Original article

Perceived occupational stigma and its associated factors among hospital nurses in Central Vietnam: A cross-sectional study

Tran Thi Hang[1*], Tran Thi Nguyet[1], Ton Nu Minh Duc[1], Duong Thi Hong Lien[2], Truong Thi Han[2]

[1]Faculty of Nursing, Hue University of Medicine and Pharmacy, Hue University
[2]Nursing and Social Work Department, Hue University of Medicine and Pharmacy Hospital

***Corresponding author:** Tran Thi Hang; email: tthang@huemed-univ.edu.vn
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Abstract

Background: Perceived occupational stigma may influence nurses' professional identity, job satisfaction, and retention, yet evidence among practising nurses in Vietnam remains limited. This study examined perceived occupational stigma and its associated factors among hospital nurses.

Methods: A cross-sectional study was conducted among 165 hospital nurses. Data were collected using the 16-item Nurse Occupational Stigma Scale (NOSS), participants also completed measures of career commitment, organisational support, job satisfaction, and a structured questionnaire on sociodemographic and work-related characteristics. Descriptive statistics, bivariate analyses, correlation and hierarchical multiple linear regression were performed.

Results: The mean NOSS score was 34.11 ± 6.66 (range: 17 – 53). Among the three dimensions, Devaluation and Discrimination had the highest mean item score, followed by Negative Label and Nurse–Patient Relationship. Perceived occupational stigma was negatively correlated with career commitment ($r = -0.23$, $p = 0.003$) and perceived organisational support ($r = -0.19$, $p = 0.012$). Nurses who were satisfied with their jobs reported lower perceived occupational stigma than those with neutral job satisfaction ($p = 0.011$). In hierarchical regression, career commitment was a significant correlate of perceived occupational stigma in the initial model ($\beta = -0.17$, $p = 0.038$), but associations attenuated after adding job satisfaction; the final model explained 8% of variance in perceived occupational stigma.

Conclusion: Perceived occupational stigma was associated with career commitment, organisational support, and job satisfaction at the bivariate level, although these factors explained only a limited proportion of variation in stigma. The findings highlight the importance of professional recognition and supportive work environments alongside broader efforts to improve public perceptions of nursing.

Keywords: *perceived occupational stigma; nurses; nurse occupational stigma scale; career commitment; organisational support; job satisfaction.*

1. INTRODUCTION

Nurses constitute the largest group of healthcare professionals and are indispensable to the delivery of safe, high-quality care across health systems [1]. Despite their central role, the nursing profession has long struggled with a negative and often distorted public image, shaped by gendered stereotypes that portray nurses as female, subordinate helpers with low professional status rather than autonomous, highly skilled practitioners [2, 3]. Such perceptions may influence nurses' self-concept, professional identity and social recognition of nurses and limit career opportunities for nurses, impacting their job retention and performance [4, 5].

Occupational stigma refers to socially constructed negative perceptions directed toward members of a particular occupation, including negative stereotyping, devaluation, status loss, and discriminatory attitudes or behaviours [6]. In nursing, such stigma may involve perceiving nurses as inferior to medical practitioners or viewing nursing as a less prestigious profession [7]. This concept has been further conceptualized through the Nurse Occupational Stigma Scale (NOSS), which defines stigma as the negative label and negative evaluation attached by the public to nurses' behaviours, characteristics, social status, and nurse–patient relationships [8]. Drawing on Link and Phelan [9] model of stigma, the NOSS framework highlights three interrelated components: Negative Label, reflecting negative stereotypes about nurses, such as perceptions of being less educated or subordinate; Nurse-Patient Relationship, reflecting social perceptions that may position nurses and patients as separate social groups; and Devaluation and Discrimination, reflecting perceptions of lower occupational status and unequal social or economic

recognition [8]. The three-dimensional structure highlights that occupational stigma is not simply a negative feeling about one's occupation, but a multidimensional social construct encompassing stereotypes, relational perceptions, and devaluation or discrimination directed toward nursing as an occupation.

A growing body of evidence shows that occupational stigma has substantial consequences for nurses' health and organisational outcomes. Higher perceived occupational stigma among clinical nurses have been linked to poorer mental wellbeing, emotional exhaustion, reduced job satisfaction, and stronger intentions to leave their jobs [8, 10]. A recent study by Yaosonga and Keatb [11] indicate that occupational stigma negatively influences employees' commitment and emotional well-being. These findings suggest that occupational stigma may be shaped not only by broader societal stereotypes but also by nurses' experiences within their workplaces. Consistent with research on the public image of nursing, persistent perceptions of nursing as a low-status occupation may also undermine professional identity and contribute to challenges in recruitment, retention, and workforce stability [3, 4]. Taken together, prior work positions occupational stigma as an important issue related to nurses' wellbeing and organisational performance, reinforcing the need to understand stigma in relation to career commitment, job satisfaction, and supportive work environments.

Despite increasing recognition of the potential consequences of occupational stigma, evidence regarding this issue among practising nurses remains limited, particularly in low- and middle-income countries. Moreover, integrative reviews of the public image of nursing highlight that the impact of negative, low-status portrayals on recruitment, retention, and satisfaction may differ by country and health system, highlighting the need for context-specific evidence from under-studied settings [4]. In Vietnam, sociocultural expectations, professional hierarchies, and workplace conditions may shape how nursing is perceived and experienced; however, empirical evidence on occupational stigma among Vietnamese nurses remains scarce. Therefore, this study aimed to assess perceived occupational stigma and examine its associated factors among nurses in central Vietnam.

2. METHODS

2.1. Study design and setting

A cross-sectional study was conducted to examine perceived occupational stigma and its associated factors among nurses. The study was conducted at Hue University of Medicine and Pharmacy Hospital, Central Vietnam, between June 2026 and July 2026. The study setting included nurses working across clinical departments, including internal medicine, surgery, obstetrics and gynecology, pediatrics, intensive care, emergency care, and other clinical or nursing-related units.

2.2. Participants and sampling

The target population comprised nurses working at Hue University of Medicine and Pharmacy Hospital. Nurses were eligible to participate if they were currently employed as nurses at the study setting, had sufficient experience to report on their professional and workplace experiences, and were able to understand and complete the study questionnaire. Nurses who were on extended leave or unable to complete the questionnaire during the data collection period were excluded.

The required sample size was calculated using the formula for estimating a single population mean:

$$n = \left(\frac{Z_{1-\alpha/2} \times \sigma}{d} \right)^2$$

In which:

$Z_{1-\alpha/2}$ = 1.96 for a 95% confidence level; σ = 11.40 was the expected standard deviation of the total perceived occupational stigma score based on a previous study by Atta et al. [7] among nursing students using the same 16-item Nurse Occupational Stigma Scale (NOSS); d = 2 points was the allowable margin of error. Although the previous study involved nursing students rather than practising nurses, it was used as the best available estimate of variability because the same instrument and construct were assessed and no prior SD estimate among practising nurses was available at the time of study planning.

The calculated minimum sample size was 125 nurses. A total of 165 nurses participated in the study, exceeding the minimum required sample size.

Participants were recruited using convenience sampling. Eligible participants were invited to participate and were provided with information about the study before completing the questionnaire.

2.3. Data collection

Data were collected using a structured self-administered questionnaire developed based on the study objectives. The questionnaire consisted of four sections:

Perceived occupational stigma

Perceived occupational stigma was the primary outcome of the study and was assessed using the

16-item Nurse Occupational Stigma Scale (NOSS) developed by Yang *et al.* [8]. The scale comprises three dimensions: Negative Label (5 items), Nurse–Patient Relationship (6 items), and Devaluation and Discrimination (5 items). Each item was rated on a five-point Likert scale. The total score was calculated by summing the responses to all 16 items, resulting in a possible score range of 16 – 80. Higher scores indicated higher levels of perceived nurse occupational stigma [8].

The NOSS was originally developed to assess occupational stigma toward nurses from an external perspective. In the present study, it was administered to practising nurses to assess perceived occupational stigma, reflecting nurses' perceptions of negative labelling, devaluation, discrimination, and social distancing associated with the nursing profession. Thus, the NOSS score was interpreted as perceived occupational stigma rather than external occupational stigma or internalized occupational stigma. In the present study, the NOSS demonstrated acceptable internal consistency, with a Cronbach's alpha coefficient of 0.81.

Career commitment

Career commitment was assessed using an 8-item career commitment scale [12]. Each item was rated on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The total score was calculated by summing the responses across the eight items, yielding a possible score range of 8 - 40. Higher scores indicated stronger commitment to a nursing career. The scale demonstrated good internal consistency, with a Cronbach's alpha coefficient of 0.85.

Organisational support

Perceived organisational support was measured using an eight-item organisational support scale [13]. Each item was rated on a seven-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). A total score was calculated by summing the item responses, with possible scores ranging from 8 to 56. Higher scores indicated greater perceived organisational support. The internal consistency of the scale was acceptable, with a Cronbach's alpha coefficient of 0.80 in the present study.

Sociodemographic and work-related characteristics

The questionnaire collected information on participants' age, gender, living area, educational level, work experience, and job satisfaction. Age and work experience were recorded as continuous variables. Educational level was categorised as diploma, bachelor's degree, or postgraduate qualification. Job satisfaction was categorised as dissatisfied, neutral, or satisfied.

Translation and cultural adaptation

The original English instruments were used with permission from the original authors and translated and culturally adapted according to the guidelines of Cruchinho *et al.* [14]. The adaptation process involved forward translation, back-translation, and review by two nursing experts with relevant professional experience. The Vietnamese versions were reviewed for clarity, comprehensibility, relevance, and cultural appropriateness. Any discrepancies or unclear wording identified during the review process were discussed and revised by the research team.

The revised Vietnamese version was subsequently pilot-tested among 20 practising nurses who were not included in the main study to assess the clarity and comprehensibility of the items and the feasibility of the questionnaire administration. Feedback from the pilot participants was considered in finalising the questionnaire. A formal content validity index (CVI) was not calculated in the present study. Therefore, the psychometric properties of the Vietnamese NOSS, particularly its content validity and factorial structure, require further evaluation in future studies. The internal consistency of the NOSS in the present study was acceptable (Cronbach's $\alpha = 0.81$).

Data were collected during continuing professional development training sessions, where eligible nurses were gathered in a hall and invited to participate. Before participation, participants were informed about the study objectives, procedures, voluntary nature of participation, confidentiality, and their right to decline participation. Participants completed an anonymous, self-administered questionnaire electronically by scanning a QR code that linked to a Google Forms survey. Completion of the questionnaire required approximately 10 minutes. Participation was voluntary, and no directly identifying information was collected. All responses were treated confidentially and used solely for research purposes.

2.4. Data analysis

Data were analysed using IBM SPSS Statistics version 26.0. Descriptive statistics were used to summarize participants' characteristics and study variables. Categorical variables were presented as frequencies and percentages, while continuous variables were expressed as means and standard deviations. Distributional characteristics, outliers, and the assumptions of the relevant statistical tests were assessed using graphical and statistical

methods. Bivariate analyses included independent-samples t-tests, one-way analysis of variance, and Pearson's correlation.

Hierarchical multiple regression was performed to examine factors associated with perceived occupational stigma. Career commitment and perceived organisational support were entered in Block 1 based on their theoretical relevance to professional identity and commitment [15, 16] and their observed associations with perceived occupational stigma in the present study. Job satisfaction was entered in Block 2 to assess its additional contribution beyond career commitment and perceived organisational support. Regression assumptions were assessed using residual plots and diagnostic statistics. Normality of residuals was assessed using the histogram and normal P–P plot, while linearity and homoscedasticity were examined using the residual scatterplot. Multicollinearity was assessed using tolerance and variance inflation factor (VIF). Standardized residuals were examined for potential extreme observations, and the Durbin–Watson statistic was used to assess residual independence. All tests were two-tailed, and a p value < 0.05 was considered statistically significant.

2.5. Ethical consideration

The study was approved by the Institutional Review Board of Hue University of Medicine and Pharmacy, Hue University (Approval No.: H2026/102, date March 31,2026).

All eligible participants received information about the study objectives, procedures, voluntary nature of participation, and confidentiality of the collected information. Participation was entirely voluntary, and completion or non-completion of the questionnaire had no influence on participants' employment, professional evaluation, training participation, or relationship with their managers or institution. No individual responses were shared with managers or used for employment-related evaluation. Informed consent was obtained from participants before questionnaire completion. Participants were informed that they could decline participation or withdraw from the study without any consequences. Questionnaires were collected and managed confidentially, and data were used solely for research purposes.

3. RESULTS

3.1. General characteristics of participants

Table 1. General characteristics of participants and perceived occupational stigma scores by participant characteristics (N = 165)

Variables		n (%)	Perceived Occupational Stigma	
			Mean ± SD	p-value
Age	Mean ± SD (Range)	36.16 ± 6.37 (23 – 52)		r = 0.02 p = 0.79
Gender	Female	147 (89.1%)	34.29 ± 6.59	0.33
	Male	18 (10.9%)	32.67 ± 7.22	
Living area	Urban	115 (69.7%)	34.04 ± 7.09	0.85
	Rural	50 (30.3%)	34.26 ± 5.60	
Educational level	Diploma	98 (59.4%)	33.47 ± 6.72	0.30
	Bachelor	61 (37.0%)	34.93 ± 6.36	
	Post graduate	6 (3.6%)	36.17 ± 8.47	
Job Satisfaction	Dissatisfied[a]	5 (3.0%)	37.20 ± 7.60	**0.008* (b > c, p = 0.011)**
	Neutral[b]	51 (30.9%)	36.24 ± 6.76	
	Satisfied[c]	109 (66.1%)	32.97 ± 6.34	
Working experiences (year)	Mean ± SD (Range)	12.70 ± 6.39 (1 – 26)		r = 0.02 p = 0.77

** Note. p-values represent independent-samples t-tests or one-way ANOVA/Welch tests, as appropriate. For age and working experiences, r represents the Pearson correlation coefficient with occupational stigma. Post-hoc comparisons for job satisfaction indicated a significant difference between the neutral and satisfied groups (p = 0.011).*

Among the 165 nurses, the mean age was 36.16 ± 6.37 years (range: 23 - 52), and the majority were female

(89.1%). Most participants lived in urban areas (69.7%) and held a diploma-level qualification (59.4%). The mean working experience was 12.70 ± 6.39 years (range: 1-26). Two-thirds of participants (66.1%) reported being satisfied with their jobs, while 30.9% were neutral and 3.0% were dissatisfied.

Perceived occupational stigma scores did not differ significantly according to gender, living area, or educational level ($p > 0.05$). Age and working experiences were also not significantly correlated with occupational stigma. In contrast, occupational stigma differed significantly by job satisfaction ($p = 0.008$), with nurses who were satisfied with their jobs reporting lower perceived occupational stigma scores than those in the neutral group ($p = 0.011$).

3.2. Nurse perceived occupational stigma and its subscales

Table 2. Mean scores of nurse perceived occupational stigma and its subscales (N = 165)

Variables	Mean ± SD	Mean item scores	Min – Max
Nurse Occupational Stigma (16 items)	34.11 ± 6.66	-	17 – 53
Dimension 1: Negative Label (5 items)	10.41 ± 2.38	2.08	5 – 18
Dimension 2: Nurse-Patient Relationship (6 items)	10.48 ± 2.70	1.75	6 – 18
Dimension 3: Devaluation and Discrimination (5 items)	13.22 ± 3.57	2.64	5 – 24

The mean total score for nurse perceived occupational stigma was 34.11 ± 6.66, with scores ranging from 17 to 53. Among the three dimensions, Devaluation and Discrimination had the highest mean item score (2.64), followed by Negative Label (2.08) and Nurse-Patient Relationship (1.75).

3.3. Correlations among perceived occupational stigma, career commitment, and organisational support

Table 3. Pearson correlations among perceived occupational stigma, career commitment, and organisational support (N = 165)

	Mean ± SD (Range)	Perceived Occupational Stigma	Career commitment	Organisational support
Perceived Occupational Stigma	34.11 ± 6.66 (17 – 53)	1		
Career commitment	27.89 ± 5.30 (8 – 40)	**-0.23 p = 0.003**	1	
Organisational support	40.92 ± 6.43 (19 – 52)	**-0.19 p = 0.012**	**0.36 p < 0.001**	1

** Pearson's correlation coefficients are presented.*

Pearson correlation analysis showed that perceived occupational stigma was significantly and negatively correlated with career commitment ($r = −0.23$, $p = 0.003$) and organisational support ($r = −0.19$, $p = 0.012$). Career commitment was also positively correlated with organisational support ($r = 0.36$, $p < 0.001$).

3.4. Perceived Occupational stigma and related factors

Table 4. Hierarchical multiple linear regression examining factors associated with perceived occupational stigma among nurses.

Dependent variable: Nurse Occupational Stigma Scale (NOSS) total score

Variables	Unstandardized Coefficients		Standardized Coefficients	95% CI	p
	B	SE	β		
Model 1: Block 1					
Constant	46.20	3.58	-	39.13; 53.27	**< 0.001**
Career commitment	-0.22	0.10	-0.17	-0.42; -0.01	**0.038**
Organisational support	-0.15	0.09	-0.14	- 0.32; 0.02	0.086
$R = 0.26$; $R^2=0.07$; adjusted $R^2 = 0.06$; $F(2,162) = 6.07$; $p = 0.003$					
$\Delta R^2 = 0.07$; F-change = 6.07; p = 0.003					

Model 2: Block 2					
Constant	42.51	4.93	-	32.78; 52.25	**< 0.001**
Career commitment	-0.15	0.12	-0.12	-0.38; 0.09	0.22
Organisational support	-0.12	0.09	-0.11	-0.30; 0.06	0.20
Job satisfaction					
Neutral vs satisfied	1.76	1.35	0.12	-0.92; 4.43	0.19
Dissatisfied vs satisfied	1.04	3.38	0.03	-5.64; 7.71	0.76
$R=0.28$; $R^2=0.08$; $F(4,160)=3.46$; $p = 0.01$					
$\Delta R^2 = 0.01$; F-change = 0.86; p = 0.43					

Notes. B = unstandardized regression coefficient; β = standardized regression coefficient; CI = confidence interval; R^2 = coefficient of determination. Model 1 included career commitment and organisational support. Model 2 additionally included job satisfaction dummy variables.

A hierarchical multiple linear regression analysis was conducted to examine factors associated with perceived occupational stigma among nurses. In Block 1, career commitment and organisational support were entered into the model. The model was statistically significant, F (2,162) = 6.07, p = 0.003, explaining 7.0% of the variance in occupational stigma (R^2 = 0.07; adjusted R^2 = 0.06). Career commitment was negatively associated with perceived occupational stigma (p = 0.038), whereas organisational support showed a negative but non-significant association (p = 0.086).

In Block 2, job satisfaction was added to the model, with the satisfied group used as the reference category. The full model remained statistically significant, F (4,160) = 3.46, p = 0.01; however, the explained variance increased only slightly from 7.0% to 8.0% (ΔR^2 = 0.01). This increase was not statistically significant, F-change (2,160) = 0.86, p = 0.43. Neither the neutral group (p = 0.19) nor the dissatisfied group (p = 0.76) showed a statistically significant association with perceived occupational stigma.

After the addition of job satisfaction, the association between career commitment and perceived occupational stigma was attenuated and was no longer statistically significant (p = 0.22). Similarly, organisational support remained negatively but non-significantly associated with perceived occupational stigma (p = 0.20).

The regression diagnostics indicated no substantial violations of the main assumptions. The histogram and normal P–P plot indicated approximately normally distributed residuals, while the residual scatterplot showed no clear pattern suggesting substantial problems with linearity or homoscedasticity. The Durbin–Watson statistic was 1.861. No problematic multicollinearity was identified, with VIF values ranging from 1.188 to 1.554 and tolerance values ranging from 0.643 to 0.842. Standardized residuals ranged from −2.524 to 2.399, with no extreme residuals exceeding ±3.

4. DISCUSSION

Overall, nurses reported a mean perceived occupational stigma score of 34.11 ± 6.66. Among the three dimensions, Devaluation and Discrimination had the highest mean item score, followed by Negative Label and Nurse–Patient Relationship. At the bivariate level, perceived occupational stigma was negatively associated with career commitment and perceived organisational support, while nurses who reported being satisfied with their jobs had lower stigma scores than those reporting neutral satisfaction. However, these associations were attenuated and no longer statistically significant after adjustment in the multivariable analysis. Overall, the findings suggest that perceived occupational stigma among nurses is related to, but not fully explained by, career-related and organisational factors.

Level and Dimensions of Occupational Stigma

The mean NOSS total score in this study was 34.11 ± 6.66 (range: 17 – 53), reflecting variation in nurses' perceived occupational stigma. Nevertheless, the mean score in the present study was lower than those reported in previous studies using the same 16-item NOSS among nursing students (53.15 ± 11.40) [7] and patients (39.61 ± 12.97) [8]. These differences should be interpreted cautiously because the studies involved different populations and perspectives. Nursing students may perceive occupational stigma differently during professional identity development, whereas practising nurses have direct experience of the workplace context and patients evaluate nursing from an external perspective. Thus, differences in NOSS scores may reflect variations in respondent

characteristics and professional experience rather than differences in the absolute level of occupational stigma. Nevertheless, the lower score among practising nurses provides preliminary evidence that occupational stigma may be perceived differently across stages of professional involvement.

Among the three dimensions, Devaluation and Discrimination had the highest mean item score. This finding is consistent with conceptualisations of occupational stigma in which negative social evaluation may involve perceived status loss and discriminatory treatment of an occupational group [8, 9]. Qualitative work with nurses has similarly found that perceptions of low social status and a sense of being devalued relative to other health professionals form a central part of how nurses experience occupational stigma in daily practice [17]. Similar concerns regarding low social status, lack of recognition, and occupational devaluation have also been reported in other health and social care professions [18, 19]. In contrast, the Negative Label and Nurse–Patient Relationship dimensions showed somewhat lower mean scores, indicating that stereotyping (e.g. "less educated", "servant") and problematic interactional dynamics with patients are important components of stigma but appear less pronounced than perceptions of structural devaluation and discrimination.

Occupational stigma and related factors

In this study, perceived occupational stigma was negatively correlated with career commitment and perceived organisational support, indicating that nurses who perceived higher levels of stigma tended to report weaker attachment to the profession and lower perceptions of being valued by their organisations. These patterns are congruent with previous work showing that occupational stigma is associated with emotional exhaustion and, which in turn is related to lower professional and career commitment among employees in stigmatized roles [11]. They also align with a broader literature in which perceived organisational support is negatively related to turnover intention and positively associated with psychological resilience and organisational commitment in nursing [20].

Occupational stigma differed significantly according to job satisfaction, with nurses in the neutral satisfaction group reporting higher stigma scores than those who were satisfied ($p = 0.011$). This finding aligns with recent evidence that perceived stigma among nurses caring for vulnerable or stigmatised patient populations is associated with lower job satisfaction, which in turn predicts weaker organisational commitment, suggesting job satisfaction may function as a key psychological pathway linking stigma to broader work attitudes [21].

In the hierarchical regression, career commitment and organisational support together explained a modest but significant proportion of variance in occupational stigma in Block 1 ($R^2 = 0.07$, $p = 0.003$), with career commitment as the only significant independent correlate ($\beta = -0.17$, $p = 0.038$). Adding job satisfaction in Block 2 did not significantly improve model fit ($\Delta R^2 = 0.01$, $p = 0.43$), and career commitment lost significance ($p = 0.22$). This attenuation may reflect shared variance among career commitment, job satisfaction, and occupational stigma rather than an independent contribution of job satisfaction. Overall, the final model explained approximately 8% of the variance in occupational stigma, indicating that these factors account for only a limited proportion of individual differences. Other factors, including professional identity, workplace environment, public perceptions of nursing, and experiences of occupational stigma, may also shape nurses' perceptions of occupational stigma and warrant further investigation [2-4].

There were no significant associations between occupational stigma and age, gender, living area, educational level, or years of experience. These findings suggest that occupational stigma may be related more broadly to perceptions of nursing as a profession than to individual characteristics of nurses. Previous literature has similarly documented persistent stereotypes concerning the social status, autonomy, and professional value of nursing, with public and media representations contributing to these perceptions [3, 22]. Accordingly, efforts to address occupational stigma may need to extend beyond specific demographic groups and focus on broader cultural and systemic influences, including public perceptions, media representations, professional recognition, and organisational and policy environments [4, 23].

Implications

The findings have implications for nursing practice, management, and policy. At the organisational level, the observed associations between perceived occupational stigma, career commitment, and organisational support highlight the relevance of professional recognition, supportive work environments, and opportunities for professional development when considering nurses' occupational experiences. At the broader system level, nursing organisations and policymakers could promote

accurate public and media representations of nursing that highlight nurses' expertise, autonomy, and contribution to healthcare, rather than relying on traditional or stereotypical portrayals. Such strategies may be considered as part of broader efforts to address the social and cultural factors underlying occupational stigma and strengthen the professional image of nursing [4, 23].

Limitations

This study has several limitations. First, its cross-sectional design limits causal inference and prevents determining the temporal relationships between occupational stigma and related factors. Second, the single-setting sample may limit the generalisability of the findings to other nursing populations and healthcare contexts. Third, reliance on self-reported data may have introduced social desirability, reporting, or common-method bias. Although anonymous data collection and confidentiality were used to minimise response bias, this potential source of bias should be considered when interpreting the findings. Fourth, the dissatisfied job satisfaction subgroup was small (n = 5); thus, findings involving this subgroup should be interpreted cautiously. Finally, the NOSS was originally developed to assess stigma toward nurses from an external perspective, whereas this study examined responses from practising nurses; therefore, differences across populations may partly reflect differences in respondent perspectives. Future multicentre and longitudinal studies are needed to confirm these findings and further explore the determinants of occupational stigma among nurses.

5. CONCLUSION

This study showed that hospital nurses reported a mean perceived occupational stigma score of 34.11 ± 6.66, with devaluation and discrimination having the highest mean item score among the three dimensions. Occupational stigma was associated with lower career commitment, perceived organisational support, and job satisfaction at the bivariate level, although these associations were not independently significant after adjustment. These findings highlight the importance of strengthening professional recognition, supportive work environments, and broader efforts to improve the public image of nursing.

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Competing interests

The authors declare that they have no competing interests.

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