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Occupational Stigma and Unethical Behavior Among Hospital Nursing Assistants: Parallel Mediating Roles of Core Self-Evaluation and Organizational Disidentification

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Abstract

Background

This study aims to investigate the mechanism through which perceived occupational stigma influences the unethical behavior of hospital nursing assistants. It focuses on the parallel mediating roles of core self-evaluation and organizational disidentification. The goal is to reveal the complex psychological pathways through which occupational stigma affects behavior, providing theoretical and empirical evidence for improving the nursing assistants' work environment and preventing unethical conduct.

Methods

A cross-sectional survey was conducted from March to June 2025 using convenience sampling among nursing assistants from several tertiary hospitals in Guangdong Province, China. Established scales were used to measure occupational stigma, core self-evaluation, organizational disidentification, and unethical behavior. Data were analyzed using AMOS and SPSS software, including structural equation modeling (SEM) for mediation analysis and the Bootstrap method (5,000 resamples) to test mediation effects.

Results

Occupational stigma significantly negatively affected core self-evaluation (β= -0.376, $p < 0.001$) and significantly positively affected organizational disidentification (β = 0.438, $p < 0.001$). Core self-evaluation significantly negatively influenced unethical behavior (β= -0.312, $p < 0.001$), while organizational disidentification significantly positively influenced it (β = 0.563, $p < 0.001$). The mediating effects of both core self-evaluation (indirect effect = 0.114, 95%*CI* [0.071, 0.175]) and organizational disidentification (indirect effect = 0.239, 95%*CI* [0.174, 0.321]) were significant. However, the direct effect of occupational stigma on unethical behavior was negative and significant (β= -0.108, $p = 0.002$), contrary to the initial hypothesis, indicating a typical "masking effect."

Conclusions

Occupational stigma influences nursing assistants' unethical behavior through complex dual pathways and a masking effect. The risk of unethical behavior arises not only from the depletion of individual psychological resources (core self-evaluation) but also from the erosion of organizational identity. This finding underscores the need for dual-pronged interventions: reducing occupational stigma at societal and organizational levels, while also enhancing nursing assistants' psychological resilience and organizational belonging through psychological capital development and positive organizational climate building, thereby safeguarding the quality of the "last mile" of healthcare services.

1 Background

In recent years, the comprehensive socio-economic development of China has powerfully driven the improvement of labor environments and the elevation of social equity levels. Against this backdrop,

enhancing working conditions for laborers, safeguarding professional dignity, and promoting social justice have become core issues within national strategic planning. In the health sector, the *"Healthy China 2030" Plan Outline* explicitly calls for optimizing the working environment for medical personnel and elevating their professional identity and social status. A series of subsequent policy documents, including *"Healthy China Action (2019–2030)"* and the *"Outline of the Plan for Deepening the Reform of the Medical and Health System (2021–2025),"* have further focused on improving institutional frameworks and career development pathways, striving to boost the job satisfaction and enhance the working environment for the vast number of medical workers—especially primary-level medical staff and nursing personnel. However, it is noteworthy that certain occupational groups within the healthcare system still face a situation where their value is underestimated, and recognition is lacking. Taking hospital nursing assistants (NAs) as an example, they operate on the clinical front lines, undertaking critical functions in patients' daily care and auxiliary medical tasks, making them an indispensable link in the operation of medical services. In reality, however, the professional contributions and social status of this group are frequently underestimated. They not only struggle to gain recognition commensurate with the importance of their work but also occupy a relatively marginalized position in terms of career advancement and resource allocation. Their work is often socially categorized as typical "dirty work," thereby being systematically devalued[1]. Within the Chinese context, hospital NAs, in particular, still face significant social prejudice and occupational stigma. This stigma manifests concretely as a disdain for the professionalism of their work and a marginalization of their social status[2]. Long subjected to social stereotypes, the NA group endures professional discrimination and psychological pressure. This not only damages their personal professional identity and mental health but may also affect the overall quality of healthcare services, thereby posing a challenge to the professional dignity and workforce motivation within the medical industry, as championed by the "Healthy China" strategy.

The formation mechanism of occupational stigma remains a continuous focus of academic research. It typically originates from negative social stereotypes about specific professions and is continually reinforced through media dissemination and social cognition. Research indicates that occupational stigma plays a key role in the interaction between the individual and their professional identity, often leading to a decline in social status and marginalization of the profession[3]. Institutional and cultural factors can also exacerbate this process, potentially subjecting occupational groups to systemic injustice[4]. Furthermore, the influence of the occupational environment cannot be ignored: when a gap exists between the actual working conditions of an occupational group and societal expectations, it can easily trigger deep psychological stress, undermining professional identity and job satisfaction. The impact of occupational stigma on individual mental health and professional conduct has attracted widespread attention. It not only increases psychological pressure but may also encourage unethical behavior. Studies show that occupational stigma can influence an individual’s behavioral choices through psychological stress and emotional alienation, leading to professional deviance[5]. At the same time, occupational stigma negatively affects individual self-identity, weakens self-esteem, and subsequently triggers negative emotional and behavioral responses[6]. Research also notes that cultural factors such as family motivation may, in specific contexts, moderate the mechanism through which stigma influences

behavior [7]. This suggests the need for an in-depth analysis of the complex impact of occupational stigma across different cultural and professional backgrounds.

Within the healthcare environment, occupational stigma among hospital Nursing Assistants (NAs) is widespread, and its negative impact on their professional identity is becoming increasingly evident. Occupational stigma may undermine the legitimacy of professional groups, exacerbate the decline in their social status, and lead to a series of negative consequences. Organizational-level research shows that stigma affects individuals' professional attitudes and behaviors, and may even cause economic losses. Specifically, emotional alienation and job burnout induced by stigma may increase practitioners' tendency toward unethical conduct [8]. Other studies confirm that occupational stigma can influence the moral judgment of healthcare providers, adversely affecting patient treatment outcomes by interfering with clinical decision-making [9]. This reveals the complex role of occupational stigma in professional behavior and ethical decision-making. First, although NAs undertake fundamental and critical tasks such as daily care, structural biases within society and medical institutions often lead to their work being undervalued. This perception stems both from widespread social attitudes and is deeply embedded in the hierarchical culture of healthcare organizations. Research indicates that NAs are often regarded as lower-level workers. This perception is internalized and reinforced through the professional socialization of registered nurses, solidifying status differences in daily work, making NAs feel marginalized, and making it difficult for their professional contributions to receive due recognition. This occupational stigma further damages their sense of professional identity[10]. Second, NAs often face multiple pressures from patients, colleagues, and the public. Research shows that in healthcare settings, NAs and nurses are among the groups most vulnerable to stigma, particularly when caring for patients with certain diseases such as AIDS[11]. Research conducted in India also reveals that social stigma is a major obstacle to treatment for breast cancer patients, and nursing staff play a complex role in this process[12]. NAs' work requires high emotional investment and is often intertwined with societal stereotypes about diseases, further intensifying their occupational stigma and stress. Furthermore, the psychological pressure brought by occupational stigma has become a key factor affecting NAs' professional behavior. In the medical field, NA work is often misinterpreted as low-skilled and low-value, invisibly increasing their psychological burden. Disdain from society and within the team subjects them to continuous pressure, which not only affects mental health but also interferes with professional conduct. Many NAs reduce their work engagement or even consider leaving the profession or changing careers due to such pressure. This phenomenon is particularly common in the field of mental health care[13]. Research also indicates that NAs lacking professional respect often experience significant psychological stress during routine tasks. This stress stems from heavy workloads and stigma within the environment. In long-term care institutions, where the work is perceived as "undignified," NAs are more prone to psychological exhaustion and stress[14]. This sustained pressure can trigger emotional reactions such as irritability, apathy, or burnout, impairing work efficiency and even jeopardizing patient safety.

Therefore, within the healthcare system, the professional status of nursing assistants (NAs) directly impacts the medical service delivery system, concerning the quality of its "last mile." As the caregivers with whom patients have the most frequent daily contact, the behaviors of NAs—whether active

engagement, passive withdrawal, or any unethical conduct—are directly transmitted to patients' healthcare experiences and recovery outcomes[15]. The NA workforce often lacks professional certification, systematic training, clear career progression paths, and adequate organizational support[16]. The intertwining of these factors makes the NA group one of the occupational categories where feelings of occupational stigma are particularly concentrated. Coupled with the distinct internal hierarchy of the healthcare system, the chronic psychological pressure and professional discrimination they endure directly influence their professional behavioral choices and mental health [17], increasing the risk of unethical behavior[18], and posing a potential threat to the quality of medical services and patient safety[19]

This study places the hospital NA group at the focal point of academic research. This is not merely concern for a specific occupation but rather treats it as a theoretical archetype for analysis. It aims to use the professional circumstances of this group to reflect broader social issues. The occupational stigma dilemma faced by NAs is a concrete microcosm of contemporary societal problems related to occupational stratification, the valuation of labor, and social equity. This research investigates how the sense of occupational stigma, through micro-level psychological mechanisms such as an individual's core self-evaluation and organizational identification, is ultimately translated into unethical organizational behavior. The goal is to provide hospital administrators with precise intervention strategies for improving the NA work environment and preventing unethical behavior. It also aims to offer profound theoretical rationale and policy insights at the societal level, thereby contributing to enhancing the professional dignity of low-status occupational groups and building fairer and more harmonious labor relations.

2 Literature Review

2.1 Occupational Stigma: Concept and Impact

Occupational stigma refers to the perceived identity devaluation experienced by individuals due to their profession being socially assigned negative labels, stereotypes, and discriminatory evaluations. This concept is rooted in [20]classic exposition on social stigma, the core of which is that a certain characteristic—here, occupational identity—causes an individual to be “devalued” in social interactions. Occupational stigma is not a static label, but rather a socio-psychological process that is dynamically constructed and reinforced through the interaction between the individual and society[21]. It profoundly affects practitioners’ self-perception, mental health, and social identity, and may ultimately lead their professional conduct to deviate from the norm, resulting in far-reaching negative consequences for both the individual and the organization[22].

Research on the causes of occupational stigma unfolds primarily across multiple levels, including the individual, the occupational, the social, and the organizational/institutional. At the individual level, gender, professional experience, and psychological traits (such as self-esteem and self-efficacy) are significant influencing factors. For example, women in professions gendered by stereotypes (e.g., nursing, education) may perceive stronger stigma[23]; whereas a higher core self-evaluation can buffer the negative effects of

stigma[24]. At the level of occupational characteristics, the “dirtiness” of work content (e.g., handling bodily waste, end-of-life care), low perceived social value, and high emotional-labor demands are key attributes that induce occupational stigma[25]. At the socio-cultural level, one-sided or negative media portrayals of specific professions solidify public stereotypes, exacerbating the dissemination and internalization of stigma [26]. Furthermore, macro-level socio-cultural values, historical changes, and specific policy systems also shape occupational stigma by defining the “legitimacy” and “value” of a profession. For instance, the rise of the gig economy has spawned new forms of occupational stigma, while a policy environment lacking social security intensifies the marginalization of relevant workers [27]

Research on the consequences of occupational stigma reveals a series of chain reactions. First, it poses a direct threat to individual psychological well-being, often leading to anxiety, depression, low self-esteem, and job burnout[28]. Second, this psychological stress can be translated into behavioral outcomes. An increasingly focal point is that occupational stigma may increase the risk of unethical professional behavior—such as work withdrawal, having a cold attitude towards service recipients, or even violations of professional ethics—by intensifying an individual's sense of relative deprivation, emotional alienation, and psychological depletion, thereby weakening their moral constraints. Studies confirm that in fields such as healthcare and social services, practitioners who perceive strong stigma are more prone to job burnout and are more likely to make decisions detrimental to service quality under high pressure[29]. Furthermore, occupational stigma erodes an individual's professional identity and organizational commitment, leading to reduced work engagement, increased turnover intention, and consequently impairing team performance and organizational stability. Finally, the negative impact of occupational stigma can spill over into the family domain, potentially causing family tension, while family support plays an important buffering or moderating role in this process[30].

Domestic research on this topic started relatively late but has progressed rapidly in recent years. Scholars similarly explore the formation and mechanism of action of occupational stigma through dual pathways: social structure (e.g., stereotypes, institutional exclusion) and individual psychology (e.g., identity threat, self-stigmatization)[31]. Research further indicates that occupational stigma not only damages the mental health and work attitudes of grassroots public service providers but may also ultimately affect their task performance and organizational citizenship behavior by influencing their work motivation[32]. These studies provide an important perspective for understanding the issue of occupational stigma within specific institutional and cultural contexts.

2.2 Unethical Behavior: Concept and Impact

Unethical behavior typically refers to actions taken by individuals or organizations to achieve specific goals that violate accepted moral and ethical standards [33]. Its core characteristics include the intentionality of the behavior, its deceptive nature, or the harm it causes to the interests of others or society. The understanding of this concept has evolved from a focus on individual character flaws to an emphasis on systemic and organizational misconduct. Early research primarily concentrated on micro-level issues such as academic cheating and personal lying [34], whereas contemporary research has expanded its scope to macro-level topics, including workplace misconduct, corporate fraud, and

institutional corruption, highlighting the formative role of external factors such as organizational culture, social norms, and situational pressures [35].

The connotation of unethical behavior is markedly context-dependent and culturally relative. The ethical judgment of the same action may differ across socio-cultural contexts, historical periods, or organizational environments, profoundly influenced by local values, legal traditions, and socio-economic conditions [36]. For instance, behavior considered dishonest in one culture might be interpreted as adaptability or relationship maintenance in another. Therefore, defining and researching unethical behavior necessitates a cross-cultural, multi-level perspective.

Regarding the causes of unethical behavior, research reveals the intertwined effects of drivers at multiple levels. At the individual level, moral identity, values, self-regulatory resources, and emotional state are key variables. For example, the strength of an individual's moral identity is negatively correlated with the tendency for unethical behavior [37], while emotional exhaustion or negative emotions may weaken self-control, increasing the risk of behavioral transgressions[38]. At the interpersonal and organizational levels, social comparison pressure, competitive performance goals, lack of ethical leadership, and an organizational climate tolerant of unethical behavior are significant situational inducements. Studies indicate that when employees perceive that unethical behavior can bring personal or organizational benefits with a low risk of punishment, their likelihood of engaging in such behavior increases significantly[39]. Particularly noteworthy is that occupational stigma, as a specific occupational stressor, may erode an individual's professional identity, self-esteem, and psychological resources, making them more susceptible to compromise when facing ethical dilemmas, thereby constituting a potential pathway for inducing unethical behavior.

Unethical behavior triggers a broad range of severe negative consequences. For the perpetrators themselves, it may cause psychological costs such as guilt, anxiety, and cognitive dissonance, and in the long term, it can even damage their professional reputation and career development[40]. Within organizations, unethical behavior corrodes the foundation of trust, undermines teamwork, lowers employee morale and organizational commitment, ultimately leading to performance decline, talent loss, and high turnover costs[41]. At a broader, macro level, organizational unethical behavior (such as financial fraud, corruption) directly harms corporate reputation and brand value, triggering lawsuits, heavy regulatory penalties, and shaking investor and public confidence(Dömeová & Jindrová, 2013). These consequences may ultimately diffuse, eroding social trust and institutional legitimacy, posing a long-term threat to healthy economic and social development.

Domestic research in this area has also grown increasingly rich in recent years. Scholars not only focus on the influencing factors of individual unethical behavior (such as role stress, moral disengagement) but also delve into phenomena with distinct Chinese organizational cultural characteristics, such as "unethical pro-organizational behavior" [42]. These studies provide a localized perspective for understanding the complex mechanisms of unethical behavior within specific institutional and cultural contexts.

2.3 Core Self-Evaluation: Concept and Impact

Core self-evaluation refers to an individual's fundamental and deep-seated assessment of their own worth and abilities, constituting a high-order, broad personality trait[43]. It is not a single construct but rather integrates four interrelated traits: self-esteem (overall feeling of self-worth), general self-efficacy (belief in the ability to cope with life's challenges), locus of control (belief that life outcomes are controlled by oneself versus external forces), and emotional stability (the capacity to resist tendencies toward negative emotions) [44]. This combination of traits forms the cornerstone of an individual's cognitive, affective, and behavioral responses and has been consistently shown to predict a wide range of work and life outcomes, such as job satisfaction, job performance, and subjective well-being[45].

Research indicates that core self-evaluation exerts its influence through several mechanisms. First, as a positive personal resource, a high core self-evaluation helps individuals interpret events in their work environment more positively, interpreting them as challenges rather than threats, thereby directly enhancing job satisfaction and work engagement[46]. Second, it acts as a stress buffer. When facing pressure and adversity, individuals with high core self-evaluation, due to their intrinsic confidence, sense of control, and emotional resilience, can more effectively employ positive coping strategies, maintaining a higher level of mental health and reducing symptoms of anxiety and depression[47]. Finally, this positive self-schema generalizes to one's overall evaluation of life, promoting greater life satisfaction and well-being[48].

The relationship between core self-evaluation and unethical behavior represents a significant recent expansion in research directions. Grounded in the Conservation of Resources (COR) theory, core self-evaluation can be conceptualized as a critical psychological resource. When individuals face stressful situations that may induce unethical behavior—such as high-performance pressure, occupational stigma, or ethically ambiguous work environments—those with high core self-evaluation possess richer internal resources to maintain self-regulatory capacity. They exhibit a stronger tendency to uphold a positive self-image and moral identity, thereby demonstrating greater resistance to the temptation of using unethical means to obtain short-term benefits or alleviate pressure[49].

Conversely, individuals with low core self-evaluation have limited psychological resources and are more susceptible to self-regulatory failure under similar pressures. Their low self-esteem and external locus of control may make them more vulnerable to external unethical incentives or more prone to employing moral disengagement mechanisms to rationalize unethical behavior, serving as a strategy to protect a fragile self-concept or cope with external stress[50]Empirical research supports this pathway, revealing that low core self-evaluation is associated with a higher tendency for workplace deviant behavior, and this relationship is partially mediated by moral disengagement or ethical cognition[51].

Consequently, when examining the pathway through which occupational stigma influences unethical behavior, core self-evaluation likely plays a significant mediating role. On one hand, chronic experiences of occupational stigma deplete an individual's psychological resources, leading to a reduction in their core self-evaluation [52]. On the other hand, diminished core self-evaluation weakens an individual's moral fortitude and self-regulatory capacity, thereby increasing the risk of unethical behavior[53]. Understanding the mediating role of this personality trait provides important insights for developing intervention

strategies targeting susceptible individuals and for preventing unethical behavior from the perspective of enhancing psychological resilience.

2.4 Organizational Disidentification: Concept and Impact

Organizational disidentification refers to a psychological state in which an individual actively engages in psychological detachment from their employing organization, develops negative cognitions towards its values, practices, or identity, and may be accompanied by emotional alienation and behavioral distancing[54]. It goes beyond simple non-identification or low identification, representing an active process of "dis-identification." In this process, the individual differentiates their self-concept from the perceived negative organizational image, even viewing the organization as an "opposite," in order to maintain or enhance self-worth[55]. The core of this concept lies in the fact that when individuals perceive a severe and irreconcilable conflict between their own values, moral standards, or social identity and organizational characteristics, an active desire for separation arises.

The emergence of organizational disidentification stems from a severe mismatch between the individual's and the organization's cognitions and values. Its antecedents can be summarized as follows: 1) Value and moral conflict: When individuals perceive organizational actions as violating their personal moral principles or social ethics (e.g., witnessing organizational misconduct) [56]2) Identity threat: When the organizational identity conflicts with other social identities cherished by the individual (e.g., professional identity, ethnic identity), or when the organization's reputation is damaged by negative events (e.g., scandals, high occupational stigma), potentially "staining" the individual's identity [57]; 3) Negative organizational practices: Such as perceived organizational injustice, lack of support, or exploitative management [58]. For hospital nursing assistants (NAs) operating in an environment of occupational stigma, organizational disidentification is more likely to be fostered if they perceive the organization as part of the system that reinforces or fails to effectively alleviate their stigmatized situation.

Organizational disidentification triggers a series of negative individual and organizational consequences. At the individual level, it significantly erodes work attitudes, leading to diminished job satisfaction, reduced organizational commitment, and intensified emotional exhaustion [59]. Furthermore, it serves as a powerful predictor of turnover intention and actual turnover behavior. When psychological alienation accumulates to a certain degree, seeking an organization with more congruent values becomes a crucial pathway for individuals to restore self-consistency[60]. Moreover, organizational disidentification impairs job performance and extra-role behaviors. Affected individuals may demonstrate reduced work engagement, diminished task performance, and withdrawal of organizational citizenship behaviors that would otherwise be voluntarily offered. In more severe cases, this may escalate into passive resistance or workplace deviance[61]. The persistent cognitive conflict and emotional alienation constitute a chronic stressor that negatively impacts mental health, thereby increasing susceptibility to anxiety and depression[62].

More significantly, organizational disidentification may constitute a key psychological mechanism linking occupational stigma to unethical behavior. When employees develop disidentification with their

organization due to occupational stigma, their sense of allegiance and responsibility toward the organization diminishes. They are more likely to perceive the organization as "them" rather than "us." This psychological detachment not only reduces the intrinsic motivation to adhere to organizational norms but may also provide rationalization for unethical conduct or foster retaliatory motives[63]. Empirical studies confirm that organizational disidentification plays a significant mediating role between negative workplace experiences (such as exclusion or injustice) and counterproductive work behaviors, including unethical acts[64].

For hospital nursing assistants, organizational disidentification stemming from occupational stigma may lead to indifference or resistance toward the organization's ethical requirements. Consequently, in high-pressure situations or under insufficient supervision, this may increase their risk of engaging in unethical behaviors such as perfunctory care or information concealment. Therefore, understanding organizational disidentification is crucial for analyzing the behavioral responses of nursing assistants under occupational stigma pressure. It represents not only a potential negative outcome of occupational stigma but also a critical catalytic state and explanatory mechanism that exacerbates behavioral risks, including unethical conduct.

3 Research Hypotheses

3.1 The Impact of Occupational Stigma on Unethical Behavior Among Hospital Nursing Assistants

Hospital Nursing Assistants (NAs) frequently face social devaluation due to the nature of their work. Persistent occupational stigma becomes internalized as psychological stress. According to the Conservation of Resources (COR) theory, this stress continuously depletes their psychological resources [65]. When these resources are exhausted, an individual's capacity for self-regulation and moral adherence is compromised, leading them to potentially perceive unethical behavior, such as perfunctory care, as a "recovery strategy" [66]. Specific pathways through which this operates include: 1)The Emotional Exhaustion Pathway: Chronic stigma depletes emotional resources and diminishes empathetic capacity[67]. 2)The Moral Justification Pathway: To alleviate cognitive dissonance, individuals may engage in moral disengagement, rationalizing unethical actions[56]. 3)The Negative Reciprocity Pathway: Perceived injustice fosters organizational disidentification, leading to unethical behavior as a form of implicit resistance. Research indicates that resource depletion and moral disengagement are key mediating mechanisms leading to behavioral transgressions [68]. Consequently, occupational stigma is likely to significantly increase NAs' propensity for unethical behavior. Based on this reasoning, the following hypothesis is proposed:

H1: Occupational stigma has a positive influence on unethical behavior among hospital nursing assistants.

3.2 The Mediating Role of Core Self-Evaluation

Core self-evaluation represents an individual's fundamental assessment of their own worth and capabilities, serving as a psychological foundation for coping with external pressures[43]. Occupational stigma, as a chronic social stressor, undermines this foundation through mechanisms of "self-threat" and "resource depletion." On one hand, persistent social devaluation leads nursing assistants to internalize negative labels, consequently lowering their self-evaluation to maintain cognitive consistency[52]. On the other hand, resisting stigma consumes substantial psychological resources, and repeated experiences of failure reinforce perceptions of "low competence" or "low worth" [69]. Consequently, occupational stigma can damage core self-evaluation. Based on this reasoning, the following hypothesis is proposed:

H2: Occupational stigma has a negative impact on the core self-evaluation of hospital nursing assistants.

As a key psychological resource, core self-evaluation helps individuals maintain moral standards under pressure by enhancing moral identity, self-regulation, and positive attribution[49]. Nursing assistants with high core self-evaluation possess stronger self-esteem and self-efficacy, and their behavior tends to align with a positive self-concept. Engaging in unethical behavior would threaten this self-image, leading them to actively resist such conduct. This supports the following hypothesis:

H3: Core self-evaluation has a negative impact on the unethical behavior of hospital nursing assistants.

Integrating H2 and H3, the promoting effect of occupational stigma on unethical behavior may be partially realized through the erosion of core self-evaluation as a key psychological resource. According to the gain-loss spiral of Conservation of Resources Theory, occupational stigma initiates a loss spiral of psychological resources: external stigma pressure → impaired core self-evaluation → diminished self-regulation and moral adherence → increased tendency for unethical behavior [70]. Therefore, core self-evaluation constitutes a crucial internal bridge connecting external stigma with individual behavioral transgressions. This leads to the final hypothesis:

H4: Core self-evaluation mediates the relationship between occupational stigma and unethical behavior among hospital nursing assistants.

3.3 The Mediating Role of Organizational Disidentification

Organizational disidentification refers to an individual's active psychological detachment from and negative differentiation with their organization. For hospital nursing assistants, occupational stigma may lead to a "spillover" effect, where negative social evaluations of their profession extend to their employing organization. When the organization is perceived as tacitly consenting to or failing to effectively counteract their marginalized status, organizational disidentification is fostered[56]. Specific mechanisms include attributional bias (blaming personal difficulties on organizational injustice), psychological contract breach (perceiving that the organization has failed to deliver on promises of respect and support), and emotional avoidance (distancing from the organization to reduce identity-based shame)[71]. To protect their self-worth, nursing assistants may proactively sever psychological ties with the organization they view as stigmatizing[72]. This leads to the following hypothesis:

H5: Occupational stigma has a positive influence on organizational disidentification among hospital nursing assistants.

Once formed, organizational disidentification acts as a catalyst for unethical behavior. According to social exchange theory, disidentification weakens the sense of reciprocal obligation between employees and the organization, reducing the intrinsic motivation to adhere to organizational ethical norms[59]. More significantly, moral disengagement theory suggests that organizational disidentification provides a psychological "excuse" for unethical conduct; when individuals view the organization as an "outsider," actions that harm organizational interests become cognitively detached from their self-concept, thereby loosening moral constraints[64]. Consequently, nursing assistants may come to view their work as a purely transactional exchange, making them more likely, under pressure, to choose behaviors that are personally convenient but detrimental to patient or organizational interests. This reasoning supports the hypothesis:

H6: Organizational disidentification has a positive influence on unethical behavior among hospital nursing assistants.

In summary, a second significant mediating pathway may exist through which occupational stigma influences unethical behavior: namely, by triggering organizational disidentification. Occupational stigma first erodes nursing assistants' psychological attachment to the organization (H5). This sense of alienation, in turn, weakens the internal restraint to follow organizational norms and provides a psychological justification for unethical behavior (H6) [63]. In other words, organizational disidentification serves as a critical mechanism that translates external social pressure (occupational stigma) into internal organizational detachment, ultimately leading to behavioral transgressions[64]. When nursing assistants feel like "outsiders" within the organization due to stigma, their motivation to protect the organization's interests and reputation diminishes, correspondingly increasing the likelihood of engaging in unethical behavior [73]. Therefore, the following hypothesis is proposed:

H7: Organizational disidentification mediates the relationship between occupational stigma and unethical behavior among hospital nursing assistants.

4 Participants and Methods

4.1 Study Design and Participants

A cross-sectional study was conducted through questionnaire surveys between March and June 2025. Participants were recruited using a convenience sampling method from the nursing assistant population across multiple tertiary hospitals in Guangdong Province. No strict restrictions were applied regarding demographic characteristics such as gender or age to ensure sample diversity and representativeness.

The electronic questionnaire was developed using the Questionnaire Star online platform and distributed via QR codes. The first page of the questionnaire contained informed consent information, and

participants could withdraw immediately if they declined participation. Questionnaires with identical responses throughout or completion times of less than 100 seconds were considered invalid.

A total of 950 individuals participated in the survey, with 892 valid questionnaires collected, yielding a valid response rate of 93.89%. The reliability and validity of the questionnaire were assessed using Cronbach's α coefficient, KMO test, and Bartlett's test of sphericity. Both Cronbach's α coefficient and KMO values exceeded 0.9, with all p-values < 0.001, indicating good scale reliability and validity suitable for further analysis.

4.2 Research Methods

4.2.1 Demographic Questionnaire

The survey indicators included personal information such as gender, age, educational level, and years of work experience.

4.2.2 Occupational Stigma Scale

Focusing on hospital nursing assistants, this study examined the social prejudice and self-deprecation perceptions they endure due to their professional identity. Measurement was conducted using the Perceived Occupational Stigma Scale (POSS) developed by Manchha AV etal[74]. This scale covers dimensions such as social evaluation and social alienation, has been applied to various occupational groups, and demonstrates good reliability and validity.

4.2.3 Unethical Behavior Scale

Measurement was based on the Workplace Unethical Behavior Scale developed by Mitchell MS etal[75]. This scale aims to systematically assess whether employees exhibit behaviors that violate professional ethics—such as deception, concealment, or exploitation—under complex situations involving pressure and motivation.

4.2.4 Core Self-Evaluations Scale

This study utilized the Core Self-Evaluations Scale (CSES) compiled by Judge TA etal[76]. The scale consists of 12 items covering four dimensions: self-esteem, general self-efficacy, emotional stability, and locus of control.

4.2.5 Organizational Disidentification Scale

Measurement employed the Organizational Disidentification Scale developed by Kreiner GE etal[72]. By assessing dimensions such as an individual's negative emotions towards the organization, value conflicts, and identity denial, this scale effectively captures the psychological alienation between employees and the organization. It is widely used in organizational behavior research and exhibits good reliability and validity.

All the above questionnaires were measured using the Likert scale. Respondents rated their personal feelings based on the item content, with scores ranging from 5 points ("strongly agree") to 1 point ("strongly disagree"). The final data will be tested using Exploratory Factor Analysis (EFA) to ensure the scales' structural validity and reliability meet the research requirements. Information such as Cronbach's α coefficient is presented in Table 1.

Table 1
Results of the Questionnaire Reliability and Validity Analysis

Scale	Number of Items	Cronbach's α Coefficient	KMO Value
Occupational Stigma	6	0.844	0.862**
Core Self-Evaluation	6	0.788	0.793**
Organizational Disidentification	12	0.898	0.906**
Unethical Behavior	7	0.931	0.906**

Note: ** indicates $p < 0.001$ for Bartlett's Test of Sphericity. All scales demonstrated good to excellent internal consistency reliability, with Cronbach's α coefficients ranging from 0.788 to 0.931. The KMO values exceeded the recommended threshold of 0.7, confirming the sampling adequacy for factor analysis.

4.3 Statistical Analysis

The data analysis was conducted using SPSS 26.0, AMOS 28.0, and the Process macro. SPSS was primarily employed for descriptive statistical analysis, reliability and validity assessments, and correlation analysis. AMOS was utilized to perform confirmatory factor analysis (CFA) within the structural equation modeling (SEM) framework and to test the mediating effects.

5 Results

5.1 Demographic and Work-Related Characteristics

Females constituted the overwhelming majority (92.26%) of the sample, which aligns with the requirement for meticulous caregiving abilities inherent to the profession. The age distribution exhibited a "middle-aged concentration" characteristic, with the 51–55 age group representing the highest proportion (35.31%). The percentages of individuals below 35 years old and above 55 years old were relatively low. Educational attainment was predominantly high school level or below (95.29%). These findings indicate a demographic profile of the nursing assistant workforce characterized by middle-aged concentration and lower educational attainment.

The vast majority of the surveyed nursing assistants were employed in public hospitals (92.71%) and worked in general wards (94.51%). Regarding employment nature, the proportions of full-time (55.27%) and outsourced/part-time (44.73%) workers were comparable. In terms of professional experience, over half (58.75%) possessed more than five years of work experience, suggesting a workforce with both

experience and mobility. Slightly more than half (52.47%) reported a monthly income below 5,000 RMB, which corresponds to their overall educational background and employment patterns. Detailed information is presented in Table 2.

Table 2
Demographic and Work-Related Characteristics (N = 892)

Category		N	%	Category		N	%
Gender	Male	69	7.74%	Employment Type	Full-time	493	55.27%
	Female	823	92.26%		Outsourced/Part-time	399	44.73%
Age (years)	≤ 35	39	4.37%	Work Unit	General Ward NAs	843	94.51%
	36~45	232	26.01%		Emergency/ICU NAs	49	5.49%
	46~50	239	26.79%	Work Experience	<2 years	168	18.83%
	51~55	315	35.31%		2~5 years	298	33.41%
	>55	67	7.51%		5~10 years	226	25.34%
Education	High school or below	850	95.29%		>10 years	200	22.42%
	College or above	42	4.71%	Monthly Income	< 5000 RMB	468	52.47%
Hospital Type	Public hospital	827	92.71%		>5000 RMB	424	47.53%
	Private/Other	65	7.29%				

5.2 CFA results

A two-step approach incorporating confirmatory factor analysis (CFA) and structural equation modeling (SEM) was employed to test the hypotheses, consistent with established methodological frameworks[77, 78]. The initial step involved using CFA to examine the discriminant validity of the study variables, followed by model comparison methods to evaluate the structural model in the second step. Model fit was assessed using multiple indices: the overall model chi-square test, Tucker-Lewis Index (TLI)[79], Comparative Fit Index (CFI)[80], and Root Mean Square Error of Approximation (RMSEA)[81].

We select the four-factor model with better model indicators for the next step of verification analysis.. The results are presented in Table 3.

Table 3
the CFA results

Measurement Model	χ^2	df	χ^2/ df	CFI	TLI	RMSEA
4-Factor Model(1,2,3,4)	1995.404	318	6.275	0.874	0.861	0.077
3-Factor Model(1,2 + 3,4)	1339.672	149	8.991	0.858	0.837	0.095
2-Factor Model(1 + 2+3,4)	829.900	64	12.976	0.889	0.865	0.116
1-Factor Model(1 + 2+3 + 4)	5374.246	324	16.587	0.622	0.590	0.132

Note: 1 = Occupational Stigma. 2 = Core Self-Evaluation. 3 = Organizational Disidentification. 4 = Unethical Behavior.

5.3 Common Method Deviation Test

To rule out potential common method bias resulting from a single data source, Harman's single-factor test was conducted on all measurement items of the variables [82]. This method is a commonly used statistical technique for detecting such bias[83]. The results of the unrotated exploratory factor analysis extracted five factors with eigenvalues greater than one, which corresponds to the number of research variables. The first factor accounted for 35.45% of the variance, which is well below the 40% [84]. Detailed information is presented in Table 4.This indicates that the data in this study were not subject to serious common method bias, and subsequent analyses could proceed.

Table 4
Results of Exploratory Factor Analysis for Harman's Single-Factor Test (N = 892)

Initial Eigenvalues				**Extraction Sums of Squared Loadings**		
Factor	Total	% of Variance	Cumulative%	Total	% of Variance	Cumulative%
1	9.572	35.452	35.452	9.572	35.452	35.452
2	3.158	11.697	47.149	3.158	11.697	47.149
3	1.842	6.823	53.972	1.842	6.823	53.972
4	1.4	5.187	59.158	1.4	5.187	59.158
5	1.336	4.947	64.106	1.336	4.947	64.106
6	0.841	3.116	67.221			
7	0.758	2.808	70.029			
8	0.677	2.508	72.537			
9	0.644	2.385	74.922			
10	0.573	2.124	77.046			
11	0.557	2.063	79.108			
12	0.525	1.945	81.053			
13	0.506	1.876	82.929			
14	0.47	1.739	84.668			
15	0.453	1.677	86.345			
16	0.423	1.567	87.912			
17	0.418	1.548	89.46			
18	0.409	1.514	90.974			
19	0.368	1.364	92.339			
20	0.337	1.247	93.585			
21	0.328	1.215	94.801			
22	0.304	1.126	95.926			
23	0.28	1.038	96.965			
24	0.271	1.003	97.968			
25	0.218	0.807	98.774			
26	0.187	0.691	99.466			

Initial Eigenvalues			Extraction Sums of Squared Loadings
27	0.144	0.534	100

5.4 Correlation Analysis

The Kolmogorov-Smirnov test (K-S test) employed in exploratory statistical analysis revealed that the data for all variables exhibited a skewed distribution ($P < 0.001$). Consequently, the median (Med) and interquartile range (IQR) were used to describe their central tendency and dispersion. The degree of dispersion was analyzed based on the proportion of the IQR within the total range (Max-Min). A larger proportion indicates that the middle part of the data is relatively spread out, signifying a high degree of dispersion; conversely, a smaller proportion suggests that the middle part of the data is relatively concentrated, indicating a low degree of dispersion.

As shown in Table 5, the analysis of occupational stigma indicates that nursing assistants overall maintained a neutral attitude toward their professional identity, with stigma perception at a moderate level (Med = 3.0). The low dispersion suggests that only a small subset of nursing assistants exhibited significant variation in their perception of social prejudice. Regarding core self-evaluation, the overall self-assessment among nursing assistants was relatively high (Med = 3.75), with low dispersion reflecting that the majority held a positive view of their own capabilities. For organizational disidentification, nursing assistants demonstrated a generally positive identification with their organization (Med = 2.00), and the low dispersion indicates broad acceptance of their hospital's values or practices among most respondents. Finally, Unethical behavior was reported infrequently overall (Med = 2.00), with the dispersion metric confirming that such behaviors were uncommon among the majority of nursing assistants.

To further examine the relationships between variables, correlation analysis was performed using SPSS 26.0 on the scales measuring occupational stigma, core self-evaluation, organizational disidentification, and unethical behavior. Spearman correlation analysis revealed that occupational stigma demonstrated significant positive correlations with unethical behavior ($r = 0.162$, $p < 0.001$), and organizational disidentification ($r = 0.375$, $p < 0.001$), while showing a significant negative correlation with core self-evaluation ($r= -0.168$, $p < 0.001$). Unethical behavior was positively correlated with organizational disidentification ($r = 0.544$, $p < 0.001$) and negatively correlated with core self-evaluation ($r= -0.453$, $p < 0.001$). These results support the feasibility of proceeding with subsequent empirical analysis. The complete results are presented in Table 5.

Table 5
Correlation Analysis Results

Scale	Med	IQR(Q3-Q1)	Range	1	2	3	4
1 Occupational Stigma	3.00	1.00	4.00	1			
2 Core Self-Evaluation	3.75	0.72	3.12	-0.186**	1		
3 Organizational Disidentification	2.00	0.72	4.00	0.375**	-0.481**	1	
4 Unethical Behavior	2.00	0.67	4.00	0.162**	-0.453**	0.544**	1

Note: Med = Median; IQR = Interquartile Range. **Correlation is significant at the p < 0.001 level (two-tailed).

5.5 Exploratory Factor Analysis

5.5.1 Factor Analysis Procedure

Exploratory factor analysis was conducted on the scales using orthogonal rotation (varimax method). To ensure sufficient correlation between items and their corresponding factors, and that the extracted factors adequately represented the original variable information[85], the following criteria were applied: factor loadings greater than 0.50[86]and a cumulative contribution rate (after rotation) exceeding 70%[85]. This approach served to simplify the variable structure and enhance the interpretability of the factors [87], allowing multiple observed variables to be categorized into a smaller number of composite factors for subsequent verification and hypothesis testing.

The occupational stigma variable was optimally divided into three dimensions, with a post-rotation cumulative contribution rate of 78.434%. This indicates that the three extracted common factors collectively explained 78.434% of the total variance. Based on the content of the different dimensions, they were defined as External Image, Self-Evaluation, and Identity Impact.

The core self-evaluation variable was suitably divided into four dimensions, with a post-rotation cumulative contribution rate of 75.047%. The dimensions were defined as Frustration Helplessness, Autonomous Efficacy, Life Autonomy, and Success Belief.

The organizational disidentification variable was appropriately divided into two dimensions, with a post-rotation cumulative contribution rate of 75.746%. These dimensions were identified as Professional Shame and Identity-Driven Avoidance.

The unethical behavior variable was best divided into two dimensions, achieving a post-rotation cumulative contribution rate of 81.915%. The dimensions were defined as Camouflage Behavior and Concealment Behavior.

5.6 Mediation Effect Test

5.6.1 Model Fit Indices

A parallel mediation model was constructed with occupational stigma as the independent variable, core self-evaluation and organizational disidentification as mediating variables, and unethical behavior as the dependent variable. The initial overall model fit indices were χ^2/df = 258.7, SRMR = 0.118, CFI = 0.842, GFI = 0.873, NFI = 0.835, indicating unsatisfactory model fit. Modification indices suggested adding covariance relationships between the error terms of several observed variables (e1-e6, e1-e13, e4-e5, e12-e13). These modifications were not arbitrary but were implemented based on strong substantive and methodological rationales to achieve a more parsimonious and theoretically sound measurement model[88, 89].

The decision to allow these error covariances was based on two primary considerations: 1) Shared Method Variance: The scales utilized a common method (self-report Likert-scale questionnaires), which could introduce systematic covariance not accounted for by the latent constructs themselves. Correlating errors within the same scale (e.g., within the "Perceived Occupational Stigma Scale") helps control for this common measurement bias, leading to more accurate estimation of structural relationships[90]. 2) Substantive Overlap in Item Content: Certain sections of different questionnaires exhibited conceptual overlap or highly similar wording in their content, which could lead to correlations between their error terms beyond the influence of the overarching latent variables. For instance, the correlation between error terms e1 and e6 might reflect a shared specific nuance in measuring one aspect of support that is not fully captured by the broader "Identity Impact" factor. This approach is an accepted and justified practice in Structural Equation Modeling (SEM); when modifications align with theoretical expectations regarding the measurement instrument, they can improve model fit [91].

It is important to note that these modifications were applied to the measurement model (i.e., the relationships between indicators and their latent constructs) and did not alter the hypothesized structural model (the paths between latent variables). Consequently, they enhance measurement validity without capitalizing on chance relationships in the structural paths, thereby mitigating concerns about overfitting the structural model [92]. After modification, the model fit indices are presented in Table 6. All indices met the established criteria, indicating good model fit.

Table 6
Model Fit Indices

Common Indices	χ^2	*df*	χ^2/df	*GFI*	*TLI*	*CFI*	*NFI*	*SRMR*
Criterion	-	-	1–5	> 0.9	> 0.9	> 0.9	> 0.9	<0.08
Value	135.2	35	3.863	0.973	0.964	0.977	0.970	0.048

5.6.2 Mediation Model and Hypothesis Testing

To examine the dual pathways through which occupational stigma influences unethical behavior via core self-evaluation and organizational disidentification, a structural equation model was constructed and

analyzed.

5.6.2.1 Direct Paths and Hypothesis Verification

The standardized path coefficients and their significance among the variables are presented in Table 7. Specifically:

Occupational stigma demonstrated a significant negative direct effect on core self-evaluation (β = -0.376, P < 0.001), supporting Hypothesis H2.

Core self-evaluation exhibited a significant negative direct effect on unethical behavior (β = -0.312, P < 0.001), supporting Hypothesis H3.

Occupational stigma showed a significant positive direct effect on organizational disidentification (β = 0.438, P < 0.001), supporting Hypothesis H5.

Organizational disidentification demonstrated a significant positive direct effect on unethical behavior (β = 0.563, P < 0.001), supporting Hypothesis H6.

Notably, the direct path coefficient from occupational stigma to unethical behavior was negative and significant (β = -0.108, P = 0.002), which is contrary to the direction predicted by Hypothesis H1, indicating the existence of a more complex "masking effect" among the variables.

Table 7
Effects of Occupational Stigma, Core Self-Evaluation, and Organizational Disidentification on Unethical Behavior

Path	Standardized Path Coefficient	Unstandardized Path Coefficient	S.E.	T-value	P-value
Occupational Stigma → Core Self-Evaluation	-0.376	-0.064	0.017	-3.77	<0.001
Core Self-Evaluation → Unethical Behavior	-0.312	-1.77	0.504	-3.512	<0.001
Occupational Stigma → Organizational Disidentification	0.438	0.415	0.035	11.685	<0.001
Organizational Disidentification → Unethical Behavior	0.563	0.577	0.052	10.995	<0.001
Occupational Stigma → Unethical Behavior	-0.108	-0.105	0.034	-3.105	0.002

5.6.2.2 Mediation Effect and Masking Effect Test

Building on the verification of the direct paths, the bias-corrected Bootstrap method (with 5,000 resamples) was employed to estimate the indirect mediation effects to test hypotheses H4 and H7. This

method provides more robust standard errors and confidence intervals[93]. The results are presented in Table 8.

The indirect effect of occupational stigma on unethical behavior through core self-evaluation was 0.114, with a 95% confidence interval of [0.071, 0.175], which does not include zero. Thus, hypothesis H4 was supported.The indirect effect of occupational stigma on unethical behavior through organizational disidentification was 0.239, with a 95% confidence interval of [0.174, 0.321], which also excludes zero, supporting hypothesis H7.

A comprehensive analysis of the data in Table 8 reveals that the total indirect mediation effect (0.114 + 0.239 = 0.353) was positive, while the direct effect was negative (-0.105), resulting in opposite signs. According to the theoretical framework of mediation analysis, when the direct and indirect effects have opposite signs, it indicates a typical "masking effect" [94]. In this study, the positive indirect effect and the negative direct effect counteracted each other, causing the value of the total effect (0.248) to be smaller than the total indirect effect(0.353), and the total effect shared the same sign as the indirect effect. This pattern clearly reveals that the relationship between occupational stigma and unethical behavior is not simply promotive or inhibitory but involves a competitive "push-pull" mechanism. The mediation model diagram is shown in Fig. 1.

Table 8
Bootstrap Analysis of Path Effect Significance

Path	Effect	Point estimate	Product of coefficients		95%CI	Proportion of Total Effect (%)	P
			SE	Z			
Occupational Stigma → Core Self-Evaluation → Unethical Behavior	Indirect Mediation Effect	0.114	0.026	4.385	0.071 ~ 0.175	45.80	<0.001
Occupational Stigma → Organizational Disidentification → Unethical Behavior	Indirect Mediation Effect	0.239	0.037	6.459	0.174 ~ 0.321	96.50	<0.001
Occupational Stigma → Unethical Behavior	Direct Effect	-0.105	0.037	-2.838	-0.184~-0.034	---	0.003
Occupational Stigma → Unethical Behavior	Total Effect	0.248	0.051	4.863	0.148 ~ 0.347	---	<0.001

6 Discussion

This study systematically investigated the mechanism through which occupational stigma influences unethical behavior among hospital nursing assistants by constructing and testing a dual-mediation model. The findings demonstrate that occupational stigma does not directly or unidirectionally lead to unethical behavior. Instead, it operates through two parallel yet opposing pathways: core self-evaluation and organizational disidentification, collectively forming a complex "masking effect" model. This discovery significantly deepens our understanding of the consequences of occupational stigma.

6.1 The Depletion of Intrinsic Psychological Resources: How Occupational Stigma Erodes Core Self-Evaluation and Promotes Unethical Behavior

First, the study confirms that occupational stigma increases unethical behavior by reducing core self-evaluation (Pathway 1: Occupational Stigma → Core Self-Evaluation↓ → Unethical Behavior↑). This pathway supports the perspective of the Conservation of Resources (COR) theory. As a chronic social stressor, occupational stigma continuously depletes the psychological resources of nursing assistants[65]. When nursing assistants repeatedly experience social devaluation due to their professional identity, the foundational elements of core self-evaluation—such as self-esteem and self-efficacy—are eroded[44]. The results show a significant negative impact of occupational stigma on core self-evaluation (β= -0.376), consistent with the findings of [95], indicating that the internalization of stigma damages an individual's sense of self-worth. Subsequently, impaired core self-evaluation weakens nursing assistants' self-regulatory capacity and moral identity, making them more likely to adopt unethical behavior as a coping strategy when facing difficulties (β= -0.312). This finding also resonates with research by[96] on moral identity as a "psychological shield." This pathway reveals that occupational stigma indirectly promotes unethical behavior through a "weakening mechanism" that erodes an individual's internal psychological resources. This "mechanism of depletion of intrinsic psychological resources" not only empirically validates the core premise of Conservation of Resources Theory—that defensive behaviors are triggered to preserve remaining resources when individuals perceive a continuous loss of valuable resources (e.g., self-esteem, self-efficacy)—but also extends the theory's explanatory scope from general work stress contexts to the specific domain of "occupational stigma," which carries distinct socio-structural characteristics. It profoundly reveals how external social devaluation ultimately leads to behavior deviating from organizational ethics by eroding an individual's intrinsic core self-evaluation. This finding suggests to both managers and researchers that understanding and intervening in employee unethical behavior must go beyond correcting superficial conduct to focus deeply on the underlying state of core self-evaluation. For an employee whose sense of self-worth is continuously damaged by occupational stigma, unethical behavior is likely a passive coping response under resource depletion.

6.2 The Spillover Effect and Social Identity Alienation: How Occupational Stigma Fuels Unethical Behavior via Organizational Disidentification

Furthermore, the study revealed that occupational stigma also increases unethical behavior by enhancing organizational disidentification (Pathway 2: Occupational Stigma → Organizational Disidentification↑ → Unethical Behavior↑). This pathway provides an alternative explanation from the perspectives of social

identity and social exchange theory. Nursing assistants partially attribute the occupational stigma they experience to the organization's failure to provide adequate support and respect, thereby triggering a sense of alienation from the organization (β = 0.438). This sense of organizational disidentification (β = 0.563) leads them to perceive the organization as "them" rather than "us," which weakens their intrinsic motivation to comply with organizational norms. It may even result in unethical behavior being viewed as a form of passive resistance or psychological compensation directed towards the organization[64]. This pathway confirms the 'spillover effect' of occupational stigma, meaning that negative evaluations of a profession can extend to evaluations of the organization itself. This pathway confirms the 'spillover effect' of occupational stigma, meaning that negative evaluations of a particular occupational group by outsiders can cross professional boundaries and generalize to employees' perceptions and evaluations of their organization, causing the organization itself to become stigmatized[56]. This finding offers a profound insight: in organizational behavior research related to occupational stigma, an integrated perspective combining Social Identity Theory and Social Exchange Theory is essential. Examining the impact of stigma solely through individual psychological processes is incomplete. Researchers must simultaneously consider how individuals interpret stigma through the social categorization and comparison processes involving their "professional identity" and "organizational member identity" (the social identity perspective), and how they evaluate the fairness and worthiness of maintaining the exchange relationship with their organization based on the level of support the organization provides in coping with the stigma (the social exchange perspective).

6.3 Expose the masking effect: The Dual-Pathway Mechanism and Behavioral Ambivalence in Occupational Stigma's Impact on Unethical Conduct

The analysis of data in this study revealed a key statistical phenomenon and theoretical mechanism: a significant "masking effect" exists in the influence of occupational stigma on unethical behavior. In this research, the total indirect effect of the two aforementioned pathways was positive (0.114 + 0.239 = 0.353), whereas the direct effect of occupational stigma on unethical behavior was significantly negative (-0.108). This indicates that occupational stigma itself might directly trigger behavioral inhibition among nursing assistants. One plausible explanation is that, being acutely aware that their profession is already viewed negatively, nursing assistants may become more vigilant about and avoid any behavior—including unethical actions—that could provoke further blame or punishment, thereby exhibiting stronger self-restraint[94]. Theoretically, this aligns with the 'Stereotype Reactance' mechanism, where individuals facing identity threats actively engage in 'moral vigilance' to disprove negative societal biases, effectively turning stigma pressure into a motivation for stricter ethical compliance.This positive indirect effect and the negative direct effect compete and offset each other, resulting in the total observed effect being partially "masked." This finding not only clearly demonstrates the statistical characteristics of the masking effect but, more importantly, theoretically reveals the complex and dual nature of the influence of occupational stigma on individual behavior: It indirectly "pushes up" the risk of unethical behavior through psychological resource depletion and organizational alienation, while potentially directly "pulling down" this risk by triggering defensive vigilance. If only the total effect were observed without mediation analysis, the potential harm caused by occupational stigma through psychological and organizational

mechanisms would be seriously underestimated. This underscores that future research investigating similar complex socio-psychological phenomena must delve into the underlying mechanisms to avoid being misled by surface appearances.

6.4 limitations

This study has several limitations. First, the cross-sectional research design cannot definitively establish causal relationships between variables. Future research could employ longitudinal tracking or experimental methods for further verification. Second, all data were collected through self-report measures from nursing assistants, which may introduce common method bias. Although statistical tests indicated this was not a severe issue, future studies could attempt to gather multi-source data (e.g., evaluations from patients, colleagues). Third, the sample was primarily drawn from public hospitals in Guangdong Province. Future research should test the model's generalizability across broader geographical regions and different types of healthcare institutions (e.g., private hospitals, community facilities). Finally, the underlying motivations for the negative direct effect of occupational stigma (whether stemming from moral vigilance or opportunistic avoidance) warrant further exploration through qualitative interviews or other methods in future studies.

7 Conclusions

This study makes two primary theoretical contributions. First, by validating the dual-mediation pathways involving both the internal factor of "core self-evaluation" and the external factor of "organizational disidentification," a more comprehensive theoretical model was constructed. This model integrates perspectives from Conservation of Resources Theory and Social Identity Theory, thereby revealing the mechanisms through which occupational stigma operates in a more systematic manner.

Second, the discovery of a significant "masking effect" is not merely a statistical phenomenon but profoundly illuminates the complexity and paradoxical nature of how occupational stigma influences behavior. This underscores the critical importance of mechanism analysis and provides methodological insights for deepening stigma research.

The findings of this study provide clear directions for hospital management and policy formulation. Primarily, the fundamental strategy lies in reducing occupational stigma. Healthcare institutions and society should actively promote the professional value and social contribution of nursing assistants' work through positive publicity, establish sound career development systems, and improve compensation and benefit structures. These actions can tangibly enhance their professional dignity and social status, thereby reducing stigma at its source.

Secondly, intervention measures should adopt a dual-pronged approach. On one hand, efforts should focus on enhancing nursing assistants' "core self-evaluation." This can be achieved by providing psychological counseling, empowerment training, and establishing peer support groups to strengthen their self-esteem and self-efficacy, effectively building an internal "floodwall." On the other hand, it is

crucial to actively foster "organizational identification." Hospital management should create an inclusive and respectful organizational climate through fair treatment, involving them in decision-making, and providing timely recognition and support. This helps nursing assistants build positive connections with the organization, constructing an organizational "firewall."

In conclusion, this study reveals the complex mechanism through which occupational stigma influences the unethical behavior of hospital nursing assistants via dual mediating pathways and a masking effect. The findings emphasize that improving the situation for nursing assistants and safeguarding the quality of healthcare services requires a systematic approach to addressing occupational stigma. This entails building a comprehensive support system focused on both enhancing individual psychological resources and optimizing the organizational environment.

Abbreviations

NAs
Nursing Assistants

Declarations

Ethics approval and consent to participate

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Ethical approval for this study was obtained from the Ethics Committee of the Second Affiliated Hospital of Guangzhou Medical University (Approval No.: KY-2025-037-01). Informed consent was obtained from all individual participants prior to their participation in the study. The confidentiality and privacy of all participants' data were strictly protected throughout the research process.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

H.X.G. conceived the study, designed the methodology, administered the project, performed the investigation, curated and analyzed the data, and wrote the original draft. H.X.G., J.F.L.,L.N.H., Z.Y.C., and J.H.L. contributed to methodology, investigation, data curation, and writing–review & editing. Y.J.Y. and M.Z. contributed to methodology, project administration, resources, and writing–review & editing. All authors read and approved the final manuscript.

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Data Availability

The questionnaire datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

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Figures

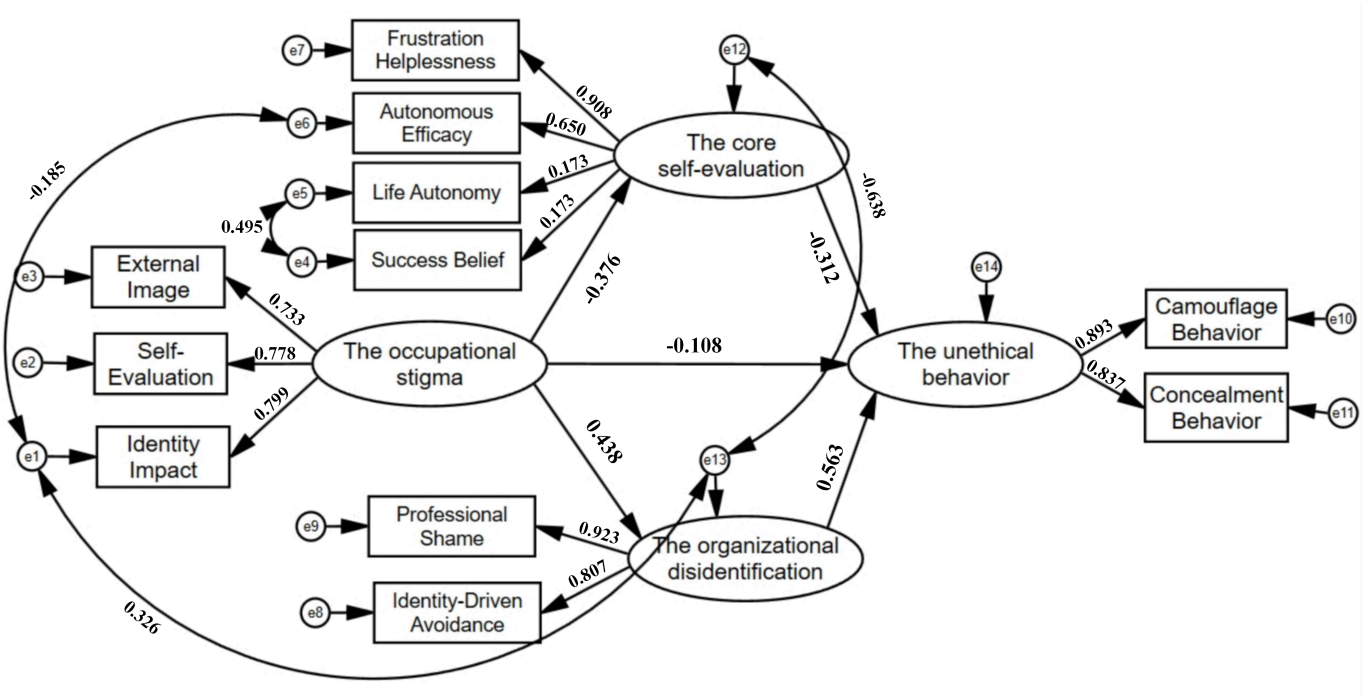


Figure 1

The Parallel Mediation Model of Occupational Stigma and Unethical Behavior