

**EMPIRICAL RESEARCH QUANTITATIVE** **OPEN ACCESS**

# Does Structural Empowerment of Nurse Leaders Moderate the Relationship Between Destructive Leadership and Nursing Outcomes?—A Cross-Sectional Study

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## ABSTRACT

**Aim:** To describe how nursing staff assess their superiors' destructive leadership and nurse leaders' structural empowerment. A further aim is to examine the associations between destructive leadership and staff outcomes and how nurse leaders' structural empowerment moderates these associations.

**Design:** A cross-sectional study.

**Methods:** The data were collected during November 2022–April 2023. Nursing staff assessed their work well-being, commitment, decision-making and career advancement. Destructive leadership was evaluated using the Employment Precariousness Scale and some additional questions. Nurse leaders' structural empowerment was assessed using the Conditions For Work Effectiveness Questionnaire-II. The data were analysed using statistical methods including linear regression.

**Results:** Nursing staff ( $n = 381$ ) assessed destructive leadership as rare, but it negatively associated with their commitment, decision-making, career advancement and work well-being. Nurse leaders' ( $n = 97$ ) structural empowerment had a positive association with nursing staff outcomes. The interaction between destructive leadership and nurse leaders' structural empowerment positively affected the work well-being and commitment of nursing staff. The models explained 32% of nurses' work well-being and 19% of their commitment.

**Conclusion:** Destructive leadership undermines nursing staff outcomes. Structural empowerment of nurse leaders should be enhanced to protect against destructive leadership and other protective factors should be explored in the future to identify and prevent destructive leadership.

**Implications for the Profession:** Organisations should provide nurse leaders with appropriate resources and support to enhance their empowerment and opportunities to improve their leadership skills and expertise and should develop ways of identifying destructive leadership patterns and policies to resolve situations in which destructive leadership occurs.

**Impact:** A work environment that empowers nurse leaders may reduce the effect of destructive leadership on staff well-being, commitment, decision-making and career advancement. The significance of protective factors against destructive leadership should be explored using more robust methods in future research.

**Reporting Method:** A STROBE checklist.

**Patient or Public Contribution:** None.

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## 1 | Introduction

The associations between nurse leaders' leadership styles and staff outcomes have been widely studied (Cummings et al. 2018; Hult et al. 2023). However, much of this research has focused on relational leadership styles and their association with work-related well-being, commitment and team collaboration amongst staff members (Hult et al. 2023; Labrague 2024; Niinihuhta et al. 2022), while interest in destructive leadership in nursing has only emerged more recently (Hult et al. 2023; Labrague 2024; Milosevic, Maric, and Lončar 2020; Ofei et al. 2023).

Destructive leadership may be defined as systematic, negative behaviour by nurse leaders that harms other staff (Labrague 2024). Destructive leadership styles have multiple physiological, psychological and emotional effects on personnel (Labrague 2024; Milosevic, Maric, and Lončar 2020), and have been found to decrease employees' commitment to their organisation and profession and to negatively influence their work-related well-being and job satisfaction (Alsadaan and Alqahtani 2024; Hult et al. 2023; Kaluza et al. 2020; Labrague 2024; Ofei et al. 2023).

Empowerment relates to an individual's autonomy and self-determination, both of which are crucial to performing their professional role (Terkamo-Moisio et al. 2023). It may be divided into psychological and structural empowerment that is associated, for example, with improved participation in decision-making and job satisfaction as well as decreased burnout and turnover intentions (Niinihuhta and Häggman-Laitila 2022). There is a growing body of evidence about nurses' empowerment, but the scientific literature on nurse leaders' empowerment is limited and suggests that nurse leaders have a moderate level of structural empowerment (Niinihuhta and Häggman-Laitila 2022; Terkamo-Moisio et al. 2023; Yesilbas and Kantek 2022). Recent reviews of relational leadership styles in nursing have identified structural empowerment as a factor that mediates between leadership behaviour and staff outcomes. However, to our knowledge, no study has yet investigated the equivalent phenomenon in the context of destructive leadership styles (Hult et al. 2023; Labrague 2024).

Nurses' work well-being is a multidimensional concept, encompassing physical, psychological and social aspects. The physical dimension addresses workplace safety, physical health, fatigue management, adequate rest and manageable workloads. The psychological dimension includes stress management, work-life balance support and resilience. Social well-being refers to a positive workplace culture, good relationships with colleagues and peer support (Xiao, Cooke, and Chen 2022). Additional dimensions of work well-being have also been identified. Spiritual well-being is described as the coordinated and integrated connection between internal forces and the relationship between nursing practice and overall employee well-being. Emotional well-being involves happiness, enjoyment and personal satisfaction, while also encompassing the management of moral distress, ethical dilemmas and challenging situations (Jarden et al. 2020). Moreover, the organisational dimension of well-being includes resource availability, adequate staffing, fair compensation and job security. Finally, the intellectual dimension

focuses on professional development, offering continuous education, autonomy in decision-making and shared leadership (Xiao, Cooke, and Chen 2022). Consequently, nurses' happiness and satisfaction with their work can be viewed as a measure of work well-being and staff commitment (Van De Voorde, Paauwe, and Van Veldhoven 2012). In this study, nurses' work well-being is examined as a whole.

In the Finnish healthcare setting, nurse leaders are present at every level of nursing within the organisation. Nurse managers work at the first-line level, serving as immediate superiors (e.g., head nurse or ward nurse) to the nursing staff at the unit level. Associate nurse managers work alongside nurse managers as partners. Nurse managers can delegate duties to associate nurse managers, who may either share these responsibilities as partners or act as surrogates. The nurse manager reports to the nurse director. Nurse directors are midlevel leaders responsible for overseeing nursing in the organisation's service areas and report to the director of the service area. Chief nursing officers operate at the top management level within the organisation's strategic hierarchy and report to the organisation's director. This study focuses on the destructive leadership styles of first-line and midlevel nurse leaders and their structural empowerment.

This study contributes to nursing research by describing how nursing staff assess the destructive leadership style and structural empowerment of nurse leaders. It also examines the associations between destructive leadership styles and staff outcomes, and how the structural empowerment of nurse leaders may moderate these associations.

### 1.1 | Background

Leadership dynamics within healthcare organisations are critically important to enhancing the attractiveness of the nursing profession and may even be seen as one way of overcoming the global shortage of skilled nurses (Hult et al. 2023; Niinihuhta and Häggman-Laitila 2022; Palvimo, Vauhkonen, and Hult 2023). Nurse leaders have the power to influence other personnel, and thus have a pivotal role in creating an environment that strengthens employees' work-related well-being and ability to provide high-quality care. Recent reviews have demonstrated that relational leadership styles have a positive effect on employees' job performance and commitment and the quality of care, while destructive leadership styles have been associated with employee turnover, absenteeism and decreased well-being at work (Hult et al. 2023; Milosevic, Maric, and Lončar 2020; Niinihuhta and Häggman-Laitila 2022).

The concept of destructive leadership is broad and includes various harmful leadership styles (Mackey et al. 2021). Accordingly, destructive leadership styles may be differentiated into destructive, abusive, authoritarian, ineffective and toxic types, based on the leader's intent and the degree of harm to personnel or the organisation (Alsadaan and Alqahtani 2024; Milosevic, Maric, and Lončar 2020; Vives et al. 2010). For example, toxic or abusive leaders may set self-serving goals that cause harm, whereas the harm caused by ineffective leaders is rooted in their passiveness (Klasmeier

et al. 2022; Milosevic, Maric, and Lončar 2020). It has been argued that the primary intent of destructive leaders is to disguise their lack of competence or avoid taking responsibility and making decisions (Milosevic, Maric, and Lončar 2020). Whatever the type, destructive leadership has been found to predict poor productivity, job dissatisfaction and an increased intention to leave the nursing profession amongst employees (Alilyyani, Wong, and Cummings 2018; Cummings et al. 2018; Labrague 2021; Ofei et al. 2023).

These may be addressed to leader's harm-causing behaviour patterns, such as selective information sharing, limiting interaction, micromanagement or even verbal hostility (Milosevic, Maric, and Lončar 2020). Further, destructive leadership styles have been associated with employees experiencing poor mental health, increased stress and burnout and decreased trust in the leader and the organisation (Klasmeier et al. 2022; Niinihuhta and Häggman-Laitila 2022; Palvimo, Vauhkonen, and Hult 2023; Türkmen Keskin and Özduyan Kiliç 2024). In terms of patient outcomes, destructive leadership has been related to a decrease in the quality of patient care and increased adverse events (Labrague 2024).

Empowerment of nurse leaders has been identified as being essential to their workplace effectiveness and ability to promote their employees' capacity to provide high-quality care (Hartviksen, Aspfors, and Uhrenfeldt 2019). This finding is based on Kanter's concept of structural empowerment which encompasses access to opportunity, information, support and resources at work (Fragkos, Makrykosta, and Frangos 2020; García-Sierra and Fernández-Castro 2018; Niinihuhta et al. 2022; Terkamo-Moisio et al. 2023). Access to opportunity refers to the possibilities for autonomy and individual professional growth (Hartviksen, Aspfors, and Uhrenfeldt 2019; Moura et al. 2020), and access to information encompasses formal and informal knowledge. Access to support relates to feedback and guidance amongst colleagues, supervisors and other professionals, and access to resources concerns having the means and time required to carry out one's work (García-Sierra and Fernández-Castro 2018; Hartviksen, Aspfors, and Uhrenfeldt 2019; Orgambidez et al. 2024). According to previous research (Niinihuhta et al. 2022; Terkamo-Moisio et al. 2023), structural empowerment manifests itself as formal (e.g., work-related rewards, visibility and flexibility) and informal power (social connections and collaboration at work). Structural empowerment relates to social structures that facilitate employees' work and is similar to job resources, which help achieve work goals.

Psychological empowerment is a motivational state that includes dimensions of meaning, competence, self-determination and impact (Spreitzer 1995). Meaning refers to the significance of an individual's work, competence to the ability to perform tasks, self-determination to the freedom of choice at work and impact to the influence of an individual's work on the organisation. Leaders can enhance these dimensions through effective work design. Psychological empowerment arises from positive experiences in practices, while personal resources are individual traits like optimism and self-efficacy. Both structural and psychological empowerment, despite their differences, contribute uniquely to work engagement by facilitating job aspects and providing

motivational qualities (Monje-Amor et al. 2021; Orgambidez et al. 2024). In this study, we focus on nurse leaders' structural empowerment.

Among nurses, structural empowerment is associated with numerous positive effects. For example, it has been found to decrease burnout and increase nurses' motivation, intention to stay in the profession and organisational commitment (Arslan Yürümezoğlu and Kocaman 2019; Fragkos, Makrykosta, and Frangos 2020; Orgambidez et al. 2024; Şenol Çelik, Sariköse, and Çelik 2024). Furthermore, nurses' structural empowerment has been positively linked with their work engagement (García-Sierra and Fernández-Castro 2018; Monje-Amor et al. 2021). The equivalent associations among nurse leaders have not been widely studied, although Niinihuhta et al. (2022) reported a positive association between nurse leaders' structural empowerment and their work-related well-being. Structural empowerment of nurse leaders also moderated the positive associations between relational leadership styles and employee satisfaction and engagement, well-being (Hult et al. 2023; Niinihuhta and Häggman-Laitila 2022) and patient satisfaction and safety (Hult et al. 2023).

Destructive leadership, structural empowerment and their consequent outcomes can be explained through the lens of Conservation of Resources (COR) theory (Hobfoll 1989; Hobfoll et al. 1990). Applying COR theory to leadership shows that different styles can either generate or deplete resources. According to COR theory, individuals strive to acquire, protect and build resources such as energy, time, social support and personal capabilities. When these resources are threatened, lost or unattainable, it leads to stress and, burnout, (Hobfoll 1989; Hobfoll et al. 1990) and over time, to leave the work. In a nursing environment, resources include supportive leadership, a positive work environment, teamwork, professional growth and work-life balance. Resource loss occurs when nurses face unmanageable workloads, lack of autonomy, unsupportive leadership or toxic work cultures, which all contribute to stress and burnout. Empowering nurse leaders, who demonstrate emotional intelligence, and inspire and support followers, are seen as resourceful, while destructive leadership exhausts followers' resources and well-being. In this study, destructive leadership, characterised by micromanagement, bullying, lack of support or poor communication, can threaten nurses' essential resources. Conversely, empowering nurse leaders can positively influence nurses' well-being and organisational commitment by fostering an environment that protects and nurtures these key resources through supportive leadership, autonomy in decision-making, professional development and healthy workplace culture.

## 2 | The Study

This study aims to describe how nursing staff assess their immediate superiors' destructive leadership style and how nurse leaders assess their own structural empowerment. A further aim is to examine the associations between destructive leadership and staff outcomes and how nurse leaders' structural empowerment moderates these associations. The research questions are as follows:

- How do nursing staff assess the level of destructive leadership by their immediate superiors?
- How do nurse leaders assess their own structural empowerment?
- What are the associations between destructive leadership style and staff outcomes?
- How does the structural empowerment of nurse leaders moderate these associations?

### 3 | Methods

#### 3.1 | Design

A cross-sectional study design was used and our reporting follows the STROBE checklist.

#### 3.2 | Study Setting and Sampling

Total sampling was employed as the target group consisted of the nurse leaders ( $N=129$ ) and nursing staff ( $N=2492$ ) in a 24-h, long- or short-term elderly care facility in a large public organisation in Finland. The inclusion criteria for nursing staff were personnel who work closely with patients, for example, registered nurses, practical nurses, physiotherapists, occupational therapists, social workers and care assistants. The inclusion criteria for nurse leaders were any immediate superiors to nursing staff, including nurse managers, associate nurse managers and nurse directors. In the rest of this paper, 'nursing staff' are collectively referred to as 'nurses'.

Participants were informed about the study through an email sent by the organisation's contact person. One member of the research group also visited the units. The study information included a link to the survey, and the researcher also left paper questionnaires with the units during their visits. The data were collected between November 2022 and April 2023. Participants could choose whether to complete the questionnaire in electronic or paper form. The completed paper forms were sent to the organisation's contact person, who forwarded them to the researchers.

#### 3.3 | Instruments

The questionnaire for nursing staff included seven background questions (age, gender, occupation/current job title, work experience in the current unit and in healthcare, highest level of education and pattern of work). Nurses were then asked to assess their work well-being (three items) and commitment (two items) on a VAS scale ranging from 0 (most negative) to 10 (most positive). Nurses were also asked about decision-making (one item) and career advancement (one item) on a 5-point Likert scale (1 = A lot—5 = Not at all). The background questions for nurse leaders included 11 items (age, gender, highest level of education, leadership education, form of employment, leadership experience in current position, leadership experience in current unit, leadership experience in social and healthcare sector, number of units, number of employees, number of patients/clients and budget responsibility).

Staff's perceptions of their leader's destructive leadership were assessed using six authoritarian leadership questions from the Employment Precariousness Scale (EPRES; Vives et al. 2010) supplemented with three additional questions: 'Your actions are repeatedly controlled?', 'You experience constant inadequacy?' and 'Unreasonable expectations are placed on you?'. These items were scored on a 5-point Likert scale (1 = Never—5 = Always). Earlier study reported an alpha of 0.91. In this study, the Cronbach's alpha was 0.87.

Nurse leaders were asked to assess their structural empowerment using the Conditions For Work Effectiveness Questionnaire-II (CWEQ-II), based on Kanter's original ethnographic study of work empowerment as modified by Chandler (1986; Spence Laschinger et al. 2001). The CWEQ-II contains subscales for Opportunity (three items), Information (three items), Support (three items), Resources (three items), a Job Activities Scale (three items) and an Organisational Relationships Scale (four items), on a scale from 1 (none) to 5 (a lot). In addition, the CWEQ-II includes a subscale for Global Empowerment (two items) on a scale of 1 (strongly disagree) to 5 (strongly agree). The total score range for Structural Empowerment is between 6 and 30. Higher scores represent stronger perceptions of working in an empowered work environment: 6–13 describe low levels; 14–22 moderate levels and 23–30 high levels of empowerment. Cronbach's alpha values for the total CWEQ-II have been established as 0.89, and 0.87 for Global Empowerment (Spence Laschinger et al. 2001). This study had a Cronbach's alpha of 0.912.

#### 3.4 | Data Analysis

Firstly, prior to data analysis, respondents who did not give consent to use the data were removed from both datasets, resulting in  $n=503$  nurses (response rate 20%). Secondly, cases with more than 50% missing values were removed, resulting in 497 nurses. This sample size was determined to be acceptable based on the power analysis, which included a 95% confidence level, 0.8 statistical power and an expected mean difference of 0.10 in structural empowerment between the original sample and this study's sample. These parameters indicated a sufficient sample size of 335 participants. There were no missing values in the data from nurse leaders. Finally, both datasets were compounded. The unifying factor combining the data was a common unit for nurses and nurse leaders. A total of 86 units, 381 nurses and 97 nurse leaders (response rate 76%) were included in the final analysis.

Common method bias was analysed in the staff dataset with Harman's one-factor test (if < 50%, no risk of bias). One factor explained 38% of the variance, so there was no risk of bias. Frequency, percentage, mean, median, range, minimum, maximum and standard deviation were used to describe the data. The average variance extracted (AVE) for destructive leadership and structural empowerment was calculated by summing the squared factor loadings and dividing the sum by the number of items in each scale. An AVE of 0.5 or higher confirms convergent validity (Shrestha 2021). Pearson correlations were calculated between destructive leadership, structural empowerment, staff work well-being, commitment, career advancement and decision-making. Strong correlations yield coefficient values ( $r$ ) of between  $\pm 0.50$  and  $\pm 1$ , and moderate correlations of between

$\pm 0.30$  and  $\pm 0.49$  (Field 2013). Destructive leadership and structural empowerment scales were adjusted to a scale of 0–1. After standardising all the study variables, linear regression analysis was used to model bivariate and multivariate associations between destructive leadership and structural empowerment as explanatory variables and staff work well-being, commitment and career advancement (controlled for age, gender and education) as variables to be explained. The confidence interval was calculated at 95%, and significance at a  $p$ -value of 0.05 accordingly (Field 2013).

### 3.5 | Ethical Considerations

Research permit was obtained from the target organisation according to their guidelines. The research followed the ethical principles of research with human participants (Finnish National Board on Research Integrity TENK 2023). According to Finnish legislation, the ethical statement was not required, as the study did not include patients or clients (Finlex. 1999). Data were collected anonymously, and informed consent was obtained from participants on the first page of the questionnaire. Only designated members had access to the collected data.

## 4 | Results

### 4.1 | Participants' Demographic Information

The mean age of nurses was 44.9 years (range 20–70,  $SD = 12.8$ ), and most of them were female (88.7%). The majority (64.8%) were practical nurses, followed by registered nurses (22.3%). They had an average of 14 years' (ranging from 0 to 43,  $SD = 10.6$ ) work experience in the social and healthcare sector. Their work experience in the current unit ranged from 0 to 43 years (mean 6.5 years,  $SD = 6.7$ ). Most worked either two (43.8%) or three shifts (38.6%). A minority (5.5%) of nursing staff held a master's or higher degree (Table 1).

Most nurse leaders (57.7%) were over 50 years old and female (94.8%). Nearly half of them (48.5%) held a master's or higher degree, and most (70%) had been educated in leadership. They had an average of 10.5 years' (range 0.5–34 years,  $SD = 8.3$ ) work experience as a nurse leader. Their work experience in the current unit ranged from 0 to 39.5 years (mean 7.3 years,  $SD = 8.1$ ). 40.2% of nurse leaders led one unit, 32.0% led two units and 22.7% led three units. The average number of personnel reporting to the leader was 33 (range 1–270,  $SD = 39.8$ ) and the average number of patients or clients in their care was 41 (range 0–272,  $SD = 43.8$ ). Most (77.3%) of the nurse leaders had no budget responsibility (Table 2).

Nurses' assessment of their work well-being ranged from 0 to 10 (mean 7.5,  $SD = 1.8$ ) and their commitment was on average 8.27 (range 0.35 to 10,  $SD = 1.8$ ). Their assessment of career advancement and decision-making ranged from 1 to 5 (mean 2.49,  $SD = 1.19$  for career advancement; mean 3.34,  $SD = 1.05$  for decision-making; see Table 3). A strong, positive correlation (Table 4) was found between commitment and work well-being among nursing staff ( $r = 0.618$ ,  $p < 0.01$ ), and between their career advancement and decision-making ( $r = 0.506$ ,  $p < 0.01$ ).

### 4.2 | Nurses' Assessment of Destructive Leadership

Nurses assessed that destructive leadership occurred rarely (total mean 1.75,  $SD = 0.70$ ). The most frequently experienced aspect was constant inadequacy (mean 2.39,  $SD = 1.27$ ), and the least frequently experienced aspect was unreasonable expectations (mean 1.24,  $SD = 0.65$ ; Table 5). A strong negative correlation was found between destructive leadership and employees' work well-being ( $r = -0.510$ ,  $p < 0.01$ ), indicating that the more destructive a nurse evaluated their leader to be, the less well they felt in their work. Similarly, a moderate negative correlation was found between nurses' assessments of destructive leadership and decision-making ( $r = -0.344$ ,  $p < 0.01$ ), indicating that the less destructive a nurse assessed their leader to be, the more they felt to participate in decision-making. All correlations were statistically significant (Table 4).

### 4.3 | Nurse leaders' Structural Empowerment as a Moderator

The total structural empowerment of nurse leaders was, on average, 21.24 (on a sum scale of 6–30), representing moderate-level perceptions of working in an empowered work environment. Nurse leaders assessed access to information as the strongest area in their current work (mean 4.12), followed by opportunities in their job (mean 4.05), while access to support (mean 3.25) and resources (mean 2.99) were weaker. Nurse leaders' assessment of global empowerment of their current workplace was 3.61 (Table 6).

In the bivariate model, nurses' assessments of destructive leadership showed statistically significant negative associations with their commitment, decision-making, career advancement and work well-being, while nurse leaders' structural empowerment had a positive association with nursing staff outcomes (Table 7).

In the multivariate model, the interaction between destructive leadership and structural empowerment was found to have a significantly positive effect on nurses' well-being at work ( $\beta = 1.269$ ,  $p < 0.01$ ) and commitment ( $\beta = 1.539$ ,  $p < 0.01$ ). This means that a leader's high level of structural empowerment reduced the harmful effect of destructive leadership, as assessed by staff, on their work well-being and commitment. The model of destructive leadership and structural empowerment explains 32% of nurses' work well-being and 19% of their commitment (Table 7).

Figure 1 shows how nurse leaders' structural empowerment moderates the associations between destructive leadership and staff outcomes that resulted from the bivariate (Model 0) and multivariate (Model 1) models.

## 5 | Discussion

This study described how nurses assess the destructive leadership style of their immediate superiors and the structural empowerment of nurse leaders, enhancing the knowledge base in a little-researched area. The study focused on older people's care,

**TABLE 1** | Characteristics of nursing staff.

	N		%	Mean	Med.	SD
	Valid	Missing				
Age	366	15		44.91	46	12.80
< 35	115		30.2			
35–50	119		31.2			
> 50	147		38.6			
Gender	377					
Female	338		88.7			
Male	30		7.9			
Other	1		0.3			
Do not want to tell	8		2.1			
Occupation	377	4				
Care assistant	7		1.8			
Practical nurse	247		64.8			
Registered nurse	85		22.3			
Social worker	15		3.9			
Physio/occupational therapist	20		5.2			
Other	3		0.8			
Work experience	373	8				
Current work				6.46	4	6.76
Social and health sector				14.02	11	10.58
Education	378	3				
Professional degree	257		67.5			
Bachelor (UAS)	100		26.2			
Master or higher	21		5.5			
Working time format	377	4				
Day work	61		16.0			
Two shift work	167		43.8			
Three shift work	147		38.6			
Night work	2		0.5			

where leadership styles have rarely been studied. This study further generated new knowledge by describing the associations between destructive leadership styles and staff outcomes and examining the role of nurse leaders' structural empowerment in moderating these associations.

The results show rather low levels of destructive leadership behaviour. These results align with other recent findings that indicate the prevalence of destructive leadership to be low to moderate (Ofei et al. 2023; Palvimo, Vauhkonen, and Hult 2023; Türkmen Keskin and Özduyan Kiliç 2024). However, this contrasts with the findings of Alsadaan and Alqahtani (2024), who reported a high prevalence of destructive leadership in emergency department settings. The connection between the work context

and the occurrence of destructive leadership should be investigated further. Although direct comparison is not possible due to the different instruments and settings, these results support other findings which have identified the presence of destructive leadership styles within the healthcare sector (Hult et al. 2023; Labrague 2024; Niinihuhta and Häggman-Laitila 2022), even though they are considered obsolete (Chiang et al. 2021). There is increasing research interest in this topic (Labrague 2024), because the negative effects of destructive leadership styles are significant. Although the current results suggest that destructive leadership styles are rare, their wide range indicates that some participants feel their leaders are often or always destructive. It has been suggested that some individuals are more prone than others to interpret their leaders' behaviour as destructive

**TABLE 2** | Characteristics of nurse leaders.

	N		%	Mean	Med.	SD
	Valid	Missing				
Age	97			50.90	52	9.67
< 35	5		5.2			
35–50	36		37.1			
> 50	56		57.7			
Gender	97					
Female	92		94.8			
Male	5		5.2			
Education	97					
Professional degree	21		21.6			
Bachelor (UAS)	29		29.9			
Master of higher	47		48.5			
Leadership education						
Yes	67		69.1			
No	30		30.9			
Form of employment	97					
Permanent	89		91.8			
Temporary	8		8.2			
Working years as a nurse leader position	93	4		10.45	10	8.35
Working years in the current unit	96	1		7.32	3	8.18
Working years in the social and health sector	96	1		23.67	25	10.43
Units per nurse leader	92	5				
1	39		40.2			
2	31		32.0			
3 or more	22		22.7			
Number of subordinates	94		3	32.99	23.5	39.80
Number of patients/clients	89		8	41.34	28	43.80
Budget responsibility	95	2				
Yes	20		20.6			
No	75		77.3			

(Almeida et al. 2022; Hancock et al. 2023). An individual's levels of distrust (Almeida et al. 2022), higher education and years of experience (Alsadaan and Alqahtani 2024) have been suggested to affect such perceptions. Thus, future research on destructive leadership styles should consider contextual aspects and employees' characteristics, as suggested by Almeida et al. (2022) as well as the leader themselves (Stempel and Rigotti 2018).

In the current results, destructive leadership was strongly associated with lower work well-being, strengthening existing evidence about this phenomenon (Hult et al. 2023; Niinihuhta and Häggman-Laitila 2022; Palvimo, Vauhkonen, and Hult 2023).

When exposed to destructive leadership nurses suffer psychological stress, poor mental health, job stress and burnout, which could lead to sick leaves and eventually leaving their work (Hult et al. 2023; Niinihuhta and Häggman-Laitila 2022; Palvimo, Vauhkonen, and Hult 2023). According to the COR theory, destructive leadership wears down followers' resources and well-being (Hobfoll 1989; Hobfoll et al. 1990). Well-being is an individual's most important asset and resource at work. In organisations, it is crucial to recognise the nature of leadership to identify and address destructive leadership, as its consequences for followers can be severe as resource loss. It is notable that, in this study, work well-being was evaluated as a whole, even though

**TABLE 3** | Nursing staff's assessments about commitment, decision-making, career advancement and work well-being.

	N		Mean	Med.	SD	Range	Min.	Max.
	Valid	Missing						
Work Well-being <sup>a</sup>	381	0	7.88	8.27	1.44	8.97	1.03	10
Commitment <sup>a</sup>	381	0	8.27	8.95	1.80	9.65	0.35	10
Decision-making <sup>b</sup>	371	10	3.34	3	1.05	4	1	5
Career Advancement <sup>b</sup>	372	9	2.49	2	1.19	4	1	5

<sup>a</sup>Scale: 0–10.<sup>b</sup>Scale: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree.**TABLE 4** | Correlations between destructive leadership (staff), structural empowerment (nurse leaders) and nursing staffs' work well-being, commitment, decision-making and career advancement.

	1	2	3	4	5	6
1. Destructive Leadership	1					
2. Structural Empowerment	−0.179**	1				
3. Work Well-being	−0.510**	0.096	1			
4. Commitment	−0.299**	0.162**	0.618**	1		
5. Decision-making	−0.344**	0.170**	0.273**	0.237**	1	
6. Career advancement	−0.186**	0.115*	0.224**	0.234**	0.506**	1

Note: Strong correlation coefficient values (*r*) (from ± 0.50 to ± 1), and moderate correlations (from ± 0.30 to ± 0.49) are in bold.\**p* < 0.05.\*\**p* < 0.01.**TABLE 5** | Destructive leadership assessed by nursing staff (range: 1 = never; 2 = rarely; 3 = sometimes; 4 = often; 5 = always).

	N		Mean	Med.	SD	Range	Min.	Max.	AVE
	Valid	Missing							
Q1	377	4	2.39	2	1.27	4	1	5	
Q2	375	6	2.05	2	1.08	4	1	5	
Q3	379	2	2.03	2	1.09	4	1	5	
Q4	373	8	1.72	1	1.06	4	1	5	
Q5	379	2	1.67	1	0.97	4	1	5	
Q6	374	7	1.63	1	0.95	4	1	5	
Q7	375	6	1.53	1	0.88	4	1	5	
Q8	379	2	1.44	1	0.89	4	1	5	
Q9	380	1	1.24	1	0.65	4	1	5	
TOTAL	381	0	1.75	1.56	0.70	3.89	1	4.89	0.79

Note: Q1 = You experience constant inadequacy?, Q2 = Unreasonable expectations are placed on you?, Q3 = If I wanted better working conditions, I would be afraid to ask, Q4 = My bosses make me feel that I am easily replaceable, Q5 = I am treated in an authoritarian way, Q6 = If I were to be treated unfairly, I would not dare to argue, Q7 = Your actions are repeatedly controlled?, Q8 = I would have to worry about getting fired if I don't immediately do what I'm told, Q9 = I am being treated aggressively.

it is a multifaceted concept that encompasses psychological, social, emotional and physical aspects, such as job satisfaction and well-being relating to professional development (Labrague 2024; Niinihuhta et al. 2022; Xiao, Cooke, and Chen 2022). Resource reduction can occur on multiple levels: physically, when nurses face unmanageable workloads; psychologically, when stress

disrupts work–life balance (Xiao, Cooke, and Chen 2022); emotionally, when they experience moral distress, ethical challenges (Jarden et al. 2020) and difficult situations in their work; and socially, when a negative workplace climate undermines collegiality and support (Xiao, Cooke, and Chen 2022). Future research is needed to explore work well-being in further depth.

**TABLE 6** | Subscales of nurse leaders' structural empowerment, total structural empowerment and global empowerment.

	N		Mean	Med	SD	Range	Min.	Max.	$\alpha$	AVE
	Valid	Missing								
Opportunity <sup>a</sup>	97	0	4.05	4	0.72	3	2	5	0.858	
Information <sup>b</sup>	97	0	4.12	4	0.65	2.67	2.33	5	0.831	
Support <sup>a</sup>	97	0	3.25	3	0.83	4	1	5	0.850	
Resources <sup>a</sup>	97	0	2.99	3	0.79	3.67	1.33	5	0.789	
Job activities scale <sup>a</sup>	97	0	3.31	3.33	0.72	3	2	5	0.754	
Organisational relationships scale <sup>a</sup>	97	0	3.53	3.5	0.67	3.25	1.75	5	0.732	
Total structural empowerment <sup>c</sup>	97	0	21.24	21	3.07	16.08	12.5	28.58	0.891	0.85
Global empowerment <sup>d</sup>	97	0	3.61	4	0.84	3	2	5	0.912	

Abbreviations: AVE, average variance extracted; SD, standard deviation.

<sup>a</sup>Scale 1 = None; 2 = A Little; 3 = Some; 4 = Quite A Lot; 5 = A Lot.

<sup>b</sup>Scale 1 = No Knowledge; 2 = A Little Knowledge; 3 = Some Knowledge; 4 = Quite A Lot Knowledge; 5 = Know A Lot.

<sup>c</sup>Total sum = Opportunity + Information + Support + Resources + Job Activities Scale + Organisational Relationships Scale.

<sup>d</sup>Scale 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree.

**TABLE 7** | Bivariate and multivariate associations between destructive leadership, structural empowerment and commitment, decision-making, career advancement and work well-being.

	Commitment			Decision-making		
	Beta	SE	95% CI	Beta	SE	95% CI
Model 0						
Destructive leadership	-0.299***	0.049	-0.395 to -0.202	-0.344***	0.050	-0.449 to -0.253
Structural empowerment	0.162**	0.054	0.050 to 0.261	0.170**	0.057	0.058-0.281
Model 1						
Destructive leadership	-1.369***	0.303	-1.879 to -0.687	-0.568 <sup>ns</sup>	0.332	-1.208 to 0.098
Structural empowerment	-0.065 <sup>ns</sup>	0.076	-0.213 to 0.087	0.066 <sup>ns</sup>	0.082	-0.096 to 0.228
Destructive leadership * structural empowerment	1.103***	0.308	0.466 to 1.679	0.216 <sup>ns</sup>	0.334	-0.441 to 0.875
R <sup>2</sup>	0.19			0.13		
	Career advancement			Work well-being		
	Beta	SE	95% CI	Beta	SE	95% CI
Model 0						
Destructive leadership	-0.186***	0.052	-0.292 to -0.087	-0.510***	0.044	-0.597 to -0.423
Structural empowerment	0.115*	0.057	0.002-0.227	0.096	0.056	-0.016 to 0.206
Model 1						
Destructive leadership	-0.463 <sup>ns</sup>	0.346	-1.135 to 0.226	-1.435***	0.288	-1.957 to -0.825
Structural empowerment	-0.017 <sup>ns</sup>	0.086	-0.151 to 0.186	-0.140 <sup>ns</sup>	0.072	-0.284 to 0.001
Destructive leadership * structural empowerment	0.286 <sup>ns</sup>	0.349	-0.398 to 0.975	0.910**	0.293	0.339 to 1.491
R <sup>2</sup>	0.06			0.32		

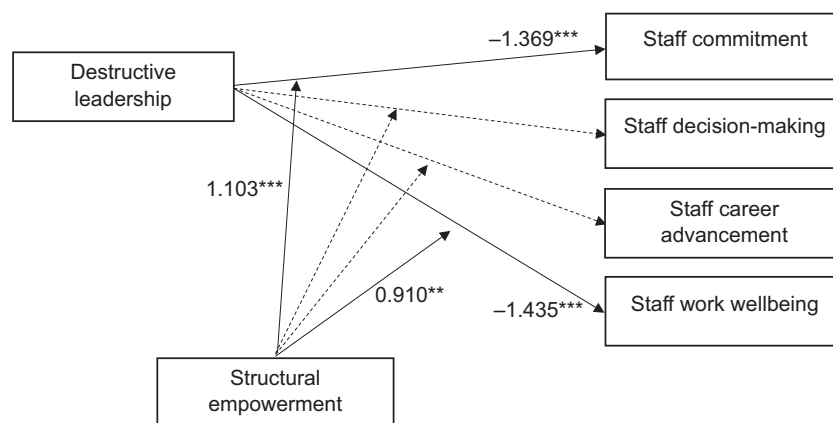
Note: Model 0 = bivariate associations. Model 1 = multivariate associations, controlled for age, gender and education.

Abbreviations: Beta, standardised estimate; CI, confidence interval; <sup>ns</sup>Nonsignificant; SE, standard error.

\* $p < 0.05$ .

\*\* $p < 0.01$ .

\*\*\* $p < 0.001$ .



**FIGURE 1** | Nurse leaders' structural empowerment's moderating effect on the associations between destructive leadership and staff outcomes. Standardised regression weights from the interaction model, controlled for age, gender and education.  $***p < 0.001$ ,  $**p < 0.01$ , dashed lines nonsignificant.

The current results found a further association between destructive leadership and participants' commitment. However this was weaker, possibly due to the strong association between participants' work well-being and their commitment, both of which were at quite good levels. According to COR theory, individuals strive to achieve, protect and build resources (Hobfoll 1989; Hobfoll et al. 1990). In this study, this was achieved despite the threat to nurses' well-being and commitment posed by destructive leadership. The negative effect of destructive leadership styles on employees' commitment has been reported in several previous studies (Hancock et al. 2023; Hult et al. 2023; Labrague 2024; Türkmen Keskin and Özduyan Kiliç 2024). In the context of a global shortage of nurses, this result urges organisations to pay attention to the leadership styles that are employed and strengthen (Hult et al. 2023).

In this study, nurse leaders' structural empowerment was moderate, aligning with previously reported findings (Niinihuhta et al. 2022; Terkamo-Moisio et al. 2023). Our results also show that nurse leader's structural empowerment moderates the associations between destructive leadership and nurses' outcomes. In other words, nurse leaders' experience of working in an empowered work environment reduced the effect of destructive leadership on staff well-being and commitment. According to COR theory (Hobfoll 1989; Hobfoll et al. 1990), resources in a nursing environment include supportive leadership, a positive work environment, teamwork, professional growth and work-life balance—all components of structural empowerment. Our findings support this theory, showing that empowering nurse leaders who demonstrate emotional intelligence and inspire and support their followers can mitigate the effects of destructive leadership. This is reflected in improved nurse well-being and commitment. This novel result opens up new perspectives for future research and development, indicating the existence of protective factors against destructive leadership styles that organisations should take into account and strengthen.

## 5.1 | Strengths and Limitations

A strength of this study is that it employed total sampling. The response rate among nursing staff was low (20%) and may be seen as

a limitation. Factors that may have prevented nursing staff from participating include the sensitive research topic, workloads in elderly care and limited time resources. However, the response rate among nurse leaders was high (76%), which strengthens the study. The study is further strengthened by employing validated instruments or parts of them (Spence Laschinger et al. 2001; Vives et al. 2010). In this study, the Cronbach alpha values for subscales of CWWQ-II were between 0.732 and 0.858, 0.891 for CWWQ-II as a whole and 0.912 for global empowerment. In addition, the Cronbach alpha for destructive leadership was 0.874. These values indicate good reliability of the instrument used. Also, the average variance extracted for both scales was good ( $> 0.5$ ). The data were collected using a self-reported questionnaire, which can be seen as a limitation due to the risk of social desirability or response biases, particularly in sensitive research areas (Rosenman, Tennekon, and Hill 2011). However, the common methods bias was assessed, and the test showed no risk of bias. The good response rate among nurse leaders and similarity with the results of previous research strengthen the generalisability of the current results. It must be taken into account that this study was conducted in the context of elderly care. Accordingly, its generalisability may be limited in terms of other contexts in social and healthcare or other organisations. Finally, the reliability of this study was strengthened by consulting a statistician.

## 5.2 | Recommendations for Further Research

Destructive leadership styles exist in the social and healthcare sector, as shown by current and previous research (Hult et al. 2023; Labrague 2024; Niinihuhta and Häggman-Laitila 2022). It seems, however, that their prevalence differs based on the area within the healthcare sector, culture and individual characteristics of employees. As well as the prevalence of destructive leadership, future research should address the possible factors associated with it, to gain a comprehensive overview of the phenomenon.

The negative effects of destructive leadership and employees' defence mechanisms have been recognised, at least to some extent (Hult et al. 2023; Niinihuhta and Häggman-Laitila 2022),

but little is known about the long-term effects on nursing staff who have experienced destructive leadership. In addition, little is known about the factors that predict the emergence of destructive leadership from the perspectives of nurse leaders, employees and organisations. To our knowledge, there is no information about how previously destructive leaders have been supported to change their leadership style towards more relational behaviours. Future research to address these questions could identify ways of preventing and promptly identifying destructive leadership styles within the healthcare sector. The knowledge produced could also strengthen support for employees and nurse leaders, thus reducing the negative effects. Comparing results requires using the same instrument. Therefore, future research should focus on the conceptual examination of destructive leadership and further development of a robust instrument.

The role of structural empowerment as a moderator in the relationship between destructive leadership and nursing outcomes identified in this study is a novel result that warrants further research in the future. In the current study, the structural empowerment of nurse leaders was addressed, but the role of structural empowerment of nurses and its association with destructive leadership should also be addressed. Our findings highlight the significance of protective factors that should be explored using more robust methods in future research.

### 5.3 | Implications for Policy and Practice

The results of both current and previous studies demonstrate the multifaceted, mainly negative effects that destructive leadership has on the well-being and commitment of employees that is so crucial to the success of their organisations. Therefore, organisations should develop and strengthen ways of identifying destructive leadership patterns at an early stage. Increasing knowledge about destructive leadership and the organisation's leadership philosophy could improve employees' awareness. In addition, enhancing organisational support and confidential guidance and counselling for those who experience destructive leadership (Klasmeier et al. 2022) could strengthen such early identification. The destructive leadership style is associated with increased adverse events as well as decreasing quality of patient care (Labrague 2024) that highlight the significance of early identification and prevention. Therefore, organisations should develop guidelines and policies to prevent destructive leadership and, more importantly, identify how to proceed if a leader employs destructive leadership styles.

Attention should also be paid to the work-related well-being of nurse leaders, as the use of destructive leadership styles has also been negatively associated with their well-being (Kaluza et al. 2020). The structural empowerment of nurse leaders has a twofold role, on one hand enhancing their well-being (Fragkos, Makrykosta, and Frangos 2020; Niinihuhta et al. 2022) and, on the other, moderating the negative effects of destructive leadership on employees, as shown in the current results. To enhance nurse leaders' structural empowerment, organisations should create an empowering work environment, offering appropriate resources and sufficient formal power so that nurse leaders are able to accomplish their work at a high standard.

It is also important to address the educational level of nurse leaders as lack of competence has been identified as one reason for destructive leadership behaviour (Milosevic, Maric, and Lončar 2020). In the current study, fewer than half of the leaders had a master's degree or higher, and almost a third of them had no additional leadership education. This raises a general question as to whether nurse leaders have sufficient leadership skills to tackle the increasing demands that are placed on them. To support nurse leaders and enhance their structural empowerment, organisations should monitor their leadership skills and provide them with regular opportunities to enhance their expertise through education. In addition, when employing new nurse leaders, organisations should ensure that their education and expertise align with the requirements of the position.

## 6 | Conclusion

Destructive leadership undermines nursing staff outcomes and puts nurses in a vulnerable position. Therefore, identifying and eliminating it within the organisation is extremely important. Structural empowerment of nurse leaders should be enhanced to protect against destructive leadership and other protective factors should be further explored.

### Author Contributions

All authors (A.N., M.H., A.H.L. and A.T.M.) have agreed on the final version and meet at least one of the following criteria: substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; and drafting the article or revising it critically for important intellectual content.

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The authors have nothing to report.

### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

### Peer Review

The peer review history for this article is available at <https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16684>.

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### Supporting Information

Additional supporting information can be found online in the Supporting Information section.