of social identity on self-stigma is not entirely negative; some respondents developed coping strategies by adjusting to their social environment, which helped reduce feelings of alienation. This suggests that the effects of stigma are not uniform but depend on the social context and the strength of group identity.

The results align with Major and O'Brien (2005), who explained that when individuals categorize themselves as members of a stigmatized group, they tend to interpret discrimination as intergroup hostility. This perception can lead to social exclusion and emotional distress, as identity threat occurs when stigma-related stressors are perceived to endanger the smoker's social identity. Such identity threats trigger stress responses and motivate coping efforts (Major et al., 2018). Harsh anti-smoking campaigns may increase self-stigma among active smokers (Blondé & Falomir-Pichastor, 2021) as they depict smoking as an unattractive behavior and contribute to social exclusion (McCool et al., 2013), thereby reinforcing self-stigma among smokers..

Although anti-smoking campaigns often succeed in reducing smoking rates, their negative tone can lead to unintended consequences such as reactance. The stigma embedded in such campaigns can lower smokers' self-esteem, make quitting more difficult, provoke anger, and increase smoking behavior (Evans-Lacko, 2016). This is because these campaigns are widely disseminated across media platforms—television, newspapers, social media, billboards, and cigarette packaging—using denormalization strategies and strong visual imagery to evoke fear. Consequently, smokers exposed to these campaigns may perceive society as holding negative attitudes toward them, which in turn contributes to self-stigmatization.

Interestingly, this study found a negative (inverse) relationship between social identity and self-stigma. This means that when individuals identify themselves as smokers, their self-stigma decreases. This can occur because social identity provides social support that buffers the negative effects of stigma (Jetten et al., 2018). Additionally, self-stigma can be mitigated through three other key factors: having a psychological connection with one's environment, possessing purpose, values, and meaning in life, and maintaining control and trust within one's group (Greenaway et al., 2015). These factors may explain why social identity does not necessarily have a positive relationship with self-stigma.

Further supporting this finding, Armenta and Hunt (2009) and Jetten et al.. (2001) found that perceived stigma can strengthen ingroup identification, reinforcing a sense of belonging to one's group (see also). In other words, when a group is stigmatized, its members may become more strongly identified with it. For example, if smokers face stigma due to their smoking behavior, they may perceive their group as undervalued by society and thus develop a stronger identification with fellow smokers. The negative influence of social identity on self-stigma is also supported by Rudika et al.. (2023), who found that environmental factors such as family and peer influence play an important role in shaping smoking behavior. In many Indonesian communities, smoking is considered a social norm, leading smokers to feel minimal societal stigma.

Similarly, data from Indonesia's Basic Health Research (Riskesdas) 2013 (Nurhalina, 2019) indicate that social environmental factors, such as family members or peers who smoke, influence smoking behavior in Indonesia. The study found that 70.6% of respondents reported that their family members at home also smoke. This normalization of smoking behavior from an early stage helps explain why smoking is socially accepted. Other research has also shown that smoking can be perceived as an

accepted or even desirable identity among peers and fellow smokers (Tombor *et al.*, 2015), demonstrating that social identity can make smoking more socially acceptable.

Moreover, the study found a negative relationship between attitudes toward anti-smoking campaigns and self-stigma. This means that when a smoker holds a positive attitude toward anti-smoking campaigns (i.e., supports them), their level of self-stigma tends to be lower and vice versa. This is consistent with Evans-Polce *et al.*. (2015), who noted that anti-smoking campaigns can produce both positive and negative outcomes. While they may reduce smoking rates, they can also increase self-stigma and resistance toward anti-smoking messages, leading to relapse, heightened resistance to quitting, and increased stress.

Thompson *dkk*. (2007) explain that smokers in low-income communities may perceive smoking as a form of "resistance" to broader social norms, making them less receptive to anti-smoking messages and information about the health consequences of tobacco use. This behavior tends to persist, leading to a situation in which people in Indonesia—especially those from lower socioeconomic groups in Yogyakarta—remain less exposed to strong anti-smoking campaigns. This suggests that smokers from lower social classes may experience less stigmatization than those from higher social groups, as smoking is more socially accepted within their communities than among upper social groups (Strech et al., 2013). Accordingly, lower-income communities tend to have higher levels of resistance toward health sector campaigns (Boulware et al., 2003); therefore, it is necessary to design anti-smoking health campaigns that can positively and consistently change beliefs and attitudes toward smoking (Riley et al., 2017).

A possible solution to this issue is to present anti-smoking campaign messages in emotional formats that can convey health information to smokers in ways that are difficult to ignore, appear natural, and are easily processed. Emotional messages tend to evoke feelings that increase perceived vulnerability to smoking-related diseases and enhance the motivation to quit (Hinyard & Kreuter, 2007). This explains why the study's findings indicate that attitudes toward anti-smoking campaigns have a negativeor inverseeffect on self-stigma among smokers in Yogyakarta.

Furthermore, regarding the effective contribution of social identity and attitudes toward anti-smoking campaigns to smokers' self-stigma, the study found a total contribution of 13.64%. This relatively small percentage indicates that many other factors shape self-stigma among smokers, apart from social identity and attitudes toward anti-smoking campaigns. For example, Lipperman-Kreda et al.. (2019) found that multiple intersecting forms of self-stigma, such as race and economic disadvantage, contribute to the smoking-related self-stigma experienced by sexual and gender minority adults.

In addition, the finding of a negative effect provides an important contribution to future research. This indicates that self-stigma among smokers is not solely determined by attitudes toward anti-smoking campaigns but also by other factors such as social support, perceived self-control, and cultural norms embedded in smoking behavior in Indonesia. Thus, this study broadens the understanding of stigma dynamics within the local cultural context and highlights the need for more empathetic and context-sensitive intervention.

5. Conclusions

This study shows that social identity and attitudes toward anti-smoking campaigns simultaneously affect smokers' self-stigma negatively and significantly. This means that the stronger the social identity and the more positive the attitude toward anti-smoking campaigns, the lower the level of self-stigma in smokers.

The findings reinforce Goffman's (1968) stigma theory and the stigma internalization concept proposed by Lucksted and Drapalski (2015), demonstrating that self-stigma is shaped not only by external social labels but also by individuals' perceptions of social identity and acceptance of public messages.

Moreover, this study extends the application of stigma theory by linking it to smoking behavior among young adults in Indonesia, a topic rarely explored empirically.

Practically, the results can serve as a basis for health practitioners and university counselors to develop psychosocial intervention programs that help young smokers build a positive self-image without relying on smoking. Peer support and psychoeducation-based approaches can be utilized to reduce feelings of shame and guilt associated with self-stigma.

For policymakers, the findings highlight the importance of designing non-punitive anti-smoking campaigns that emphasize empathy, education, and empowerment. Overly stigmatizing campaigns may instead strengthen guilt and hinder the motivation to quit smoking. Therefore, tobacco control policies should be accompanied by public communication strategies that are sensitive to the psychological aspects of young smoking.

Limitations and Future Research

Future research should include electronic cigarettes as a variable to examine differences in usage and their influence on self-stigma. Further studies could also explore other dimensions of self-stigma, such as social stigma, perceived stigma, and experiences of discrimination, as anti-smoking campaigns and social identity may contribute differently to each dimension, leading to varying outcomes. Exploring such relationships would help elaborate on both the intended and unintended effects of anti-smoking campaigns and social identities. Additionally, similar studies should be conducted among adolescents, as the prevalence of smoking in Indonesia is dominated by this age group.

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Referensi

Anggarianto, O. M. (2018). Konsep diri pada wanita perokok. In *Fakultas Psikologi UMS*.

Armenta, B. E., & Hunt, J. S. (2009). Responding to societal devaluation: Effects of perceived personal and group discrimination on the ethnic group identification and personal self-esteem of Latino/Latina adolescents. *Group Processes and Intergroup Relations*, *12*(1), 23–39. https://doi.org/10.1177/1368430208098775

Arnett, J. J. (2023). Emerging Adulthood: The Winding Road from the Late Teens Through the Twenties. In *Emerging Adulthood: The Winding Road from the Late Teens Through the Twenties*. Oxford University Press. https://doi.org/10.1093/oso/9780197695937.001.0001

Badan Pusat Statistik. (2022). *Persentase merokok pada penduduk umur ≥ 15 tahun menurut provinsi (Persen), 2019-2021*. Badan Pusat Statistik. bps.go.id

Bennett, M. J. (1990). Stigmatization: experiences of persons with acquired immune deficiency syndrome. *Issues in Mental Health Nursing*, *11*(2), 141–154. https://doi.org/10.3109/01612849009014550

Berger, B. E., Ferrans, C. E., & Lashley, F. R. (2001). Measuring stigma in people with HIV: Psychometric assessment of the HIV stigma scale. *Research in Nursing and Health*, *24*(6), 518–529. https://doi.org/10.1002/nur.10011

Blondé, J., & Falomir-Pichastor, J. M. (2021). Smoker identity and resistance to antismoking campaigns: The role of group entitativity. *Group Processes and Intergroup Relations*, *24*(1), 160–176. https://doi.org/10.1177/1368430219884633

Bottorff, J. L., Oliffe, J. L., Kelly, M. T., Johnson, J. L., & Chan, A. (2013). Reconciling parenting and smoking in the context of child development. *Qualitative Health Research*, *23*(8), 1042–1053. https://doi.org/10.1177/1049732313494118

Boulware, L. E., Cooper, L. A., Ratner, L. E., LaVeist, T. A., & Powe, N. R. (2003). Race and trust in the health care system. *Public Health Reports*, *118*(4), 358–365. https://doi.org/10.1016/S0033-3549(04)50262-5

Bovin, G., Koskenvuo, K., Oksanen, A., Lindström, J., Leino-Arjas, P., & Härkänen, T. (2016). The

influence of smoking stigma on the association between smoking and common mental disorders. *Journal of Epidemiology & Community Health*, *70*(12), 1232–1238.
Cameron, J. E. (2004). A three-factor model of social identity. *Self and Identity*, *3*(3), 239–262. https://doi.org/10.1080/13576500444000047
Corrigan, P. W., Rüsch, N., Watson, A. C., Kosyluk, K., & Sheehan, L. (2024). *Principles and practice of psychiatric rehabilitation : promoting recovery and self-determination*. Guilford Publications.
Crandall, C. S., & Coleman, R. (1992). Aids-Related Stigmatization and the Disruption of Social Relationships. *Journal of Social and Personal Relationships*, *9*(2), 163–177. https://doi.org/10.1177/0265407592092001
Etikan, I. (2017). Sampling and Sampling Methods. *Biometrics & Biostatistics International Journal*, *5*(6), 149. https://doi.org/10.15406/bbij.2017.05.00149
Evans-Lacko, S. (2016). *Why campaigns that stigmatize smokers can make them want to quit even less*. Ise.Ac.Uk. blogs.lse.ac.uk.
Evans-Polce, R. J., Castaldelli-Maia, J. M., Schomerus, G., & Evans-Lacko, S. E. (2015). The downside of tobacco control? Smoking and self-stigma: A systematic review. *Social Science and Medicine*, *145*, 26–34. https://doi.org/10.1016/j.socscimed.2015.09.026
Evans-Polce, R. J., Castaldelli-Maia, J. M., Schomerus, G., Evans-Lacko, S. E., Choi, J., Noh, G., Riley, K. E., Ulrich, M. R., Hamann, H. A., Jamie, S., Emathia, D., Arifin, H. S., Mulyana, S., Komunikasi, J. I., Ilmu, F., Dan, S., Politik, I., Diponegoro, U., Durkin, S. J., … Warner, K. E. (2015). The downside of tobacco control? Smoking and self-stigma: A systematic review. *Social Science and Medicine*, *145*(1), 26–34. https://doi.org/10.1016/j.socscimed.2015.09.026
Goffman, E. (1968). Stigma; Notes on the management of spoiled identity. In *Jason Aronson, New York, N.Y.* Penguin Books. https://doi.org/10.2307/2575995
Graham, H. (2012). Smoking, stigma and social class. *Journal of Social Policy*, *41*(1), 83–99. https://doi.org/10.1017/S004727941100033X
Greenaway, K. H., Haslam, S. A., Cruwys, T., Branscombe, N. R., Ysseldyk, R., & Heldreth, C. (2015). From "we" to "me": Group identification enhances perceived personal control with consequences for health and well-being. *Journal of Personality and Social Psychology*, *109*(1), 53–74. https://doi.org/10.1037/pspi0000019
Hadi, C. (2024). Detoks Digital dan Otonomi Relasional pada peningkatan pemaknaan budaya kolektivitas. *Kajian Psikologi dan Kesehatan Mental, 2*(2), 95-107. doi:10.35912/kpkm.v2i2.5527
Haighton, C., Wilson, G., Ling, J., McCabe, K., Crosland, A., & Kaner, E. (2016). A qualitative study of service provision for alcohol related health issues in mid to later life. *PLOS ONE*, *11*(2), e0148601. https://doi.org/10.1371/journal.pone.0148601
Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, *103*(5), 813–821. https://doi.org/10.2105/AJPH.2012.301069
Hinyard, L. J., & Kreuter, M. W. (2007). Using narrative communication as a tool for health behavior change: A conceptual, theoretical, and empirical overview. *Health Education and Behavior*, *34*(5), 777–792. https://doi.org/10.1177/1090198106291963
Jetten, J., Branscombe, N. R., Schmitt, M. T., & Spears, R. (2001). Rebels with a cause: Group identification as a response to perceived discrimination from the mainstream. *Personality and Social Psychology Bulletin*, *27*(9), 1204–1213. https://doi.org/10.1177/0146167201279012
Jetten, J., Haslam, S. A., Cruwys, T., & Branscombe, N. R. (2018). *Social identity, stigma, and health.* psycnet.apa.org. https://psycnet.apa.org/record/2017-57025-016
Lee, S., Ahn, D., Kim, J., Park, C., Kim, K., Kim, A., & ... (2021). Human Rights and Social Stigma Review for Leprosy Patients in Korea. In *Advances in Infectious …*. scirp.org. https://www.scirp.org/html/9-1950425_107920.htm
Link, B. G. (1987). *Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection*. *52*(1), 96–112.
Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment. *American Sociological Review*, *54*(3), 400. https://doi.org/10.2307/2095613

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385.

Lipperman-Kreda, S., Antin, T. M. J., & Hunt, G. P. (2019). The role of multiple social identities in discrimination and perceived smoking-related stigma among sexual and gender minority current or former smokers. *Drugs: Education, Prevention and Policy*, *26*(6), 475–483. https://doi.org/10.1080/09687637.2018.1490391

Lu, X., Chen, H., Bai, D., Chen, X., Ji, W., Gao, H., Yuan, Y., Hou, C., & Gao, J. (2025). Worldwide changes in self-stigma among people with mental illness from 2005 to 2023: A cross-temporal meta-analysis and systematic review. *International Psychogeriatrics*, 100106. https://doi.org/10.1016/j.inpsyc.2025.100106

Lucksted, A., & Drapalski, A. L. (2015). Self-stigma regarding mental illness: Definition, impact, and relationship to societal stigma. *Psychiatric Rehabilitation Journal*, *38*(2), 99–102. https://doi.org/10.1037/prj0000152

Major, B., Dovidio, J. F., & Link, B. G. (2018). *The Oxford handbook of stigma, discrimination, and health*. books.google.com. https://books.google.com/books?hl=en&lr=&id=aOw9DwAAQBAJ&oi=fnd&pg=PP1&dq=stigma+and+discrimination&ots=dKRPcZ_fUy&sig=qbdQ1PvTQ2cfpcOLcvt3iiZqZzQ

Major, B., Dovidio, J. F., Link, B. G., & Calabrese, S. K. (2018). *Stigma and its implications for health : Introduction and overview stigma and its implications for health : Introduction and overview*. https://doi.org/10.1093/oxfordhb/9780190243470.013.1

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology*, *56*, 393–421. https://doi.org/10.1146/annurev.psych.56.091103.070137

McCool, J., Hoek, J., Edwards, R., Thomson, G., & Gifford, H. (2013). Crossing the smoking divide for young adults: Expressions of stigma and identity among smokers and nonsmokers. *Nicotine and Tobacco Research*, *15*(2), 552–556. https://doi.org/10.1093/ntr/nts136

Nurhalina, N. (2019). Sosial Determinan dan Perilaku Merokok di Indonesia (Analisa Data Riskesdas Tahun 2013). *Borneo Journal of Medical Laboratory Technology*, *1*(2), 67–76. https://doi.org/10.33084/bjmlt.v1i2.714

Putri, S. E., & Hamdan, S. R. (2021). *Pengaruh Stigma Merokok terhadap Perilaku Merokok pada Perokok Aktif Dewasa Awal Usia 18- 30 Tahun*. *November*, 420–423.

Pramesti, V. A., & Arianti, R. (2023). Kebersyukuran pada Anak yang Sudah Mengetahui Statusnya sebagai Anak Adopsi. *Kajian Psikologi dan Kesehatan Mental, 1*(1), 1-15. doi:10.35912/kpkm.v1i1.1948

Putri, Y., & Nurhuda, A. (2023). Moralitas Aborsi karena Kehamilan Remaja: Ditinjau dalam Perspektif Feminisme dan Sains. *Kajian Psikologi dan Kesehatan Mental, 1*(1), 17-24. doi:10.35912/kpkm.v1i1.2284

Reinius, M., Wettergren, L., Wiklander, M., Svedhem, V., Ekström, A. M., & Eriksson, L. E. (2017). Development of a 12-item short version of the HIV stigma scale. *Health and Quality of Life Outcomes*, *15*(1), 1–10. https://doi.org/10.1186/s12955-017-0691-z

Ristianto, P. S. M., & Jatnika, R. (2023). Gambaran Self-Concept pada Mahasiswi Fakultas Psikologi Universitas Padjadjaran yang Pernah Mengalami Body Shame. *Kajian Psikologi dan Kesehatan Mental, 1*(2), 87-95. doi:10.35912/kpkm.v1i2.2371

Riley, K. E., Ulrich, M. R., Hamann, H. A., & Jamie, S. (2017). *Decreasing Smoking but Increasing Stigma? Anti-tobacco Campaigns, Public Health, and Cancer Care*. *19*(5), 475–485. https://doi.org/10.1001/journalofethics.2017.19.5.msoc1-1705.Decreasing

Rose, S., Boyes, A. W., Kelly, B., Bridge, P., Carlson, M., Coutts, E., & Paul, C. (2022). Antitobacco advertising and lung cancer stigma: A qualitative study of the experiences of people with a lung cancer diagnosis. *Journal of Psychosocial Oncology Research and Practice*, *4*(1), E069. https://doi.org/10.1097/OR9.0000000000000069

Rosenberg, M. J., & Hovland, C. I. (1960). *Cognitive, affective and behavioral components of attitudes. in M.J. Rosenberg, C.I. Hovland, W.J. McGuire, R.P. Abelson and J.W. Brehm (Eds.), Attitude organization and change: An analysis of consistency among attitude components*. Yale University Press.

Rössler, W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Reports*, *17*(9), 1250–1253. https://doi.org/10.15252/embr.201643041

Rudika, W., Putri, S. R., dan Casiavera, Sosiologi, P. S., dan Ilmu Politik, F. I. S., & Haji, U. M. R. A. (2023). Perilaku Merokok Sebagai Identitas Sosial di Kalangan Pelajar Kacamatan Tanjungpinang Timur. *Social Issues Quarterly*, *1*(2), 284–292. https://ejournal.umrah.ac.id/index.php/siq/article/view/57

Santrock, J. (2023). *Life-span development. Thirteenth Edition* (Vol. 21, Issue 1). McGraw-Hill. http://journal.um-surabaya.ac.id/index.php/JKM/article/view/2203

Scheff, T. J. (1974). The Labelling Theory of Mental Illness. *American Sociological Review*, *39*(3), 444–452. https://doi.org/10.2307/2094300

Strech, D., Hirschberg, I., Marckmann, G., & Studies, C. (2013). *Ethics in public health and health policy : Concepts, methods, case studies*. Springer Science+Business Media.

Sugiyono, D. (2013). *Metode Penelitian Kuantitatif, Kualitatif, dan R & D*. alfabeta.

Tajfel, H., & Turner, J. C. (2019). The Social Identity Theory of Intergroup Behavior. In *Political Psychology* (pp. 276–293). Psychology Press. https://doi.org/10.4324/9780203505984-16

Thompson, L., Pearce, J., & Barnett, J. R. (2007). Moralising Geographies: Stigma, Smoking Islands and Responsible Subjects. *Area*, *39*(4), 508–517. http://www.jstor.org/stable/40346072

Tombor, I., Shahab, L., Herbec, A., Neale, J., Michie, S., & West, R. (2015). Smoker identity and its potential role in young adults' smoking behavior: A meta-ethnography. *Health Psychology*, *34*(10), 992–1003. https://doi.org/10.1037/hea0000191

Triandafilidis, Z., Ussher, J. M., Perz, J., & Huppatz, K. (2017). An intersectional analysis of women's experiences of smoking-related stigma. *Qualitative Health Research*, *27*(10), 1445–1460. https://doi.org/10.1177/1049732316672645

Ulfa, A., Agustiani, H., Qodariah, L., & Jatnika, R. (2023). Children's Perceptions of Parental Mediation on Internet Use. *Kajian Psikologi dan Kesehatan Mental, 1*(2), 97-108. doi:10.35912/kpkm.v1i2.2759

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology*, *60*(2), 311–316. https://doi.org/10.1037/a0031889

Weitz, R. (1990). Living with the stigma of AIDS. *Qualitative Sociology*, *13*(1), 23–38. https://doi.org/10.1007/BF00988594

WHO. (2022). *Tobacco*. Who.Int. Di askes pada 20 juni 2021.