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Title

Nurses' and nurse leaders' perceived expectations and obstacles: An interview study

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ABSTRACT

Background: Nurses are increasingly expected to lead themselves in order to ensure high-quality care, cope with workplace challenges, and sustain their own well-being in a rapidly changing healthcare environment. Effective self-leadership, however, requires reflection, support, and appropriate organizational structures. This study examines nurses' and nurse leaders' perceptions of the expectations placed on nurses' self-leadership as well as the obstacles that hinder it.

Methods: A qualitative interview study was carried out. One individual interview and nine focus group interviews were conducted between December 2024 and February 2025, representing various units across different parts of a Wellbeing Services County in Finland. In total, 17

27 registered nurses and 12 nurse leaders participated in the study. Inductive content analysis was
28 used to analyze data.

29 **Results:** Four main themes regarding the expectations for nurses' self-leadership were identified:
30 strong professional self-esteem, ability to work independently, taking care of one's own work well-
31 being, and open collaboration to achieve goals. In addition, three main themes were recognized to
32 describe the obstacles to self-leadership: external work-related constraints, insufficient support for
33 self-leadership, and personal factors.

34 **Conclusion:** Self-leadership in nursing is a complex phenomenon shaped by both individual and
35 organizational factors. Expectations and obstacles related to nurses' self-leadership are often
36 reflected in everyday clinical practice, and strengthening self-leadership can support nurses in
37 taking greater ownership of their profession. However, self-leadership is not solely an individual
38 attribute; it is also influenced by collective practices and structural conditions. A more supportive
39 nursing practice environment can be developed by identifying organizational structures and
40 workplace cultures in which nurses' self-leadership is insufficiently supported.

41 **Keywords:** expectations, interview, nurse, nurse leader, obstacles, self-leadership

42

43 1 Background

44 Nurses play a pivotal role in ensuring that the nursing practice is safe, effective, and responsive to
45 the diverse needs of patients. Within interdisciplinary healthcare teams, they contribute to
46 comprehensive care that enhances health outcomes and strengthens the resilience of health
47 systems. The World Health Organization has in recent years emphasized policy priorities that
48 support nurses' work in roles aligned with their educational preparation, enabling them to fully
49 participate in and influence their professional practice [1]. To achieve their full professional
50 potential and meet care objectives, nurses should be empowered to manage key aspects of their
51 work, such as workload, by developing self-leadership competencies [2]. Globally, nursing

52 education most commonly spans three to four years (86%), and many countries are increasingly
53 expanding pathways toward bachelor's-level qualifications. Therefore, nurses are highly educated
54 professionals working in a demanding field that requires comprehensive healthcare expertise,
55 appropriate decision-making autonomy, and responsibility for holistic care. They are expected to
56 plan and deliver patient care independently and as part of a team, striving for the best possible
57 care outcomes [1].

58 Self-leadership is a goal-oriented and comprehensive self-influence process in which employees
59 utilize internal motivation, thinking strategies, and behavioral patterns to guide themselves [3].
60 Based on their focus, self-leadership strategies are commonly classified into three distinct
61 domains: behavioral strategies, natural reward strategies, and constructive thought pattern
62 strategies. Behavior-focused strategies aim to promote actions through techniques such as self-
63 observation, self-goal setting, self-reward, self-punishment, and self-cueing. Natural reward
64 strategies enhance intrinsic motivation by integrating enjoyable elements into tasks, thereby
65 increasing perceived competence and meaningfulness, making the activity more rewarding.
66 Constructive thought strategies focus on cultivating positive cognitive processes through self-talk,
67 evaluating underlying beliefs and assumptions, and visualizing successful outcomes. Together,
68 these strategies foster performance, autonomy, and resilience in professional settings [4].

69 Self-leadership, in other words, is a process in which the individual acts as both the originator and
70 the target of influence [3]. It differs from formal leadership, which is based on a designated
71 organizational position and derives its influence from formal roles, responsibilities, and authority.
72 Thus, leadership is part of the organization's structure and hierarchy [5]. With top-down leadership
73 being increasingly deemphasized while individual autonomy is emphasized, the role of self-
74 leadership becomes significant [3]. Importantly, the employee ultimately determines how, for
75 example, organizational demands and leadership are reflected in their choices and behaviors in
76 practice [6].

77 Self-leadership is also needed in shared governance. The development of effective professional
78 governance requires strengthening shared governance structures by actively involving nurses in

79 decision-making and aligning their contributions with organizational goals. Shared governance is
80 based on open communication and collaboration between nurse leaders and nursing
81 professionals, supported by clearly defined roles. In this model, nurses are responsible for the
82 content of their work (e.g., care standards, competencies, quality, and evidence), whereas leaders
83 manage contextual elements, including resources and systems [7]. This approach reflects a low-
84 hierarchy model characterized by shared authority and professional autonomy, enabling nurses
85 and leaders to fulfill complementary roles [8].

86 In the context of nursing, self-leadership remains underexplored, although scholarly interest has
87 increased notably over the past five years [2]. The concept itself may still lack conceptual clarity
88 and is potentially confused with clinical leadership in practice. Based on a preliminary concept
89 analysis, Ntshingila and colleagues define self-leadership as an individual's capacity for self-
90 awareness and reflection, the recognition of personal capabilities, and the purposeful direction of
91 one's actions while assuming active responsibility [9]. By contrast, Prinsloo's findings suggest that
92 nurses conceptualize self-leadership in more practice-oriented terms, such as taking responsibility
93 for patient care, engaging in autonomous actions, monitoring one's own performance, and learning
94 through teamwork, thereby highlighting its clinically embedded nature. These findings indicate that,
95 in practice, nurses demonstrate self-leadership through the continuous development of their
96 competencies, skills, and attitudes, which enables them to address workplace challenges and act
97 proactively for the benefit of their patients [10]. However, clinical nursing leadership needs to be
98 differentiated from self-leadership. The daily responsibilities of a nurse require leadership
99 competencies that influence others and are therefore directed toward patients, colleagues, and the
100 broader healthcare system [11]. By contrast, self-leadership refers to the internal mechanisms
101 through which nurses regulate, motivate, and direct themselves [12].

102 Research on expectations related to nurses' self-leadership remains limited, with the topic
103 addressed mostly indirectly through discussions on role expectations, demands for self-direction,
104 and work environment conditions. Nurses are generally expected to act proactively and
105 autonomously, with organizations enabling such practices [2, 10]. Similarly, empirical evidence on

106 obstacles to nurses' self-leadership is scarce and has primarily been approached through related
107 constructs such as autonomy [12], working conditions, and leadership [13].

108 Overall, existing research indicates a significant gap in understanding the concrete conditions that
109 enable nurses' self-leadership. Previous nursing studies mainly focused on self-leadership
110 strategies, outcomes, and interventions, while less is known about how nursing professionals
111 themselves understand the expectations and obstacles associated with nurses' self-leadership in
112 practice. This study approaches the topic from the perspectives of clinical nurses and nurse
113 leaders at higher organizational levels such as nurse directors, thereby contributing to a deeper
114 understanding of current practices from two viewpoints: bedside care and nursing leadership.

115

116 **2 Aims**

117 This study aimed to describe nurses' and nurse leaders' perceptions of the expectations and
118 obstacles concerning nurses' self-leadership. Two research questions were addressed:

119 1. How do nurses and nurse leaders perceive others' expectations regarding nurses' self-
120 leadership?

121 2. What obstacles do nurses and nurse leaders identify in nurses' self-leadership?

122

123 **3 Methods**

124 **3.1 Study Design**

125 This is a descriptive interview study. The Standards for Reporting Qualitative Research were used
126 [14].

127

128 **3.2 Study Setting and Sampling**

129 The study was conducted in a Wellbeing Services County responsible for organizing social, health,
130 and rescue services for approximately 273,000 residents in Finland. The participating registered
131 nurses and nurse leaders were recruited from healthcare services employing approximately 2,150
132 registered nurses and 50 nurse leaders across primary healthcare and specialized medical care.
133 Registered nurses worked in clinical roles involving direct patient contact, whereas nurse leaders
134 held administrative positions at higher organizational levels, with broad responsibility for nursing
135 practice and its development. These leaders were not the direct supervisors of the interviewed
136 nurses, a role typically held by nurse managers.

137 Potential participants were approached through a contact person employed by the Wellbeing
138 Services County, who distributed the study information sheet and interview invitation to nurse
139 leaders for further forwarding to each unit. All registered nurses and nurse leaders employed within
140 the Wellbeing Services County were invited to participate in the study. To minimize any perceived
141 pressure, the invitation was formulated in a neutral, factual tone, and the number of reminder
142 messages was limited to two. Participation was explicitly described as voluntary in the study
143 information sheet. Voluntary participants contacted the researcher directly to schedule an online
144 interview. If an individual who had expressed willingness to participate did not respond to
145 messages when scheduling the interview, then no further contact was initiated.

146

147 **3.3 Data Collection**

148 The data were gathered between December 2024 and February 2025 through one individual
149 interview and nine focus group interviews. The individual interview was conducted due to
150 scheduling constraints, while the remaining focus groups consisted of two to five participants.

151 Interviews were conducted in distinct professional groups, meaning that nurses and nurse leaders
152 were not combined into the same focus groups. In total, 17 nurses and 12 nurse leaders
153 participated in the interviews, representing various units from different parts of the Wellbeing
154 Services County.

All interviews were conducted following the same interview structure (Table 1), the content of which was developed based on the previous literature [e.g., 2, 4] and aligned with the research questions. The research team, which included members with diverse experience in nursing roles, nursing practice environments, and interview-based research, collaboratively formulated several supporting questions around the main themes. The first author, with the assistance of the third author, conducted all interviews online, which lasted for 18–57 min. Afterward, the third author transcribed the recorded interviews immediately. The interviews were conducted in Finnish, and the interview data were likewise transcribed in Finnish. Altogether, the interviews yielded 7 h and 18 min of audio material, which amounted to 134 transcribed pages (Aptos, font size 12, line spacing 1.0).

Table 1. A structured interview guide. *Insert Table 1 here*

3.4 Data Analysis

Inductive content analysis was used to analyze data. The transcribed data were reviewed repeatedly and discussed within the research group in an iterative manner to ensure that they become thoroughly familiar with the content. This process supported the development of a clear, coherent, and comprehensive understanding of the dataset [15]. The first and third authors condensed the original expressions into short phrases ($n = 482$) and grouped them into codes ($n = 56$) under research questions. They also formed subthemes related to the research questions ($n = 8$ and 8 , respectively) and subsequently organized these into main themes ($n = 4$ and 3 , respectively). The grouping of short phrases into codes and subsequently into subthemes and themes was based on similarities in content, progressing from individual, concrete expressions to a more abstract level to describe expectations and obstacles related to nurses' self-leadership [15]. Subthemes and themes were evaluated through a joint discussion within the research group, and

their labels were refined collaboratively to more accurately reflect their content. An example of the analysis is presented in Table 2.

Table 2. Example of inductive content analysis. *Insert Table 2 here*

3.5 Rigor and Trustworthiness

Credibility, dependability, and transferability were considered at various stages of the research process to enhance the rigor and trustworthiness of the study. Considering that saturation is not necessarily reached in descriptive interview studies, a sample of 17 registered nurses and 12 nurse leaders from diverse practice environments constituted a rich dataset, in which patterns of similarity emerged [16]. Focus groups consisting of individuals sharing the same professional role further supported the expression of genuine perspectives.

Two researchers (KP, ER) participated in each interview to ensure methodological consistency and to support collaborative reflection throughout the analysis process. All members of the research group had prior experience in clinical practice, which informed a nuanced understanding of the nursing role and diverse clinical practice environments, as well as the ability to formulate relevant interview and research questions. In addition, all researchers were familiar with the theoretical foundations of self-leadership. Two researchers (AN, TK) possessed extensive expertise in nursing leadership and its scholarly study, contributing to a deeper appreciation of leadership perspectives. Furthermore, all researchers had prior experience in conducting interview-based research, supporting methodological rigor in data collection and analysis. Joint critical discussions in the research group fostered reflexive dialogue across the different stages of the process and enriched interpretive understanding.

A structured interview guide (Table 1) was followed in all interviews, which strengthened dependability. The recorded data ensured that attention could be focused on all details in the discussions, and the word-by-word transcriptions ensured that the information could be revisited. An example of the analysis is provided in Table 2, and authentic quotations from the interviewees are presented alongside the results to demonstrate transparency in the analysis process and the formation of results [16].

3.6 Ethical Considerations

Ethical approval (Statement No. 17/2024) and research permission were obtained from the Committee on Research Ethics at the University of Eastern Finland in September 2024 and Wellbeing Services County in October 2024 (Hyvaks 20.10. 2024), respectively. Nurses and nurse leaders received study information via email from the contact person. The study information sheet clearly stated that participation was voluntary and that participants could withdraw from the study at any stage without consequences. Informed consent to participate was obtained from all participants, and their voluntary willingness to participate was verbally confirmed at the beginning of each interview. No participants withdrew from the study. The study followed the Declaration of Helsinki in all research phases [17]. To protect the anonymity of the informants, we collected only those background details that were assessed to be relevant to the research topic.

4 Results

4.1 Demographic Characteristics of Nurses and Nurse Leaders

A total of 17 nurses and 12 nurse leaders participated in this study, although one nurse leader did not respond to the background information questionnaire (Table 3). The mean age of the nurses was 46.9 years, with a range of 30 to 64 years. Correspondingly, the mean age of nurse leaders was 55.7 years, with a range of 41–63 years. Most of the nurses held a bachelor's degree,

whereas the nurse leaders had at least a master's degree. The nurses had an average of 16.7 years of clinical experience, with a range of 2–39 years, whereas the nursing leaders had 16.1 years of leadership experience, with a range of 3–24 years.

Table 3. Demographic characteristics of nurses and nurse leaders. *Insert Table 3 here*

4.2 Expectations Concerning Nurses' Self-Leadership

Expectations concerning nurses' self-leadership consist of four main themes and eight subthemes (Figure 1). The main themes are *strong professional self-esteem, ability to work independently, taking care of one's own work well-being, and open collaboration to achieve goals.*

4.2.1 Strong professional self-esteem

Professional self-esteem is reflected in how nurses *demonstrate nursing expertise in practice.* It emphasizes professionalism and a strong sense of responsibility in fulfilling nursing tasks. Patient-centered care is a key guiding factor in the professional practice of nurses. Nurse leaders emphasized the visibility of nursing appreciation as a foundational element of nursing expertise.

"It all really starts with valuing your own work—appreciating what you do, the role you have, and the fact that you've trained for it." (Nurse leader 4)

Nurses and nurse leaders noted that professional growth is also an important part of nurses' professional self-esteem. Hence, nurses recognize and trust their own competencies. In addition, they acknowledge areas for development and demonstrate an interest in self-improvement. A generally positive attitude toward professional development within the work community—an area in which everyone can contribute—was also highlighted.

“You need to be kind to yourself when you reflect — like, spotting the things you can grow in, but also knowing it’s totally fine not to have it all figured out right away.”
(Nurse 6)

4.2.2 Ability to work independently

Independent working is a fundamental aspect of self-leadership, and *comprehensive work management while responding to situational demands* is essential for safe practice. Nurses are expected to work in a structured manner, even under pressure, and to prioritize tasks. Furthermore, they need to demonstrate resilience in rapidly changing situations and tolerate uncertainty. Nurses and nurse leaders emphasized the importance of time management and focusing on work-related tasks during working hours.

“It’s that kind of flexibility and resilience—like being able to ride the waves a bit, go with whatever’s happening, adapt, and come up with different ways to handle stuff as it comes.” (Nurse 16)

The ability to work independently also involves *demonstrating confidence in applying one’s own expertise in practice*. Nurses are presupposed to be capable of making independent decisions based on evidence-based information. They are also expected to demonstrate a high level of self-direction. In addition to performing their own tasks, nurses also consider the overall context of patient care.

“I think this is super important—you’ve gotta trust your own professional skills and judgment and make decisions based on that. Honestly, nothing else should really get in the way of that.” (Nurse leader 12)

4.2.3 Taking care of one’s own work well-being

Two subthemes emerged in relation to taking care of work well-being: *balancing work and leisure* and *managing work-related strain*. Participants considered the ability to distinguish between work and leisure time as an important aspect of self-leadership. They emphasized the significance of

recovery during off-duty hours. Thus, work-related thoughts do not dominate during leisure time; instead, attention is directed toward engaging with and fulfilling the multifaceted dimensions of personal life. Small breaks during workdays and self-imposed workload boundaries also emerged as important aspects and are considered integral to self-leadership from the perspective of managing strain. At the same time, participants recognised that well-being management is also shaped by workplace conditions.

284

“You’ve gotta keep things in balance, y’know? Like, if you give everything to work and totally forget about your free time, it’s gonna catch up with you—and eventually it’ll start affecting your work too.” (Nurse leader 10)

288

“You need to have some ways to calm yourself down when things around you get hectic and chaotic—like, whatever works for you personally. Everyone’s got their own thing.” (Nurse 5)

292

4.2.4 Open collaboration to achieve goals

Nurses’ self-leadership includes *engaging in active and constructive interaction* within the work community to achieve goals. Collaboration must be grounded in tolerance and mutual respect. Reciprocity in offering and receiving help is essential in nursing practice. Moreover, work tasks should be distributed fairly. Engaging in reflection with colleagues and being open to learning from one another are important. Nurses and nurse leaders highlighted that openness and collaboration require a permissive atmosphere—this is a responsibility shared by everyone.

“Being able to give feedback—but also being open to receiving it. As nurses, it’s kinda our responsibility to give helpful, constructive feedback if someone does something wrong, so it doesn’t happen again.” (Nurse 13)

303

304 The importance of open collaboration is also reflected in *presenting suggestions for work-related*
 305 *development*. Clear and well-timed communication with nurse leaders was perceived as central,
 306 and it provides a strong foundation for nurses' self-leadership. Nurses are encouraged to more
 307 proactively voice their views and take ownership in driving their proposals forward.

308 Figure 1. Expectations concerning nurses' self-leadership: themes and subthemes. *Insert Figure 1*
 309 *here*

310

311 **4.3. Obstacles Concerning Nurses' Self-Leadership**

312 Three main themes and eight subthemes were identified to describe the obstacles to nurses' self-
 313 leadership (Figure 2). The main themes are *external work-related constraints, insufficient support*
 314 *for self-leadership, and personal factors*.

315 **4.3.1 External work-related constraints**

316 The nursing profession is subject to structured guidance and control in many ways. Consequently,
 317 the interviewees described some of the constraints associated with the work environment and the
 318 nursing profession as obstacles. A major obstacle is *recurrent interruptions during the day*. Nurses
 319 and nurse leaders voiced concerns about the challenges of maintaining self-directedness in
 320 constantly changing organizational structures and work environments. The financial and resource
 321 constraints within the Wellbeing Services County influence various aspects, such as access to
 322 continuing education, the realization of new development initiatives and innovations, and the
 323 general workplace climate. The workload was described as heavy, in clinical nursing and in the
 324 development of nursing care, leaving little time for self-development. In addition, nurses face
 325 challenges related to workspace and equipment. Finding a quiet space to take a proper break
 326 during the workday is often difficult. The patient information system and the accessibility of relevant
 327 data, which occasionally fail to meet practical needs, affect the efficiency of work.

“Our break room—it’s like there’s this constant noise, you know? So, if you’re in the middle of work and just want a moment to calm down or be alone with your thoughts, it’s basically impossible.” (Nurse 14)

Nurses and nurse leaders felt that nurses’ self-leadership is restricted by the fact that they have *limited opportunities for self-directed practice*. Legislation and nurses’ professional rights play a role in this, as does authoritarian leadership, and the hierarchical nature of healthcare is reflected in nurses’ work. Opportunities to influence are sometimes limited, which can lead to disappointment and passivity among nurses. Strict protocols and the influence of other individuals on one’s work were identified as obstacles to self-leadership. The interviewees highlighted that the nature of the work unit influences nurses’ self-leadership. Consequently, the extent to which nurses can influence the content of their work and the flow of their workday varies considerably.

“I mean, everyone’s got their own ways of working, sure—but in the hospital setting, we kinda simulate certain routines and structures that are super well thought-out and precise. So, it’s not really about self-leadership there. Like, if you’re in the trauma team as a nurse, you’ve got a specific role—you don’t start coming up with creative solutions.” (Nurse leader 5)

4.3.2 Insufficient support for self-leadership

Insufficient support for nurses’ self-leadership is particularly evident in interactions among colleagues, in interprofessional teams, and in communication with nurse leaders. In other words, *the lack of interaction in collaboration* stems from limited shared dialogue within the work community, inequality within the interprofessional team, and the supervisor’s limited accessibility, which is attributed to their broad areas of responsibility and the demands of their workload. To complement the perspective on support, the interviewees emphasized that challenges arise from a lack of encouragement for self-leadership, the disregard of nurses’ innovations, and even criticism directed at autonomous professional behavior. At times, nurses encounter negative preconceptions regarding their competence and ability to lead themselves.

“We’re stepping into something new here, where the nurse’s expertise is actually respected. And that’s a big deal—if that doesn’t happen, it can really block things. You start wondering, like, ‘Am I even valued enough to be part of this team?’” (Nurse leader 2)

The nurses and the nurse leaders also identified broader *negative attitudes toward the development of nursing practices* that shape nurses’ ability to exercise self-leadership. These negative attitudes are manifested in the work community as resistance to change and a negative tone in public discussions related to nursing practice. An additional challenge for support arises when *organizational culture does not encourage individuality*. The interviewees mentioned that individual competencies and strengths are not adequately recognized. Nurses are at different stages of their careers, and some have pursued additional education. Nevertheless, this potential is not effectively used. From the perspective of self-leadership, a further obstacle arises when different personalities, working styles, or the active engagement of nurses is met with disapproval among colleagues.

“In our big organization, it feels like managers are more and more focused on treating everyone the same — or how should I put it? Like, there’s no time to really think about anyone’s individual needs. Sure, they might go through the motions, but in the end, those things don’t really get revisited.” (Nurse 9)

4.3.3 Personal factors

Internal factors that arise from within the nurses themselves can also impede self-leadership. The *lack of comprehensive work management* may result from an insufficient understanding of the opportunities associated with self-leadership. The concept of self-leadership seems to be, to some extent, unfamiliar or not well understood. Readiness for self-leadership can differ among individuals and may, in part, be sometimes shaped by age differences. Nurses may also face challenges organizing their own work comprehensively, and some need clear instructions for their tasks.

“It probably also comes down to personality types. Some people just want someone to tell them exactly what to do and frame it all out. And then they might not really have that self-drive to start doing something else, like background tasks, unless someone tells them to.” (Nurse 1)

Low professional self-esteem is sometimes seen to be caused by personality traits, lower motivation, or a lack of professionalism, which are perceived to weaken self-direction and the development of self-leadership. The interviewees highlighted that a lack of commitment to work, or perceiving it as neither meaningful nor rewarding, undermines the prerequisites for self-leadership. At the core lies the valuing of one’s profession and expertise; in its absence, nurses are unlikely to engage in self-leadership aimed at achieving personal or organizational goals. Nurses may also encounter *challenges in maintaining work well-being*. In this situation, work feels hectic, and there is a risk of becoming overwhelmed at work. When such a situation persists, nurses are constantly pressured and suffer from a lack of recovery, blurring their capacity for sustainable self-leadership.

“The drive to try something new, to experience something different. If that’s missing, it’s probably the biggest thing holding you back. You just end up seeing the same stuff you’ve always done, nothing beyond that.” (Nurse leader 2)

Figure 2. Obstacles concerning nurses’ self-leadership: themes and subthemes. *Insert Figure 2 here*

5 Discussion

This study aimed to describe the expectations placed on nurses’ self-leadership, as well as the obstacles that challenge its implementation in practice. The perspectives of nurses and nurse leaders were analyzed together without comparison. The results were structured around the main themes that were formed inductively based on the experiences of nurses and nurse leaders.

406 Nurses and nurse leaders tended to describe self-leadership somewhat strongly from the
 407 perspective of clinical leadership, which is consistent with previous research findings [10]. This
 408 outcome was expected because nurses' work involves considerable clinical coordination and
 409 collaboration within multidisciplinary teams. Specifically, their work requires taking responsibility for
 410 the fluent workflow in patient care (e.g., delegation and prioritization), which is at the core of clinical
 411 leadership [11]. Although clinical leadership is emphasized as a distinct concept, it also intersects
 412 with self-leadership in a broader context because nurses are also responsible for their own
 413 proactive actions in working toward goals.

414 In a similar vein, it was not a surprising result in a nursing context that open collaboration aimed at
 415 achieving goals emerged as an expectation of self-leadership in this study. As self-leadership is
 416 closely embedded in clinical work, such collaboration was primarily described in terms of
 417 teamwork, fairness in workload distribution, and shared responsibilities. To strengthen the
 418 conditions for self-leadership in this respect, the individual's role within collaborative processes
 419 needs to be clarified. Specifically, self-determination and self-influence over one's actions are
 420 central to achieving shared goals and should also be highlighted within collaboration [4].

421 The expectation that nurses are able to work independently can also be regarded as a foundation
 422 for shared governance [e.g., 7, 18]. In this study, the ability to work independently encompassed
 423 managing work comprehensively while responding to situational demands, including demonstrating
 424 a high level of self-direction. The ability to work independently, as an expectation of self-leadership,
 425 thus strongly refers to nurses' autonomy, independence, and clinical competence. In light of this
 426 finding, nurses' autonomous professional role both in clinical practice and in organizational
 427 structures, such as shared governance, therefore needs to be strengthened to better utilize their
 428 potential. The development of shared governance is particularly important, as it has been
 429 associated with higher job satisfaction, improved patient outcomes, and increased career
 430 motivation among nurses [18, 19].

431 In this study, one of the expectations placed on nurses' self-leadership was strong professional
 432 self-esteem. This finding was explained through professionalism, a sense of responsibility, and the

nurses' own appreciation of their work. Correspondingly, Stievano and colleagues similarly emphasized that the value of nursing is embedded in professional dignity, which is expressed through words and behaviors. Such value manifests as professional identity, pride, and confidence in a nurse's competence. Nurses found it meaningful that when they valued their profession themselves, others also recognized this and demonstrated respect [20]. Self-leadership strategies stem from constructivist thinking models, particularly from positive self-talk and the evaluation of one's own beliefs and assumptions [3]. In our study, the theme of professional esteem related to expectations also emerged as a subtheme under obstacles, when interviewees emphasized the role of personal factors. Low self-esteem and a lack of professionalism are seen as hindering initiative.

In addition, individuals with these traits tend to show little interest in pursuing either personal or organizational goals through self-leadership. Thus, it would be beneficial for nurses to recognize their inner dialogue and evaluate their own beliefs and assumptions. Nurses can remain vital in their daily work and be more resilient in challenging situations by focusing on the positive and valuable aspects of the profession.

The interviewees pointed out that internal factors related to individual nurses can hinder self-leadership and that readiness for self-leadership may vary between nurses. Differences in self-leadership may at times be interpreted as differences between age groups; however, in the context of this study, such interpretations remain largely speculative. The interviewees expressed divergent views, with some suggesting that younger nurses demonstrate stronger self-leadership capabilities, while others perceived these capabilities as increasing with age. Previous research indicates that self-leadership tends to develop with age [2] as well as through education and professional experience [21, 22]. Accordingly, self-leadership should not be understood primarily as an innate trait but rather as a competency that can be learned and further developed. Interestingly, although personal factors and a lack of awareness of the self-leadership concept were highlighted as obstacles, the absence of training was not explicitly mentioned.

459 The expectation that individuals take responsibility for their work well-being is a highly significant
460 finding, that is, a nurse's overall well-being is also their own responsibility. There are several well-
461 being-related aspects that nurses can influence in their work through their own behavior, mindsets,
462 and choices. However, this requires awareness, development, and active use of self-leadership
463 strategies [22]. More specifically, a broader understanding of self-leadership as an individual self-
464 influence process is needed, alongside the more established concept of clinical nursing leadership.
465 In practice, nurses can manage their workload through prioritization, boundary-setting, and
466 promoting recovery through work breaks, adequate time off, and dedicating free time to nonwork-
467 related activities. In the healthcare context, the importance of self-leadership has been emphasized
468 in relation to vitality [12, 23], self-compassion, and recovery [21]. This matter deserves attention
469 because previous studies demonstrated a positive association between self-leadership and the
470 well-being of nurses [2].

471 At the same time, the results underscore that nursing work is shaped by substantial structural
472 constraints, including heavy workload, lack of resources, and frequent interruptions. These external
473 work-related constraints were identified as obstacles to self-leadership. In this study, external
474 constraints were reflected in comments about work pressure, with the interviewees saying that
475 nurses have little time or energy for self-development and that quiet break areas that would enable
476 recovery during the workday are lacking. These issues pose clear challenges to self-leadership
477 and call for organizational action. However, nurses can, to some extent, influence change through
478 their own actions by constructively raising concerns within the work community and proposing
479 relevant improvements.

480 In addition, issues related to nurses' professional rights were mentioned, which again suggests
481 constraints related to autonomy [24]. Our study highlighted authoritarian leadership and the
482 hierarchical nature of healthcare as obstacles, aligning with previous research regarding nurses
483 [25] and in a broader context [26]. Ideally, these factors should not affect self-leadership; however,
484 the reality is undoubtedly more complex. Interviewees described this as the supervisor's limited
485 accessibility, along with a general lack of encouragement, belittling, or even criticism toward self-

486 leadership and self-direction. Kämäräinen and colleagues described the complexity and
 487 multidimensionality of nurse leaders' interpersonal communication competence, and they
 488 emphasized the importance of successful communication when interacting with staff [27].
 489 Therefore, in communication-related interactions, successful encounters and significant
 490 misunderstandings can always exist.

491 Empowering leadership has been positioned as a key prerequisite for self-leadership and has been
 492 shown to promote psychological empowerment [28]. Psychological empowerment reflects
 493 autonomy, intrinsic motivation, and a sense of control [29], which likewise emerged in this study as
 494 expectations concerning self-leadership, although they were articulated somewhat differently in
 495 relation to the ability to work independently. Empowering leadership, together with organizational
 496 structures that support shared governance, may help facilitate favorable conditions for nurses' self-
 497 leadership and appears to be associated with positive outcomes and higher job satisfaction in
 498 organizations that emphasize empowerment [28].

499 Finally, the nurses and the nurse leaders in this study identified an obstacle to self-leadership that
 500 reflects a broader concern: a negative attitude within the work community toward nursing
 501 development, along with a lack of tolerance for different working styles and personalities.
 502 Workplace incivility has also been identified in previous studies [30], and addressing it is one
 503 responsibility of the nurse manager [31]. Although this study approached the issue from the
 504 perspective that such negative interactions among colleagues challenge self-leadership, research
 505 has shown that strong self-leadership skills can help individuals cope in demanding work
 506 environments [32].

507

508 **5.1 Strengths and Limitations**

509 The data were collected from a geographically extensive Wellbeing Services County, and the
 510 participants were experienced healthcare professionals who represent various nursing
 511 environments. The researchers were not acquainted with the participants, which helped minimize

preconceptions on both sides during the interview process. The dataset combines perspectives from nurses and nurse leaders, enriching the viewpoints and providing a broader practical understanding of the phenomenon. The data were gathered through focus groups, which were formed so that the nurses and the nurse leaders were represented in separate groups. This approach encouraged honest opinions and facilitated open discussion within each group.

When interpreting the results, certain limitations should be acknowledged. Considering the qualitative research design, the views of the nurses and the nurse leaders are subjective and may include speculation or overstatement influenced by the research situation. Although combining perspectives from nurses' and nurse leaders' interviews may broaden the examination of the phenomenon and deepen its understanding, it is important to acknowledge that they approach the phenomenon from their respective professional roles. Their perspectives may differ or be reflected differently in the results, which was not accounted for in this study. The generalizability of the results should be approached with caution owing to the context-specific nature of the study. Finally, qualitative research is also subject to researcher bias, particularly in the analysis and interpretation of data. More precisely, the analysis was conducted inductively; however, it is possible that the researchers' prior theoretical understanding may have guided the interpretation of the findings.

5.2 Recommendations for Further Research

Nurses' self-leadership requires further research in the context of an ever-changing healthcare environment. There is a clear need for further knowledge on how self-leadership is defined in nursing and how its implementation is experienced. More future research should also examine how nurses concretely apply self-leadership strategies in practice. It is equally important to examine the effects of structural opportunities on the use of self-leadership strategies. Evidence is also needed on the association between self-leadership and nursing-specific outcomes. In addition, future studies should explore how organizational structures and leadership support the development of nurses' self-leadership capabilities. Specifically, study designs that examine the role of

empowering leadership in removing obstacles to nurses' self-leadership represent a promising direction for future research. It is also noteworthy that nurses and their leaders may perceive self-leadership differently, highlighting the need for comparative research.

541

542 **6 Conclusion**

Self-leadership in nursing is a complex phenomenon influenced by individual and organizational factors. In practical work, expectations and obstacles related to nurses' self-leadership are generally not described through concepts associated with self-leadership strategies. Instead, self-leadership is often reflected in everyday clinical practice. Thus, self-leadership manifests as self-directedness and actions linked to clinical leadership, where professional self-esteem and the ability to work independently are emphasized.

External factors mainly limit self-leadership. The accessibility, encouragement, and interaction provided by nurse leaders affect the self-leadership of nurses. Strengthening self-leadership can help nurses take ownership of their profession. However, self-leadership is not solely an individual attribute; it is also influenced by collective practices and structural conditions. A more supportive nursing practice environment can be developed by identifying organizational structures and workplace cultures in which nurses' self-leadership is insufficiently supported. Overall, self-leadership appears to vary depending on context, which warrants consideration.

556

557 **Authors' contributions**

Katja Pursio: Conceptualization and design, methodology, data collection, data analysis, tables and figures, writing – original and revised draft

Anu Nurmeksela: Conceptualization and design, methodology, data analysis, writing – original and revised draft

Emilia Raula: Data collection, data analysis, writing – original and revised draft

563 Tarja Kvist: Conceptualization and design, methodology, data analysis, writing – original and
564 revised draft

565 All authors: Final approval and agreement to be accountable for all aspects of the work.

566

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570 **DECLARATIONS**

571 **Ethical Statement**

572 Ethical approval was obtained from the Committee on Research Ethics at the University of Eastern
573 Finland on September 12th, 2024 (Statement No 17/2024), while Wellbeing services county
574 provided study permission on October 20th, 2024. The study followed the Declaration of Helsinki in
575 all research phases [17]. Informed consent was obtained from all participants, and their voluntary
576 willingness to participate in the study was verbally confirmed at the beginning of each interview.

577

578 **Consent for publication**

579 Not applicable.

580

581 **Availability of data and materials**

582 The datasets generated and/or analysed during the current study are not publicly available due to
583 privacy or ethical restrictions but are available from the corresponding author on reasonable
584 request.

585

586 **Competing interests**

587 The authors declare no competing interests.

588

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592 References

- 593 1. WHO. (2025). State of the world's nursing 2025: investing in education, jobs, leadership
594 and service delivery. Geneva: World Health Organization.
- 595 2. Pursio, K., Kvist, T., Kankkunen, P., & Fennimore, L.A. (2025). Self-leadership and why it
596 matters to nurses: A scoping review. *International Nursing Review*, 72, e70014.
597 <https://doi.org/10.1111/inr.70014>
- 598 3. Knotts, K., Houghton, J.D., Pearce, C.L., Chen, H., Stewart, G.L., & Manz, C.C. (2022).
599 Leading from the inside out: a meta-analysis of how, when, and why self-leadership affects
600 individual outcomes. *European Journal of Work and Organizational Psychology*, 31(2),
601 273–291. <https://doi.org/10.1080/1359432x.2021.1953988>
- 602 4. Neck, C.P., Manz, C.C. & Houghton, J.D. (2019) Self-leadership: the definitive guide to
603 personal excellence. 2nd ed. Thousand Oaks, CA: Sage Publications.
- 604 5. Fleming, R. S. (2026). Formal and informal leadership. *Successful Transformational*
605 *Leadership*. Springer, Cham. https://doi.org/10.1007/978-3-032-13433-2_8
- 606 6. Manz, C. C. (2015). Taking the self-leadership high road: Smooth surface or potholes
607 ahead? *The Academy of Management Perspectives*, 29(1), 132–151.
608 <https://doi.org/10.5465/amp.2013.0060>
- 609 7. Porter-O'Grady, T. & Clavelle, J.T. (2021) Transforming shared governance: toward
610 professional governance for nursing. *Journal of Nursing Administration*, 51(4), 206–211.
611 <https://doi.org/10.1097/NNA.0000000000000999>
- 612 8. Nurmeksela, A., Tervo-Heikkinen, T., Junttila, K., Heikkilä, A., Kaunonen, M., Kortteisto, T.,
613 Peltokoski, J., Salmela, S., Suhonen, R., & Kvist, T. (2025). Excellent Nursing Leadership
614 Towards Magnet Culture Among Nurse Leaders: An Interview Study. *Journal of Advanced*
615 *Nursing*, 81, 4910–4922. <https://doi.org/10.1111/jan.16662>
- 616 9. Ntshingila, N., Downing, C., & Hastings-Tolsma, M. (2021). A concept analysis of self-
617 leadership: The “bleeding edge” in nursing leadership. *Nursing Forum*, 56(2), 406–414.
618 <https://doi.org/10.1111/nuf.12551>
- 619 10. Prinsloo, C. (2024). Nurses' self-leadership in the face of challenging situations, such as
620 patient deterioration. *SAGE Open Nursing*, 10, 1–10.
621 <https://doi.org/10.1177/23779608241274232>
- 622 11. Booher, L., Yates, E., Claus, S., Haight, K. & Burchill, C.N. (2021). Leadership self-
623 perception of clinical nurses at the bedside: a qualitative descriptive study. *Journal of*
624 *Clinical Nursing*, 30, 1573–1583. <https://doi.org/10.1111/jocn.15705>
- 625 12. van Dorssen-Boog, P., de Jong, J., Veld, M. & van Vuuren, T. (2020). Self-leadership
626 among healthcare workers: a mediator for the effects of job autonomy on work engagement
627 and health. *Frontiers in Psychology*, 11, 1–13. <https://doi.org/10.3389/fpsyg.2020.01420>
- 628 13. Lavoie, P. (2025). Exploring nurses' decision-making through the lens of capability: A
629 framework for understanding autonomy in complex care environments. *Journal of*
630 *Advanced Nursing*. <https://doi.org/10.1111/jan.17096>
- 631 14. O'Brien, B.C., Harris, I.B., Beckman, T.J., Reed, D.A., & Cook, D.A. (2014). Standards for
632 Reporting Qualitative Research: A Synthesis of Recommendations. *Academic Medicine*,
633 89(9), 1245–1251. <https://doi.org/10.1097/ACM.0000000000000388>

15. Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15(3), 398–405. <https://doi.org/10.1111/nhs.12048>
16. Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, 1–10. <https://doi.org/10.1177/2158244014522633>
17. World Medical Association. (2013). WMA Declaration of Helsinki—Ethical principles for medical research involving human subjects. <https://www.wma.net/policies-post/wma-declaration-of-helsinki/> Accessed 13 Feb. 2026.
18. McGinnis, J., Dee, V., Rondinelli, J., & Li, H. (2023). Associations and Predictive Pathways Between Shared Governance, Autonomy, Magnet Status, Nurse-Sensitive Indicators, and Nurse Satisfaction. *Journal of Nursing Care Quality*, 39(2), 159–167. <https://doi.org/10.1097/NCQ.0000000000000739>
19. Atalla, A.D.G., Sharif, L.S., Katooa, N.E., Kandil, F.S., Mahsoon, M., Elseesy, N.A.M. (2023). Relationship between nurses' perception of professional shared governance and their career motivation: A cross-sectional study. *International Journal of Nursing Sciences* 10, 485–491. <https://doi.org/10.1016/j.ijnss.2023.09.016>
20. Stievano, A., Mynttinen, M., Gennaro, R., & Kangasniemi, M. (2022). Public health nurses' professional dignity: An interview study in Finland. *Nursing Ethics*, 29(6), 1503–1517. <https://doi.org/10.1177/09697330221107143>
21. Dent, A., Sieg, D., Munn, L.T., Rose, R., & Swick, M. (2025). The Well-being Coaching Program An Innovative Approach to Support and Empower Healthcare Workers. *Journal of Nursing Administration*, 55(1), 61–68. <https://doi.org/10.1097/NNA.0000000000001529>
22. van Dorssen-Boog, P., van Vuuren, T., de Jong, J. & Veld, M. (2021). Facilitating health care workers' self-determination: The impact of a self-leadership intervention on work engagement, health, and performance. *Journal of Occupational and Organizational Psychology*, 94, 259–281. <https://doi.org/10.1111/joop.12352>
23. Op den Kamp, E.M. (2022). Proactive Vitality Management. Taking control over well-being, job performance, and creativity. [Doctoral dissertation, Erasmus University Rotterdam]. <https://www.publicatie-online.nl/publicaties/emma-op-den-kamp/>
24. Pursio, K., Kankkunen, P., Mikkonen, S., & Kvist, T. (2024) Organizational characteristics of nursing practice environments related to registered nurses' professional autonomy and job satisfaction in two Finnish Magnet- aspiring hospitals: structural equation modeling study. *BMC Nursing*, 23, 100, 1–13. <https://doi.org/10.1186/s12912-024-01772-9>
25. Zheng, X., Song, J., Shi, X., Kan, C., & Chen, C. (2025). The effect of authoritarian leadership on young nurses' burnout: the mediating role of organizational climate and psychological capital. *BMC Health Services Research*, 25, 292. <https://doi.org/10.1186/s12913-025-12403-7>
26. Pizzolitto, E., Verna, I., & Venditti, M. (2022). Authoritarian leadership styles and performance: a systematic literature review and research agenda. *Management Review Quarterly*, 73, 841–871. <https://doi.org/10.1007/s11301-022-00263-y>
27. Kämäräinen, P., Mikkola, I., Nurmeksela, A., & Kvist, T. (2025). Nurse Leaders' Interpersonal Communication Competence. *Nursing Research*, 74: 378–384. <https://doi.org/10.1097/NNR.0000000000000837>
28. Amundsen, S., & Martinsen, Ø. L. (2015). Linking empowering leadership to job satisfaction, work effort, and creativity: The role of self-leadership and psychological

- empowerment. *Journal of Leadership & Organizational Studies*, 22(3), 304-323.
<https://doi.org/10.1177/1548051814565819>
29. Ding, J., & Wu, Y. (2023). The mediating effect of job satisfaction and emotional exhaustion on the relationship between psychological empowerment and turnover intention among Chinese nurses during the COVID-19 pandemic: a cross-sectional study. *BMC Nursing*, 22(1):1–10. <https://doi.org/10.1186/s12912-023-01357-y>
30. Alsadaan, N., Ramadan, O.M.E., & Alqahtani, M. (2024). From incivility to outcomes: tracing the effects of nursing incivility on nurse well-being, patient engagement, and health outcomes. *BMC Nursing*, 23, 325. <https://doi.org/10.1186/s12912-024-01996-9>
31. González-García, A., Pinto-Carral, A., Marqués-Sánchez, P., Quiroga-Sánchez, E., Bermejo-Martínez, D., & Pérez-González, S. (2025). Characteristics of Nurse Managers' Conflict Management Competency. A Systematic Review. *Journal of Advanced Nursing*, 81, 1717–1733. <https://doi.org/10.1111/jan.16600>
32. Neck, C.B., Maykrantz, S.A., Houghton, J.D., & Neck, C.P. (2025). Destructive self-leadership? Self-leadership, maladaptive coping, and stress in college students. *Stress and Health*, 41(1), e3521. <https://doi.org/10.1002/smi.3521>

Table 1. A structured interview guide.

Interview theme	Supporting questions
Expectations concerning nurses' self-leadership	What kind of expectations are generally placed on nurses' self-leadership within the work unit or organization? What kind of self-leadership skills do nurse leaders expect from you? OR What kind of self-leadership skills do you as a nurse leader expect from nurses?
Challenges to nurses' self-leadership in the clinical setting	What kinds of challenges have you perceived to self-leadership / to nurses' self-leadership in general? What kinds of obstacles have you perceived to self-leadership / to nurses' self-leadership in the work unit or organization? What might hinder the development or improvement of your self-leadership skills / a nurse's self-leadership skills in the work unit or organization?

703 Table 2. Example of inductive content analysis

Codes	Sub-themes	Theme
The lack of encouragement for self-leadership	The lack of interaction in collaboration	Insufficient support for nurses' self-leadership
Supervisor's limited accessibility		
The lack of shared dialogue within the work community		
Negative preconceptions regarding one's competence		
Inequality within the interprofessional team		
Resistance to change in the work community	Negative attitudes toward the development of nursing practices	
A negative tone in public discussions related to nursing practice		
Individual strengths are not adequately recognized	Organizational culture does not encourage individuality	
The lack of openness to individual differences among colleagues		

704

705 Table 3. Demographic characteristics of nurses (n=17) and nurse leaders (n=11)

Nurses (n=17)	% (n)	Mean (SD)
Age (years)		46,9 (10,6)
Education		
College-level diploma in nursing	17,6 (3)	
College-level specialization in nursing	11,8 (2)	
Bachelor's degree	58,8 (10)	
Master's degree	11,8 (2)	
Experience in nursing practice (years)		16,6 (11,3)
Nurse leaders (n=11)		
Age (years)		55,7 (6,1)
Education		
Master's or doctoral degree	100 (11)	
Experience in nursing leadership (years)		16,1 (5,6)

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