ACHSM Asia-Pacific Journal of Health Management

ACHSM CONGRESS 2025

SUSTAINING SERVANT LEADERSHIP IN HEALTHCARE: THE ROLES OF RESILIENCE AND PROSOCIAL MOTIVATION IN ENHANCING LEADER WORK ENGAGEMENT

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ABSTRACT

The beneficial effects of servant leadership on followers have been extensively studied; however, the impact of this leadership style on leaders who employ it has been less well studied. Taking the support of Self-Determination Theory and Conservation of Resources Theory, this research investigates how two personal resources—prosocial motivation and resilience—shape servant leadership behaviour and, in turn, influence leader work engagement in healthcare organisations.

A cross-sectional study was conducted among 168 healthcare leaders in India. The Confirmatory Factor Analysis (CFA) results showed that the four variables of the conceptual model are fairly distinct from each other, and structural equation modelling revealed that both prosocial motivation ($\beta = 0.458$, $p < .001$) and resilience ($\beta = 0.375$, $p < .001$) significantly predicted servant leadership behaviour. Servant leadership, in turn, positively predicted leader work engagement ($\beta = 0.380$, $p = .001$). Mediation analysis confirmed that servant leadership behaviour fully mediated the effect of prosocial motivation and partially mediated the effect of resilience on leader work engagement. Interestingly, unlike resilience, prosocial motivation showed no direct impact on engagement, indicating that behavioral enactment is necessary for converting motivational dispositions into sustained vitality.

These findings suggest valuable additions to the servant leadership theory by highlighting the behavioral tendencies through which personal resources affect leader engagement. Practically, they suggest that healthcare organisations should foster prosocial and resilient dispositions and support servant leadership behaviours through training, introspection, and relational feedback. By doing so, organizations can cultivate emotionally sustainable leadership in high-stress clinical environments.

KEYWORDS

servant leadership; resilience; prosocial motivation; leader work engagement; healthcare leadership; emotional sustainability

INTRODUCTION

Healthcare leadership is challenging, as the role demands technical competence and requires leaders to be emotionally resilient, have ethical clarity, and relational depth [1]. Globally, healthcare systems struggle to keep their leaders engaged amid concerns such as burnout, moral distress, and workforce shortages. Servant leadership, which emphasizes prioritising the needs of employees and patients, empathy, and empowerment, offers a solution to address these challenges. However, the antecedents that enable servant leaders to maintain high work engagement remain underexplored [2].
This study adopts an actor-centric perspective as it investigates how two personal resources—resilience and prosocial motivation—predict servant leadership behavior, and how servant leadership, in turn, enhances leader work engagement by using the theories of Self-Determination [3], Conservation of Resources [4], and Servant Leadership [5]. Our conceptual framework is presented in Figure 1.

While prior research has shown that servant leadership results in positive employee outcomes such as job satisfaction, commitment, and performance [6], fewer studies have examined servant leadership behavior's influence on leaders—especially in healthcare contexts where emotional labor and ethical complexity are high. Moreover, the role of resilience—the capacity to withstand difficulties—and prosocial motivation—the desire to benefit others—as predictors of servant leadership remains under-theorized.

This paper contributes to the literature by empirically testing a mediation model in which resilience and prosocial motivation predict servant leadership behavior, predicting leader work engagement. The findings have implications for leadership development, emotional sustainability, and ethical climate in healthcare organizations.

LITERATURE REVIEW

SERVANT LEADERSHIP IN HEALTHCARE

Servant leadership has been operationalized through dimensions such as emotional healing, putting others first, and helping subordinates grow [7]. In healthcare settings, servant leadership enhanced leader involvement and enthusiasm at work and reduced adverse employee outcomes, such as disengagement [8]. Studies show that servant leadership is positively related to collaboration among nurses [9], proactive behavior [1]), pro-environmental behavior [11], and reduced turnover intentions.

However, servant leadership is more than a trait—it is a behavior that requires emotional and motivational resources to perform efficiently in high-stress environments like hospitals. Leaders must regulate their emotions, bounce back from adversities, and stay engaged despite workplace tensions. Hence, we must understand what makes leaders maintain consistent engagement levels at work.

RESILIENCE AS A PREDICTOR OF SERVANT LEADERSHIP

The ability of individuals to face adversities, handle them efficiently, and thereby improve their problem-solving skills is known as resilience. It is not just about "bouncing back" but forwarding with greater strength or insight [12]. In healthcare, resilience helps leaders manage emotional labor, moral distress, and crises [13,14]. According to the Conservation of Resources Theory, resilient individuals protect and mobilize resources to maintain functioning. Recent studies suggest that resilience predicts ethical leadership and emotional intelligence; however, its role in servant leadership remains less explored.

We propose that resilience helps leaders be emotionally stable and receptive, which promotes servant leadership traits like empowerment, empathy, and healing.

PROSOCIAL MOTIVATION AND SERVANT LEADERSHIP

Prosocial motivation is the desire to help others and contribute to their well-being [15]. It is a resource essential to healthcare workers and is consistent with servant leadership [16]. According to the theory of Self-Determination, prosocial and other forms of autonomous motivation increase moral behavior and participation. Leaders who desire to serve are more likely to prioritize others, become active listeners, and encourage growth—the fundamental tenets of servant leadership.

It has been reported that job satisfaction was a mediator between emotional intelligence and intrinsic motivation as predictors of job performance among nurses [17]. We apply this reasoning to leadership behavior and contend that servant leadership is fueled by prosocial drive.

SERVANT LEADERSHIP AND WORK ENGAGEMENT

When employees display high energy, enthusiasm, and participation and take pride in their work, they are said to be engaged [18]. Research showed that servant leadership was positively related to creativity through the mediators of psychological safety and employee well-being [19]. While most studies examine how servant leadership affects followers' engagement, we focus on leader work engagement—a critical but understudied outcome.

When enacted authentically, we hypothesise that servant leadership behaviour reinforces leaders' sense of purpose and connection, sustaining their engagement.

THEORY AND HYPOTHESES

SELF-DETERMINATION THEORY (SDT)

Self-Determination Theory asserts that individuals are most motivated when their basic psychological needs for autonomy, competence, and relatedness are fulfilled. In leadership settings, SDT explains how the intrinsic motivation to help others can lead to sustained work engagement. Prosocial motivation is a form of autonomous motivation that satisfies the SDT needs for relatedness and purpose [20]. Servant leadership behavior—which involves empowering others and putting others first—is a natural manifestation of a leader's prosocial motivation [21].

Hypothesis 1*: Prosocial motivation positively predicts servant leadership behavior.*

CONSERVATION OF RESOURCES THEORY (COR)

The COR Theory posits that when stressed, individuals strive to obtain, retain, and protect valuable resources. Resilience is viewed as a key personal resource that enables individuals to deal with hardships and continue functioning efficiently. In healthcare leadership, resilience helps leaders gather their emotional strength and continue serving others, such as employees and patients [22]. The COR also explains how resourceful leaders invest their resources, such as emotional energies, to enrich their resource pool. Hence, servant leaders invest their resilience to engage more at work and gain additional resources.

Hypothesis 2: Resilience positively predicts servant leadership behavior.

SERVANT LEADERSHIP THEORY

Servant Leadership Theory emphasises the leader's inclination to serve first prioritising the needs of followers over their own, fostering growth, and promoting ethical and relational depth. In healthcare, servant leadership has been linked to improved team collaboration, reduced burnout, and enhanced patient outcomes. While the relationship between servant leadership behavior and positive employee outcomes is well-established in the literature, we propose that enacting servant leadership can also benefit leaders, as it reinforces leaders' sense of purpose and work meaningfulness [23]. By engaging in meaningful, values-driven behavior, leaders experience greater vigor and dedication.

Hypothesis 3: Servant leadership behavior positively predicts leader work engagement.

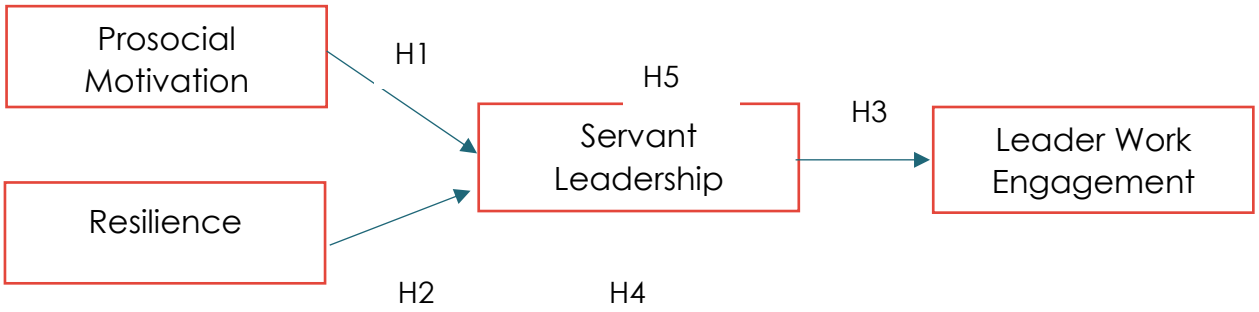
SERVANT LEADERSHIP BEHAVIOR AS A MEDIATOR

Resilience enables leaders to enact servant leadership behaviors even under stress. These behaviors, in turn, enhance engagement by fostering confidence and work meaningfulness. Thus, servant leadership is a behavioral channel through which resilience translates into sustained work engagement. Prosocially motivated leaders are inclined to serve others; this behavioral enactment reinforces their engagement. Servant leadership offers a mechanism through which intrinsic motivation is expressed, resulting in greater engagement and dedication at work. The SDT supports this pathway by linking autonomous motivation to sustained well-being and performance.

Hypothesis 4: The relationship between prosocial motivation and leader work engagement is mediated by servant leadership behavior.

Hypothesis 5: The relationship between resilience and leader work engagement is mediated by servant leadership behavior.

FIGURE 1: CONCEPTUAL FRAMEWORK



METHOD

SAMPLE AND PROCEDURE

A cross-sectional survey design was employed to assess the relationships between resilience, prosocial motivation, servant leadership behavior, and leader work engagement among healthcare leaders. We approached the CEOs of hospitals and healthcare organizations and invited them to support the study. Upon agreement, they assigned their HR managers to assist us with the survey. The HR managers provided us with the contact details of employees in formal leadership roles who were willing to participate. A purposive sampling technique was used to ensure that only leaders were included in the study. To enforce this, the survey began with a filter question on leadership tenure; those without leadership experience were automatically exited from the survey questionnaire.

Ethical approval was obtained from the institutional ethics committee before data collection. Participants were informed that the study was conducted for academic purposes, their responses would be confidential, participation was voluntary, and informed consent was obtained. We included attention-check questions to mitigate the risk of common method bias and ensure data quality. The responses from participants who wrongly answered these questions were excluded. Of the 244 responses collected, 76 were removed due to failed attention checks and incomplete responses, resulting in a final sample of 168 healthcare leaders.

Demographic characteristics were as follows: 57.6% male and 42.4% female. Age distribution was 1% under 34 years, 5% between 35–44 years, 39% between 45–54 years, and 55% between 55–64 years. Leadership experience varied: 15% had less than one year, 39% had 1–5 years, 9% had 6–10 years, and 37% had more than 10 years. Marital status was 32.5% single and 67.5% married. Annual income levels were: 31% below ₹5,00,000, 28% between ₹6–10 lakh, 16% between ₹11–15 lakh, 6% between ₹16–20 lakh, and 19% above ₹20 lakh.

MEASURES

To reduce common method bias and improve attentiveness, we used a 5-point Likert scale for two constructs and a 7-point Likert scale for the remaining two.

Prosocial motivation. This was measured using a four-item scale developed by Grant [24]. rated on a 5-point scale (1 = strongly disagree, 5 = strongly agree). An introductory question asked, "Why are you motivated to do your work?" One of the items is "because I care about benefiting others through my work." Reliability was acceptable (α = .86).

Resilience. Leader resilience was captured using a six-item scale by Smith et al. [25]. rated on a 5-point scale. An example item is "I tend to bounce back quickly after hard times." The scale reliability was strong (α = .91).

Servant leadership behavior. We adapted Liden et al.'s [26] scale to measure servant leadership behavior of leaders. Items were rated on a 7-point scale. The original scale was designed for employees to rate the servant leadership of their managers. We replaced "My manager" with "I" for every item, for leaders' self-assessment. This adaptation is widely accepted in leadership research [27]. A sample item is "I can tell if something work-related is going wrong." Internal consistency was acceptable (α = .77).

Leader work engagement. Engagement was assessed using a three-item scale by Schaufeli et al. [27]. A sample item is "At my work, I feel bursting with energy." Reliability was moderate (α = .64; ω = .75). Removing the first item increased reliability (α = .81), but the full scale was retained due to theoretical relevance.

Control variables. We controlled the demographic characteristics like age, gender, marital status, leadership experience, and annual income to remove the potential confounding effects.

RESULTS

CONFIRMATORY FACTOR ANALYSIS AND DESCRIPTIVE STATISTICS

We tested the proposed model using Jamovi version 2.4.11 and Mplus version 8.11. Confirmatory Factor Analysis (CFA) assessed the discriminant validity of four constructs: prosocial motivation, resilience, servant leadership, and work engagement. Table 1 presents CFA results. In comparison models, servant leadership and work engagement were merged (three-factor), or prosocial motivation and resilience were combined (two-factor), or all items loaded onto one factor (one-factor). The four-factor model showed superior fit: $\chi^2(164) = 247.97$, $p < .001$; TLI = 0.940; CFI = 0.949; RMSEA = 0.055; SRMR = 0.056.

All standardized factor loadings were significant ($p < .001$), ranging from 0.397 to 0.933, exceeding the recommended 0.50 threshold (Hair et al., 2009), supporting convergent validity. Although composite reliability and AVE were not computed, standardized loadings and inter-factor correlations support construct distinctiveness.

To assess common method variance (CMV), Harman's single-factor test was conducted in Jamovi. The first factor did not account for the majority of variance, with loadings from 0.355 to 0.772, suggesting CMV is unlikely to bias results.
Table 2 shows that all constructs were significantly and positively correlated, with the strongest associations between servant leadership and work engagement ($r = .623$, $p < .001$).

TABLE 1: CONFIRMATORY FACTOR ANALYSIS

Model	χ^2	df	χ^2/df	CFI	TLI	RMSEA	SRMR
Four-factor model	247.97	164	1.51	0.949	0.940	0.055	0.056
Three-factor model	412.35	167	2.47	0.882	0.864	0.089	0.078
Two-factor model	589.62	169	3.49	0.821	0.793	0.104	0.092
One-factor model	734.88	170	4.32	0.765	0.732	0.118	0.106

TABLE 2: MEANS, STANDARD DEVIATIONS, AND CORRELATIONS

Variable	M	SD	1	2	3	4
1. Prosocial Motivation	4.45	0.56	—			
2. Resilience	3.91	0.69	.457***	—		
3. Servant Leadership	6.10	0.88	.630***	.584***	—	
4. Work Engagement	5.41	0.92	.441***	.625***	.623***	—

Note. *M* = Mean; *SD* = Standard Deviation. ***p* < .001.

HYPOTHESES TESTING

The structural model was tested using Mplus version 8.11 with maximum likelihood estimation. The model demonstrated good fit: $\chi^2(164) = 247.97$, $p < .001$; CFI = 0.949; TLI = 0.940; RMSEA = 0.055 [90% CI: 0.041, 0.069]; SRMR = 0.056. These indices indicate an acceptable fit between the hypothesized model and the observed data.

DIRECT EFFECTS

As shown in Table 3, prosocial motivation significantly predicted servant leadership behavior (β = 0.458, SE = 0.077, 95% CI [0.306, 0.610], $p < .001$), supporting Hypothesis 1. Resilience also had a significant positive effect on servant leadership behavior (β = 0.375, SE = 0.078, 95% CI [0.222, 0.528], $p < .001$), supporting Hypothesis 2. Servant leadership behavior significantly predicted leader work engagement (β = 0.380, SE = 0.112, 95% CI [0.160, 0.600], $p = .001$), supporting Hypothesis 3.

INDIRECT EFFECTS (MEDIATION)

Mediation analysis revealed significant indirect effects of prosocial motivation and resilience on work engagement via servant leadership behavior. These findings support Hypothesis 4 and Hypothesis 5. Mediation analysis confirmed that servant leadership behavior fully mediated the effect of prosocial motivation on leader work engagement and partially mediated the effect of resilience on leader work engagement.

TABLE 3: REGRESSION RESULTS FOR DIRECT AND MEDIATING EFFECTS (N = 168)

Hypothesis	Path	Effect	S.E	95% CI	Significance
H1	Prosocial Motivation → Servant Leadership Behavior	0.458	.077	[.306, .610]	< .001
H2	Resilience → Servant Leadership Behavior	0.375	.078	[.222, .528]	< .001
H3	Servant Leadership Behavior → Leader Work Engagement	0.380	.112	[.160, .600]	.001
H4	Prosocial motivation → SLB → Leader Work Engagement	Indirect effect	—	Significant via SLB	< .001
H5	Resilience → SLB → Leader Work Engagement	Indirect effect	—	Significant via SLB	< .001

DISCUSSION AND CONCLUSION

This study investigated how prosocial motivation and resilience influence servant leadership behavior and, in turn, leader work engagement in healthcare settings. The structural model demonstrated good fit, and the hypotheses were supported. Specifically, prosocial motivation and resilience significantly predicted servant leadership behavior, positively influencing leader work engagement. These results support the idea that leaders are likely to exhibit servant leadership when they are motivated to strive for others' well-being and have the mettle to face adverse circumstances. This behavior can cultivate a sense of vitality at work.

Significantly, servant leadership behavior mediated the effects of prosocial motivation and resilience on work engagement. This implies that while prosocial and resilient leaders may be inclined to be engaged at work, their servant leadership behavior enables them to convert these traits into sustained energy and involvement. The insignificant direct effect of prosocial motivation on work engagement indicates that the motivation to serve others alone cannot ensure high engagement levels of leaders; what is important is the leader's effort to translate the motivation into action by employing servant leadership behavior at work.

These results contribute to leadership and healthcare management literature by identifying servant leadership as a key mechanism linking personal attributes to engagement outcomes. The findings underscore the value of cultivating servant leadership behaviors—such as empathy, listening, and stewardship—especially among leaders with strong prosocial and resilient dispositions. By fostering these behaviors, healthcare organizations can support more engaged, compassionate, and resilient leadership, which is critical for sustaining performance and well-being in demanding clinical environments.

LIMITATIONS AND FUTURE RESEARCH

Despite making significant contributions to healthcare literature, our study is not free from limitations. First, due to its cross-sectional nature, the study design limits the ability to draw causal inferences between prosocial motivation, resilience, servant leadership behavior, and work engagement. Longitudinal or experimental designs would provide more substantial evidence of directionality and temporal dynamics. Second, despite our efforts to mitigate the risk of same-source bias and common method variance using scale variation and attention-check questions, gathering data from multiple sources could reduce social desirability bias and the risk of inflated associations between the study variables.

Third, due to the restriction of the sample to healthcare leaders in India, the study might compromise on the generalizability of the findings to other cultural or organizational contexts. Leadership behaviors and motivational dynamics may differ across sectors or regions. Fourth, while the study focused on servant leadership as a mediating mechanism, other potential mediators—such as psychological safety, emotional exhaustion, or organizational support—were not examined.

Future research could explore these alternative pathways and test moderated mediation models to assess how contextual factors (e.g., organizational culture, workload, or team climate) influence the strength of these relationships. Additionally, incorporating multi-source data (e.g., peer or subordinate ratings) would strengthen the validity of leadership behavior assessments. Expanding the scope to include diverse leadership levels and healthcare systems would further enrich understanding.

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