Student Nurses' Leadership Experiences: Attribution Theory, Locus of Control and Ubuntu in South Africa

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Abstract

Leadership is a core nursing competency, yet student nurses in South Africa often enter practice psychologically underprepared due to hierarchical training environments, limited autonomy, and historical inequities. Research has focused largely on qualified nurses, with limited attention to how students interpret responsibility, control, and failure during training. Guided by Attribution Theory, locus of control, and Ubuntu, this study explored how student nurses explain clinical success and setbacks and how these explanations influence leadership identity, accountability, and resilience. A qualitative interpretivist design was used. Seventeen third- and fourth-year student nurses from two South African nursing education institutions participated in in-depth face-to-face interviews. Data analysis used reflexive thematic analysis. Trustworthiness was established through member checking, reflexive journaling, triangulation, and audit trails. Two themes emerged: (1) psychological constructs in leadership identity formation, sub-themes: Internal locus of control and proactive leadership; external locus of control and leadership avoidance; reflective learning and Ubuntu as relational moderator; leadership as relational and identity-forming. (2) Contextual and emotional influences on attributional reasoning and leadership development, sub-themes: Transition from theory to practice; systematic and environmental barriers; emotional regulation and leadership self-efficacy; attributional resilience and leadership development across participant groups. Internal locus of control was associated with accountability, confidence, and proactive leadership behaviours, whereas external attributions contributed to anxiety, avoidance, and reduced self-efficacy. Ubuntu strengthened resilience, shared accountability, and relational leadership development. Attributional interpretations of control in clinical environments shape leadership identity. Integrating attributional

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awareness and Ubuntu-informed mentorship may enhance accountability, psychological preparedness, and resilient leadership development among student nurses.

Keywords: nursing leadership; attribution theory; locus of control; Ubuntu; qualitative research; nursing education

Introduction

Leadership development in nursing constitutes a persistent global challenge, shaped by entrenched hierarchical organisational structures, limited professional autonomy, and inequitable distribution of authority within health systems (World Health Organization 2021; Matahela 2025). While leadership is widely recognised as a core competency for all nurses, many newly qualified practitioners report experiencing psychological and emotional unpreparedness for assuming leadership responsibilities. Contemporary scholarship increasingly conceptualises leadership as a relational and behavioural process grounded in collective action, mutual influence, and reciprocal responsiveness, rather than as an outcome derived solely from formal positional authority (Padayachee 2023). In the South African context, these challenges are further compounded by the enduring legacy of apartheid-era exclusion of Black nurses from leadership roles, which continues to shape professional identity formation, organisational cultures, and equitable access to leadership trajectories (Jawad et al. 2025).

Student nurses are expected to demonstrate leadership within emotionally demanding clinical environments that are frequently characterised by constrained resources (Khunou 2023). However, many nursing curricula continue to prioritise technical competencies and procedural compliance over psychological preparedness, reflective judgement, and the cultivation of leadership agency (Aryuwat et al. 2024). This curricular imbalance perpetuates the persistent theory, practice gap, resulting in graduates who are clinically competent yet hesitant to express concerns, exercise autonomous decision-making, or assume responsibility in high-pressure contexts (Buthelezi and Shopo 2023). Consequently, to elucidate the processes through which leadership capacity develops during pre-registration training, it is necessary to investigate how students interpret and internalise their experiences of success, failure, authority, and challenge.

Attribution Theory offers a robust conceptual framework for analysing these interpretative processes. Individuals characterised by an internal locus of control are more likely to attribute outcomes to their own effort and strategic approaches, thereby enhancing motivation, perseverance, and self-efficacy (Rotter 1966). In contrast, external, stable, and uncontrollable attributions such as rigid hierarchical structures or fixed configurations of authority can undermine motivation, reduce persistence, and attenuate self-efficacy, thus reinforcing passivity and avoidance behaviours (Weiner 1994). Within healthcare education, attributional patterns have been linked to resilience, employability, and professional confidence (Harvey et al. 2025); however, their specific

role in shaping the development of leadership identity among student nurses remains underexplored.

Leadership development occurs not in psychological isolation but within specific sociocultural contexts. Dominant leadership models in nursing frequently reflect prevailing normative assumptions (Jawad et al. 2025). In the South African context, the philosophical framework of Ubuntu foregrounds relationality, shared obligation, and reciprocal care (Matahela 2025). When analysed through an Ubuntu lens, clinical challenges are construed as collective rather than exclusively individual responsibilities, a perspective that may shape how student nurses conceptualise authority, accountability, and their own engagement in leadership processes (De Brún et al. 2019).

Although international policy and scholarly discourse emphasise the need for nurse leaders who integrate resilience with compassion (WHO 2021), there remains a paucity of empirical research examining how attributional beliefs, particularly those related to locus of control and informed by Ubuntu, contribute to the formation of leadership identity during clinical education. This gap is critical because shared leadership does not spontaneously arise within traditionally hierarchical healthcare systems; rather, it requires intentional cultivation through rigorously designed and adequately resourced developmental programmes (De Brún et al. 2019). In the absence of a nuanced understanding of how student nurses interpret control, responsibility, and failure, leadership interventions risk perpetuating compliance and deference, rather than fostering agency and a robust sense of collective accountability.

Addressing this gap is essential for elucidating the mechanisms through which some students develop confidence and a robust sense of leadership agency, while others experience heightened anxiety and disengagement. Accordingly, this study examines student nurses' leadership experiences by employing an integrated psychological and cultural analytical framework within the context of South African nursing education institutions.

Theoretical Framework

Attribution Theory and Locus of Control

Attribution Theory constitutes a robust conceptual framework for elucidating how student nurses interpret leadership experiences by assigning causality to internal or external factors along the dimensions of locus of control, stability, and controllability (Weiner 1994). Within the context of clinical education, locus of control assumes salience, as it shapes whether leadership outcomes are ascribed to individual competence and effort or to external determinants such as hierarchical authority, resource constraints, and organisational structures (Rotter 1966; Amoateng 2025). These attributional patterns critically influence leadership development: internal and controllable attributions are typically associated with heightened perceptions of

responsibility, greater persistence in the face of challenge, and strengthened leadership self-efficacy, whereas predominantly external attributions may diminish perceived agency and contribute to disengagement (Harvey et al. 2025; Matahela 2025).

Moreover, attributional processes are embedded within and modulated by the clinical learning environment in which institutional power relations, supervisory practices, and restricted leadership opportunities condition students' perceptions of control and accountability (De Brún et al. 2019). Attribution Theory thus offers an appropriate and insightful theoretical lens for examining how student nurses make sense of leadership experiences and construct leadership identities during their training, particularly in complex, resource-limited healthcare settings.

Ubuntu Philosophy

Ubuntu constitutes an African relational ontological and ethical framework that emphasises interdependence, mutual respect, and collective responsibility, premised on the notion that personal identity is constituted through relationships with others (Padayachee 2023; Matahela 2025). Within nursing education and practice, the sayings "*Umuntu ngumuntu ngabantu*" (IsiXhosa) and "*Motho ke motho ka batho ba bang*" (Sotho) articulate leadership as a relational and ethical imperative grounded in care, accountability, and responsiveness to communal needs. This perspective challenges individualistic and transactional leadership paradigms by foregrounding the social, cultural, and moral foundations of leadership formation and enactment (Matahela 2025). Rather than negating individual agency, Ubuntu reconfigures it within a framework of relational accountability, wherein leadership is understood to emerge through participation in supportive, respectful relationships that advance collective well-being (Jawad et al. 2025). This relational orientation is particularly salient in the South African context, where social connectedness, shared responsibility, and community-oriented values continue to underpin professional practice and leadership development.

Integration of Frameworks

This study synthesises Attribution Theory and the Ubuntu philosophical framework to construct a contextually relevant model for understanding leadership development among student nurses. Attribution Theory elucidates the cognitive processes through which student nurses interpret leadership experiences and appraise their perceived locus of control, whereas Ubuntu offers a relational, communal, and culturally grounded lens that informs how leadership is conceptualised, embodied, and enacted.

The resultant integrated framework acknowledges that leadership development is underpinned by both intrapersonal psychological mechanisms and interpersonal, relational dynamics. It advances a decolonised and contextually situated approach to exploring the formation of leadership identity among student nurses within hierarchical clinical settings, while foregrounding the interplay between personal accountability and collective responsibility as core dimensions of nursing leadership.

Purpose of the Study

The aim of this study was to explore how senior student nurses attribute success and failure in clinical leadership experiences and how these attributional interpretations influence leadership identity, accountability, and resilience during training.

The central question of the study was: How do student nurses' attributional interpretations of control, responsibility, and causality influence leadership identity formation, behaviours, and accountability, and how does Ubuntu function as a relational moderating construct in leadership development?

Method

Research Design

A qualitative research design, situated within an interpretivist paradigm, was adopted to investigate how student nurses construct meanings around leadership experiences through attributional reasoning and locus of control in clinical practice settings (Rotter 1966). This methodological orientation was deemed appropriate for eliciting and analysing participants' subjective meanings, perceptions, and lived experiences related to leadership development (Creswell and Poth 2018). Attribution Theory provided the principal theoretical framework for both data collection and analysis, facilitating an in-depth examination of how students ascribed causality and responsibility for success and failure within the complexity of clinical environments (Weiner 1994).

Setting

The study took place at two public Nursing Education Institutions (NEIs) situated in Gauteng and Limpopo Provinces, South Africa, reflecting both urban and semi-rural settings to provide contextual diversity. Both NEIs are public nursing colleges accredited by the South African Nursing Council (SANC) and operate under national policies governing nursing education and training.

During the data collection period (February–March 2022), both institutions were undergoing the national transition from legacy nursing programmes to new SANC-accredited qualifications. Specifically, the legacy four-year comprehensive nursing programme (Regulation R425), leading to registration as a General Nurse, Psychiatric Nurse, Community Nurse, and Midwife, was still being offered as a teach-out programme. This programme included third- and fourth-year students who had not yet completed their training. Concurrently, the new Diploma in Nursing (Regulation R171), a three-year programme, and the Higher Certificate in Nursing (Regulation R169) were introduced in accordance with revised SANC education regulations.

Institution A, located in a semi-rural area, enrolled approximately 410 nursing students across programmes during the data collection period, including 44 third-year and 54 fourth-year students in the legacy R425 programme. Institution B, located in an urban area in Gauteng Province, enrolled approximately 290 students, including 52 third-year and 48 fourth-year students in the legacy programme. Both institutions provided clinical training across primary healthcare clinics, district hospitals, and regional hospitals, enabling students to engage in supervised clinical practice and leadership-related responsibilities.

Population

The student population comprised senior nursing students enrolled in the legacy four-year comprehensive nursing programme (Regulation R425) who were actively engaged in clinical practice at the two participating NEIs. Third- and fourth-year students were selected because their advanced clinical exposure positioned them to reflect meaningfully on leadership roles, decision-making responsibilities, and teamwork within healthcare settings.

At Institution A, a total of 98 students were enrolled in the third and fourth year of the legacy programme (44 third year and 54 fourth year), while Institution B had 100 students in the same cohort (52 third year and 48 fourth year). From this population, a sample of 17 senior nursing students participated in the study.

Sampling and Recruitment

Purposive sampling was used to recruit participants who could provide rich and relevant insights into leadership experiences in clinical practice. This sampling strategy enabled the selection of information-rich cases that were most likely to illuminate the research question (Creswell and Poth 2018). Inclusion criteria required participants to be third- or fourth-year nursing students enrolled in the legacy R425 programme and actively participating in clinical placements during the study period. Students admitted through Recognition of Prior Learning (RPL) were also included, as their prior healthcare experience could contribute valuable perspectives to the study.

A total of 27 eligible students across the two NEIs were invited to participate. Recruitment was facilitated through information sessions organised with the assistance of institutional gatekeepers. During these sessions, the purpose of the study, voluntary nature of participation, and confidentiality measures were explained to potential participants. Seventeen students consented to participate in the study.

The final sample size of 17 participants was considered appropriate for a qualitative inquiry aimed at obtaining in-depth insights into participants' experiences rather than statistical generalisation. The sample allowed for sufficient diversity of perspectives across the two institutions and different levels of training (third and fourth year), while remaining manageable for detailed qualitative analysis. Data collection continued until

thematic saturation was achieved, whereby no substantially new insights emerged from additional interviews.

Data Collection

Data were collected through individual face-to-face semi-structured interviews conducted between February and March 2022. Interviews were held in private rooms at the NEIs to ensure confidentiality and lasted approximately 60–70 minutes. Semi-structured interviews were selected to allow flexibility for participants to describe their experiences while ensuring that key topics related to leadership development, attribution of responsibility, and locus of control in clinical practice were explored.

Open-ended questions explored participants' leadership experiences in clinical practice, perceptions of responsibility and decision-making, emotional responses to leadership expectations, and the influence of Ubuntu within clinical teams. Interviews were audio-recorded with participants' consent and transcribed verbatim. Transcripts were returned to participants for member checking to confirm accuracy and enhance the credibility of the findings.

Data collection continued until data saturation was achieved. Saturation was reached after 17 interviews, when no new themes, categories, or significant insights emerged from subsequent interviews, indicating that sufficient depth and breadth of information had been obtained to address the research objectives. Achieving saturation is a recognised principle in qualitative research, ensuring that the data adequately capture participants' experiences and perspectives (Creswell and Poth, 2018). This process strengthened the rigour of the study by confirming that the sample size was sufficient to support meaningful thematic analysis.

Data Analysis

Data was analysed using reflexive thematic analysis, following Braun and Clarke's (2022) six-phase framework: familiarising oneself with the data, generating initial codes, constructing initial themes, reviewing and refining these developing themes, defining and naming the themes, and, finally, producing the report. Analysis was theoretically informed by Attribution Theory, focusing on locus of control, controllability, and stability dimensions, as well as Ubuntu-related relational constructs. Coding was conducted inductively and at the latent and semantic levels. Reflexive memos, field notes, and iterative theme development were used to enhance analytic depth and transparency.

Trustworthiness

Trustworthiness was established in accordance with Lincoln and Guba's (1994) criteria of credibility, dependability, confirmability, and transferability to enhance methodological rigour. Credibility was ensured through prolonged engagement with participants and the dataset, member checking of interview transcripts, and sustained

reflexive journaling, thereby promoting accurate representation of participants' experiences and mitigating potential researcher bias. Dependability was supported by the systematic implementation of Braun and Clarke's reflexive thematic analysis, comprehensive documentation of analytic procedures and decision-making processes, and peer debriefing with academic supervisors to maintain methodological coherence. Confirmability was achieved through triangulation of interview data, field notes, and reflexive memos, underpinned by a transparent audit trail and explicit articulation of researcher positionality. Transferability was facilitated by providing a detailed description of the research context, participant characteristics, and clinical settings, enabling readers to evaluate the relevance and applicability of the findings to analogous nursing education environments.

Ethical Considerations

Ethical approval was obtained from the University of South Africa College Research Ethics Committee (CREC) (Ref: REC 012714-039) and the participating Nursing Education Institutions prior to data collection. Informed consent was obtained after participants received a detailed Participant Information Sheet outlining the study's purpose, procedures, risks, and benefits. Participation was voluntary, and written consent was obtained before data collection commenced.

Confidentiality and anonymity were ensured using coded identifiers and the removal of identifying information from transcripts. All data was securely stored in password-protected electronic files accessible only to the researcher. To minimise potential power imbalances and protect participant autonomy, students were recruited from institutions where the researcher had no teaching or supervisory role. Reflexivity was maintained throughout the research process to ensure ethical sensitivity and transparency. These measures ensured the protection of participants and compliance with institutional and international ethical standards.

Results

Participant Characteristics

Seventeen student nurses from two public Nursing Education Institutions (NEI A and NEI B) located in two South African provinces participated in the study. As shown in Table 1, the sample included 10 fourth-year students and seven third-year students, reflecting varying levels of clinical exposure and leadership development. NEI A contributed eight participants, while NEI B contributed nine participants.

The sample was predominantly female (n = 15), with two male participants, reflecting the gender distribution typical of the nursing profession. Participants ranged in age from 22 to 39 years, including both younger students and more mature learners. Six participants were admitted through Recognition of Prior Learning (RPL), and all

participants reported prior healthcare experience, with RPL students demonstrating more extensive clinical exposure.

Clinical placements were distributed across hospital settings (n = 8) and primary healthcare facilities (n = 9), providing diverse clinical learning environments. These demographic and educational characteristics supported the study findings, which indicated that increased clinical exposure and prior healthcare experience were associated with stronger leadership agency, greater internal attribution patterns, and higher leadership confidence.

Table 1: Demographic characteristics of participants (N = 17)

Variable	Category	NEI A (n = 8)	NEI B (n = 9)	Total (N = 17)
Institution	NEI A	8	–	8
	NEI B	–	9	9
Year of study	Third year	3	4	7
	Fourth year	5	5	10
Gender	Male	1	1	2
	Female	7	8	15
Age band (years)	22–29	5	6	11
	30–39	3	3	6
RPL status	RPL	3	3	6
	Non-RPL	5	6	11
Prior healthcare experience	Yes	8	9	17
	No	0	0	0
Clinical placement setting	Hospital	4	4	8
	PHC	4	5	9

The findings illustrate how student nurses' leadership development was shaped by attributional interpretations of clinical experiences and relational influences consistent with Ubuntu philosophy. Two themes and seven interrelated sub-themes emerged, demonstrating how perceptions of control influenced leadership agency, accountability, and identity formation.

Themes and sub-themes

Table 2: Themes and sub-themes on leadership identity formation among student nurses

Theme	Sub-theme
Theme 1: Psychological constructs in leadership identity formation	1.1 Internal locus of control and proactive leadership
	1.2 External locus of control and leadership avoidance
	1.3 Reflective learning and Ubuntu as relational moderator
	1.4 Leadership as relational and identity-forming
Theme 2: Contextual and emotional influences on attributional reasoning and leadership development	2.1 Transition from theory to practice
	2.2 Systemic and environmental barriers
	2.3 Emotional regulation and leadership self-efficacy
	2.4 Attributional resilience and leadership development across participant groups

Theme 1: Psychological Constructs in Leadership Identity Formation

This theme examines how student nurses' interpretations of clinical experiences shaped their leadership identity, agency, and accountability. Leadership development depended on whether they attributed outcomes to internal or external causes and on relational influences grounded in Ubuntu. Four sub-themes emerged.

Sub-Theme 1.1: Internal Locus of Control and Proactive Leadership

Participants who attributed clinical outcomes to internal, controllable causes reported greater leadership confidence, accountability, and proactive engagement. Recognising their clinical judgement strengthened their readiness to make decisions and assume responsibility for patient care.

One participant explained:

> When I realised my own assessment caught a patient's deteriorating vitals… I speak up faster. (P5, Female, 4th year)

Similarly, participants who reframed mistakes as learning opportunities demonstrated reflective leadership and mentorship behaviours.

One participant shared:

> Messing up that IV insertion taught me to slow down… now I mentor first-years. (P4, Female, 3rd year)

These accounts reflect an internal locus of control, where success and failure were viewed as controllable and developmental, strengthening leadership agency, accountability, and proactive engagement.

Sub-Theme 1.2: External Locus of Control and Leadership Avoidance

Participants who attributed clinical outcomes to external, uncontrollable factors showed reduced leadership engagement and accountability, often perceiving outcomes as dependent on senior professionals, which limited their perceived authority and responsibility.

One participant indicated:

> If the patient doesn't improve, it's because the doctor didn't order the right treatment. (P10, Female, 4th year)

Social and gender-related factors also influence leadership participation and attributional interpretations.

A male participant indicated:

> Patients ask for female nurses… I stop volunteering to lead. (P13, Male, 4th year, RPL)

These findings demonstrate that external attributional interpretations contributed to leadership withdrawal, reduced participation, and diminished accountability.

Sub-Theme 1.3: Reflective Learning and Ubuntu as Relational Moderator

Ubuntu-informed relational processes supported leadership development by promoting shared accountability, collective reflection, and adaptive attributional reasoning, enabling participants to reinterpret challenges constructively and internalise responsibility.

One participant explained:

> When we reflect together, I realise I am not alone in the mistake… it becomes a lesson for all of us, and I take responsibility to improve. (P7, Female, 3rd year)

Another participant emphasised collective leadership development:

> In our ward, you are never alone in responsibility. When one of us struggles, we reflect together, and that reminds me that leadership is not about being perfect, but about growing with others. (P9, Female, 4th year)

Ubuntu-informed relational support also strengthened resilience and accountability following mistakes:

> When my team supported me after I made a mistake, I realised leadership is about being accountable to others, not just yourself. That support gave me the courage to lead again. (P6, Female, 3rd year)

These findings demonstrate that Ubuntu functioned as a relational moderating construct, strengthening leadership confidence, accountability, and adaptive attributional reasoning.

Sub-Theme 1.4: Leadership as Relational and Identity-forming

Participants described leadership as relational rather than hierarchical, emphasising connection, communication, and shared responsibility, with relational affirmation and mentorship strengthening leadership identity and confidence.

One participant described:

> Leadership is not about rank; it's about connection. (P7, Female, 3rd year)

Mentorship played a key role in strengthening leadership identity:

> When my mentor said, 'We all learn through mistakes,' it changed how I saw myself. (P10, Female, 3rd year)

These findings illustrate how relational experiences supported leadership identity formation, accountability, and confidence.

Theme 2: Contextual and Emotional Influences on Attributional Reasoning and Leadership Development

This theme describes how clinical environments, organisational constraints, emotional responses, and developmental stage influenced attributional reasoning and leadership engagement. Four sub-themes were identified.

Sub-Theme 2.1: Transition from Theory to Practice

Participants described leadership development as evolving through clinical exposure, particularly during the transition from theory to practice, requiring adaptive thinking and increased attributional awareness.

One participant shared:

> I memorised every step… but real nursing is about adapting. (P8, Male, 3rd year)

Clinical exposure strengthened leadership confidence, decision-making, and attributional awareness.

Sub-Theme 2.2: Systematic and Environmental Barriers

Structural and organisational constraints, including workload pressures and resource limitations, influenced attributional interpretations and leadership engagement, sometimes reducing perceived leadership control.

One participant reported:

> Even if I see something wrong, I hesitate because no one has time. (P14, Female, third year)

However, some participants demonstrated attributional resilience despite systemic constraints:

> Even when resources are low, I focus on what I can do safely. (P11, Female, fourth year, RPL)

These findings demonstrate variability in attributional responses to organisational constraints.

Sub-Theme 2.3: Emotional Regulation and Leadership Self-Efficacy

Emotional responses influenced leadership engagement and attributional reasoning. Anxiety and self-doubt limited leadership participation among some participants.

One participant shared:

> Anxiety makes me overthink… I second-guess myself into silence. (P7, Female, 3rd year)

In contrast, participants who reframed emotional challenges demonstrated increased leadership confidence:

> Each time I prepared better, it got easier. (P2, Female, 3rd year, RPL)

These findings highlight the role of emotional regulation in leadership development.

Sub-Theme 2.4: Attributional Resilience and Leadership Development Across Participant Groups

Attributional interpretations varied according to clinical experience and level of training. Fourth-year and RPL participants demonstrated stronger internal attribution patterns associated with increased leadership confidence, accountability, and resilience, while third-year participants reflected emerging leadership identity and developing self-

efficacy. Ubuntu-informed relational support further strengthened leadership confidence and accountability across participant groups.

One fourth-year participant described increased personal responsibility and leadership confidence:

> In my final year, I realised I cannot always blame the situation. I focus on what I can do differently, and that makes me more confident to take the lead. (P12, Female, 4th year)

Similarly, a third-year participant highlighted the importance of relational support in strengthening leadership confidence:

> When my team supports and guides me, I feel more confident to take responsibility. It reminds me that leadership grows through working and learning together. (P3, Female, third year)

These accounts demonstrate how clinical experience and Ubuntu-informed relational support foster internal attribution, leadership confidence, and the progressive development of leadership identity.

Discussion

This study investigated the ways in which student nurses' attributional interpretations of clinical successes and setbacks shape the development of leadership identity, accountability, and leadership engagement, as well as the role of Ubuntu as a relational moderating construct within this process. The findings underscore the dynamic interaction among psychological, relational, emotional, and contextual factors in influencing leadership development. The discussion is organised according to the two overarching themes that emerged from the analysis.

Theme 1: Psychological Constructs in Leadership Identity Formation

The findings indicate that students who attributed clinical outcomes to internal and controllable factors demonstrated heightened leadership agency, accountability, and proactive engagement. These attributional patterns align with adaptive motivational orientations characterised by persistence, task engagement, and self-regulated learning, as articulated in Attribution Theory (Weiner 1994; Wang et al. 2023). Students exhibiting a predominantly internal locus of control reported greater confidence and decisiveness, corroborating existing evidence that internal attributions facilitate leadership development, strengthen professional responsibility, and enhance leadership self-efficacy (Field-Richards et al. 2024). Collectively, these results suggest that leadership identity formation is shaped not only by the acquisition of clinical competence but also by students' interpretive frameworks regarding their capacity to influence clinical outcomes.

In contrast, students who predominantly attributed clinical outcomes to external factors such as hierarchical authority, organisational structures, and systemic constraints displayed attenuated leadership engagement and reduced confidence. In these accounts, leadership was frequently construed as contingent upon the authority and actions of senior professionals, thereby constraining students' perceived scope of influence, authority, and responsibility. This attributional stance was associated with behavioural withdrawal, heightened dependency, and diminished accountability, supporting Rotter's (1966) contention that an external locus of control undermines initiative and leadership agency. These observations are congruent with prior research indicating that perceived lack of control erodes leadership confidence and reinforces more passive, subordinate professional roles.

Ubuntu emerged as a salient relational and contextual moderating construct that reframed attributional interpretations and fortified leadership identity. Through mentorship, collective reflection, and relational support, students began to reconceptualise clinical challenges as surmountable and to internalise responsibility with diminished fear of failure. This finding extends Attribution Theory by illustrating that attributional reasoning is not solely an individual cognitive process but is also socially and culturally mediated (Weiner 1994). Within this framework, leadership was consistently constructed as relational rather than purely positional, embodying Ubuntu principles of shared responsibility, collective accountability, and ethically grounded influence. This relational orientation enhanced leadership confidence and resilience and is consistent with relational leadership scholarship that underscores the importance of culturally grounded leadership development within nursing education (Lönn et al. 2023).

Theme 2: Contextual and Emotional Influences on Attributional Reasoning and Leadership Development

The transition from theoretical instruction to clinical practice constituted a critical period of attributional instability, during which students actively re-evaluated their perceived competence and readiness for leadership. Uncertainty in applying theoretical knowledge to real-world clinical scenarios shaped students' perceptions of control, leadership capability, and emerging professional identity. These observations are congruent with existing literature that identifies the theory–practice gap as a significant impediment to leadership self-efficacy and professional identity formation among student nurses (Buthelezi and Shopo 2023).

Structural and organisational constraints, such as staffing shortages, high workload demands, and rigid hierarchical clinical cultures, were frequently construed as external and uncontrollable determinants of practice. Such external attributions appeared to attenuate leadership agency and to reinforce avoidance-oriented behaviours. This pattern is consistent with research indicating that restrictive clinical environments foster external attributional styles and diminish leadership engagement (Dunn 2025). Nevertheless, a subset of students exhibited attributional resilience by directing their

focus towards controllable dimensions of patient care, implying that leadership agency can be sustained even under adverse contextual conditions.

Affective responses, particularly anxiety and self-doubt, also exerted a significant influence on attributional processes and subsequent leadership engagement. Students who construed emotional challenges as modifiable and within their sphere of influence demonstrated greater persistence, more adaptive coping strategies, and enhanced leadership development. Conversely, students who externalised or depersonalised their emotional experiences were more inclined to disengage from leadership opportunities. These findings corroborate evidence linking an internal locus of control with more effective emotional regulation, heightened leadership confidence, and increased professional resilience (Maraş et al. 2023).

Students entering through Recognition of Prior Learning (RPL) pathways exhibited more robust internal attributional patterns, greater attributional stability, and heightened leadership resilience. Their previous clinical exposure enabled them to appraise challenges as manageable rather than threatening, thereby supporting prior research suggesting that experiential learning strengthens leadership confidence, self-efficacy, and professional identity (Bond et al. 2024).

Overall Integration of Findings

Collectively, these findings indicate that the formation of leadership identity among student nurses is shaped by attributional interpretations of control, responsibility, and causality within clinical learning environments. Internal attributional orientations enhanced leadership agency, accountability, and resilience, whereas external attributional interpretations were associated with avoidance behaviours and diminished leadership engagement. Ubuntu operated as a cultural and relational moderating construct that reframed challenges as a collective responsibility and, in turn, strengthened leadership self-efficacy and accountability. Overall, these findings refine and extend Attribution Theory by demonstrating that attributional reasoning is socially, culturally, and relationally mediated within the context of nursing education and leadership development.

Implications and Recommendations

The findings highlight the need to strengthen leadership identity development within public NEIs in South Africa. Leadership development should explicitly address how student nurses' attributional interpretations of control, responsibility, and clinical experiences influence their leadership confidence, accountability, and engagement. Integrating attributional awareness into teaching and clinical education may support students in recognising their capacity to influence clinical outcomes and assume leadership responsibility.

Nurse educators should incorporate structured reflective pedagogies, including guided reflection, simulation-based learning, and facilitated clinical discussions, to support students in developing adaptive attributional interpretations and leadership confidence. These strategies are particularly relevant within public nursing colleges undergoing transition to new South African Nursing Council (SANC) programmes, including the Diploma in Nursing (Regulation R171), where leadership development must be progressively scaffolded across all levels of training.

Clinical mentors in public healthcare settings play a critical role in shaping leadership identity through supervision and role modelling. Mentorship approaches informed by Ubuntu principles should be strengthened to promote shared accountability, relational support, and collaborative learning. Mentor development initiatives should equip clinical supervisors to support students in recognising controllable aspects of clinical practice and developing leadership agency within resource-constrained environments.

At a programme level, leadership identity formation should be explicitly embedded as a core outcome within new nursing qualifications. Curriculum frameworks should integrate psychological and relational leadership concepts, including Attribution Theory, locus of control, and relational leadership principles. Clinical assessment strategies should include evaluation of leadership behaviours, accountability, and decision-making to ensure graduates are prepared to assume leadership roles.

Strengthening supportive clinical learning environments and structured mentorship systems within public Nursing Education Institutions and affiliated healthcare facilities may enhance leadership preparedness, resilience, and professional identity development among student nurses.

Conclusion

This study demonstrated that leadership identity formation among student nurses in public Nursing Education Institutions in two South African provinces was shaped by attributional interpretations of control, responsibility, and clinical experiences. Students who demonstrated internal and controllable attributional orientations exhibited stronger leadership agency, accountability, and resilience, while external attributions associated with systemic and hierarchical constraints reduced leadership confidence and engagement. Ubuntu functioned as a relational moderating construct, promoting shared accountability and enabling students to internalise leadership responsibility within supportive clinical environments. Integrating Attribution Theory, locus of control, and Ubuntu provides a contextually relevant framework for understanding leadership development within South African nursing education. Embedding attributional awareness, reflective pedagogies, and relational mentorship within nursing programmes may strengthen student nurses' leadership identity and preparedness to lead effectively in complex healthcare settings.

Limitations of the Study

The qualitative design, small sample, and inclusion of participants from limited Nursing Education Institutions reduce transferability. Self-reported leadership experiences may reflect subjective interpretations. The predominantly female sample limits gender-based analysis. Future research should use longitudinal and mixed methods across diverse contexts to examine how attributional orientations and leadership identity develop over time.

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