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Theory Box: Leadership Theories

| **Theory/Contributor** | **Key Idea** | **Application to Practice** |
| --- | --- | --- |
| Trait Theories | | |
| Trait theories were first studied from 1900 to 1950. These theories are sometimes referred to as the *Great Man* theory, from Aristotle’s philosophy extolling the virtue of being “born” with leadership traits. [**Stogdill (1948)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1521)is usually credited as the pioneer in this school of thought. | Leaders have a certain set of physical and emotional characteristics that are crucial for inspiring others toward a common goal. Some theorists believe that traits are innate and cannot be learned; others believe that leadership traits can be developed in each individual. | Self-awareness of traits is useful in self-development (e.g., developing assertiveness) and in seeking employment that matches traits (drive, motivation, integrity, confidence, cognitive ability, and task knowledge). |
| Style Theories | | |
| Sometimes referred to as *group and exchange* theories of leadership, style theories were derived in the mid-1950s because of the limitations of trait theory. The key contributors to this renowned research were **[Shartle (1956)](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml" \l "eid1520)**, [**Stogdill (1963)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1524), and [**Likert (1987)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1503). | Style theories focus on what leaders do in relational and contextual terms. The achievement of satisfactory performance measures requires supervisors to pursue effective relationships with their subordinates while comprehending the factors in the work environment that influence outcomes. | To understand “style,” leaders need to obtain feedback from followers, superiors, and peers, such as through the Managerial Grid Instrument developed by [**Blake and Mouton (1985)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1473). Employee-centered leaders tend to be the leaders most able to achieve effective work environments and productivity. |
| Situational-Contingency Theories | | |
| The situational-contingency theorists emerged in the 1960s and early 1970s to mid-1970s. These theorists believed that leadership effectiveness depends on the relationship among (1) the leader’s task at hand, (2) his or her interpersonal skills, and (3) the favorableness of the work situation. Examples of theory development with this expanded perspective include [**Fiedler’s (1967)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1475) Contingency Model, [**Vroom and Yetton’s (1973)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1528)Normative Decision-Making Model, and [**House and Mitchell’s (1974)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1487) Path-Goal theory. | Three factors are critical: (1) the degree of trust and respect between leaders and followers, (2) the task structure denoting the clarity of goals and the complexity of problems faced, and (3) the position power in terms of where the leader was able to reward followers and exert influence. Consequently, leaders were viewed as able to adapt their style according to the presenting situation. The Vroom-Yetton model was a problem-solving approach to leadership. Path-Goal theory recognized two contingent variables: (1) the personal characteristics of followers and (2) environmental demands. On the basis of these factors, the leader sets forth clear expectations, eliminates obstacles to goal achievements, motivates and rewards staff, and increases opportunities for follower satisfaction based on effective job performance. | The most important implications for leaders are that these theories consider the challenge of a situation and encourage an adaptive leadership style to complement the issue being faced. In other words, nurses must assess each situation and determine appropriate action based on the people involved. |
| Transformational Theories | | |
| Transformational theories arose late in the past millennium when globalization and other factors caused organizations to fundamentally re-establish themselves. Many of these attempts were failures, but great attention was given to those leaders who effectively transformed structures, human resources, and profitability balanced with quality. [**Bass (1990)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1466), [**Bennis and Nanus (2007)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1469), and **[Tichy and Devanna (1997)](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml" \l "eid1525)**are commonly associated with the study of transformational theory. | Transformational leadership refers to a process whereby the leader attends to the needs and motives of followers so that the interaction raises each to high levels of motivation and morality. The leader is a role model who inspires followers through displayed optimism, provides intellectual stimulation, and encourages follower creativity. | Transformed organizations are responsive to customer needs, are morally and ethically intact, promote employee development, and encourage self-management. Nurse leaders with transformational characteristics experiment with systems redesign, empower staff, create enthusiasm for practice, and promote scholarship of practice at the patient-side. |
| Hierarchy of Needs | | |
| Maslow is credited with developing a theory of motivation, first published in [**1943**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1509). | People are motivated by a hierarchy of human needs, beginning with physiologic needs and then progressing to safety, social, esteem, and self-actualizing needs. In this theory, when the need for food, water, air, and other life-sustaining elements is met, the human spirit reaches out to achieve affiliation with others, which promotes the development of self-esteem, competence, achievement, and creativity. Lower-level needs will always drive behavior before higher-level needs will be addressed. | When this theory is applied to staff, leaders must be aware that the need for safety and security will override the opportunity to be creative and inventive, such as in promoting job change. |
| Two-Factor Theory | | |
| [**Herzberg (1991)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1485) is credited with developing a two-factor theory of motivation, first published in 1968. | Hygiene factors, such as working conditions, salary, status, and security, motivate workers by meeting safety and security needs and avoiding job dissatisfaction. Motivator factors, such as achievement, recognition, and the satisfaction of the work itself, promote job enrichment by creating job satisfaction. | Organizations need both hygiene and motivator factors to recruit and retain staff. Hygiene factors do not create job satisfaction; they simply must be in place for work to be accomplished. If not, these factors will only serve to dissatisfy staff. Transformational leaders use motivator factors liberally to inspire work performance. |
| Expectancy Theory | | |
| [**Vroom (1994)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1527) is credited with developing the expectancy theory of motivation. | Individuals’ perceived needs influence their behavior. In the work setting, this motivated behavior is increased if a person perceives a positive relationship between effort and performance. Motivated behavior is further increased if a positive relationship exists between good performance and outcomes or rewards, particularly when these are valued. | Expectancy is the perceived probability of satisfying a particular need based on experience. Therefore nurses in leadership roles need to provide specific feedback about positive performance. |
| OB Modification | | |
| [**Luthans (2011)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1504) is credited with establishing the foundation for Organizational Behavior Modification (OB Mod), based on Skinner’s work on operant conditioning. | OB Mod is an operant approach to organizational behavior. OB Mod Performance Analysis follows a three-step *ABC* Model: *A,*antecedent analysis of clear expectations and baseline data collection; *B,* behavioral analysis and determination; and *C,*consequence analysis, including reinforcement strategies. | The leader uses positive reinforcement to motivate followers to repeat constructive behaviors in the workplace. Negative events that de-motivate staff are negatively reinforced, and the staff is motivated to avoid certain situations that cause discomfort. Extinction is the purposeful non-reinforcement (ignoring) of negative behaviors. Punishment is used sparingly because the results are unpredictable in supporting the desired behavioral outcome. |

in nursing terms, professional nurses can care for individual patients repeatedly, whereas each patient is a unique challenge. But with time and perspective, patterns emerge and nurses learn that these patterns lead to ways to control pain, engage family members in care at the end-of-life, and address a host of other issues. As healthcare providers are very focused on problems and predictable solutions, it is possible that reframing care to build on an individual, family, or community strengths presents quite a different perspective that unleashes solutions to complex problems and shifts human energy toward a positive outcome. Therefore complexity science expands the repertoire of nursing actions to include strategies that are multidimensional and with a different patient or organizational view.

In adaptive leadership, consistent with the definition of leadership provided earlier, the goal in responding to patient and organizational problems is to examine a problem through a different lens. This view might examine the “whole” that includes potential threats, exposes conflict, or challenges norms as part of the art of improvising change. An adaptive leader understands that systems are ecological—they restore themselves—and that change can happen equally from the bottom up or from the top down. One leads by entering the stream, not observing it and sitting off to the side to critique it. Questioning, observing patterns, and generating new patterns through being involved is how change unfolds. Imagine the power of social networking where no top-down leader exists. Rather, a series of powerful interactions and messages constantly shift to first re-create reality and then major social change. Adaptive leaders appreciate that they have influence and can help shape direction, with no sense that absolute control is either necessary or possible.

In complexity theory, traditional organizational hierarchy plays a less significant role as the “keeper of high-level knowledge.” It is replaced with decision making distributed among the human assets within an organization without regard to hierarchy. Less time is spent trying to control the future (which is not predictable anyway), and more time is spent moving toward and into energy while influencing, innovating, and responding to the many factors that are influencing health care. In complexity science, every voice counts and every encounter with patients and families emerge to co-create a desired outcome.

Change is an important dimension of leadership. **[Eoyang and Holladay (2013)](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml" \l "eid1474)** contrast three kinds of change, using performance appraisal as an example. The same example is used here, as each professional nurse is subject to an appraisal of performance. The first example is static change. A performance appraisal in this model is one where an annual overview of performance is described, with comparison to the performance of the previous year, against a set of defined goals and objectives. The second model is the dynamic change model. It is illustrated in the Research Perspective on p. 12. Contrary to the static model, this approach yields periodic feedback, enough that

 Research Perspective

**Resource:** Hauck, S., Winsett, R.P., & Kuric, J. (2012). Leadership facilitation strategies to establish evidence-based practice in an acute care hospital. *Journal of Advanced Nursing, 69*(3), 664-674.

A prospective comparative design was used to assess the effect of leadership facilitation strategies on beliefs regarding change, and use of evidence-based practice (EBP) as well as organizational readiness for change. A strategic plan to implement EBP in an acute care hospital was designed. All currently employed registered nurses (RNs) were surveyed at baseline and 2 years later following implementation. Three measures were used to assess beliefs, use, and organizational culture regarding EBP in their hospital. Baseline results demonstrated that direct care RNs perceived limited support from their unit directors. In response, an educational program was developed specifically for those in formal nurse leader roles. The follow-up measures demonstrated statistically significant improvement from baseline on beliefs and readiness regarding EBP, as well as meeting performance goals that were established in the strategic plan. The overall use of EBP in nursing practice improved but was not statistically significant. Evidence-based practice use was significantly lower in direct care nurses than those nurses in non-direct care who were not considered part of the management team.

Implications for Practice

This is an example of dynamic change, requiring individual attributes consistent with leading, managing, and following behaviors as new processes are designed and implemented in practice. The use of a well-developed plan with specific target measures and engagement of all RNs enhanced the effectiveness of this study. This study demonstrates how important it is for nurses in leadership roles to be well versed in EBP in order to facilitate EBP use by direct care nurses. Though the results of this study cannot be generalized to all facilities implementing EBP, they do demonstrate the importance of a well-designed plan with measurable outcomes.

it functions as a kind of thermostat and with work assignments that are marked with milestones, especially when meeting project deadlines or other work targets. The third change model is quite different. The dynamical model focuses on the interrelationship of the leader with feedback that is both regular (even daily) and summative (annually). The appraisal provides feedback relative to systems and interactions, and autonomy is given to move with opportunities that emerge, not just projects to be completed. These three change models represent that challenge in health care today: some work is static (predictable), much is dynamic (aimed at projects that interject incremental improvement), and some is dynamical (unpredictable and interactive). Adaptive leaders are driven by complexity science by nature of the shifting environment.

Historically, [**Marion and Uhl-Bien (2001)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1505) identified five ways in which complexity science encourages individuals to lead, manage, and follow. Those who use complexity principles:

Develop Networks

A network is any related group with common involvement in an area of focus or concern. Social networks are found within organizations but also beyond organizational boundaries. For example, a nursing program is not considered a part of the hospital or agency setting where clinical experiences take place; however, common interests (supply and preparation of a qualified workforce and demand for clinical services) make this network critically important for both organizations.

Encourage Non-hierarchical, “Bottom-up” Interaction Among Workers

As noted earlier, those who lead, manage, and follow may have responsibilities that are not served within the traditional hierarchy. Shared governance is an example of a decision-making structure in which staff at any level in the hierarchy are engaged in shaping policy and practices that affect patient care. In this model, each nurse is a valued human resource with rich perspective and possesses a voice in shaping direction.

Become a Leadership “Tag”

The term *tag* references the philosophic, patient-centered, and values-driven characteristics that give an organization its personality, the “energy” that it has; a tag is sometimes called an *attractor* or a *hallmark of culture,* similar to values. Although clinical organizations often perform similar procedures and functions, an intangible sense that this particular organization has a “caring” or “good energy” attractor differs from one where the sense is the focus on efficiency and cost only. The term *tag* refers to these distinctions.

Focus on Emergence

The concept of emergence addresses how individuals in positions of responsibility engage with and discover, through active organizational involvement, those networks that are best suited to respond to problems in creative, surprising, and artful ways—those who think “outside the box.” Emergence is tied to unleashing constructive energy rather than constraining energy.

Think Systematically

The principles of systems thinking theory have been characterized classically by [**Anderson and Johnson (1997)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1465) as:

* •*Thinking of the “Big Picture”* The nurse who looks past an individual assignment and comprehends the needs of all units of the hospital, or who can focus on the needs of all the residents in a long-term care facility, or who can think through the complications of emergency department overcrowding in an urban setting is seeing the big picture. These nurses have the ability to envision the context of their work beyond the immediate tasks.
* •*Balancing Short-Term and Long-Term Objectives* The nurse who recognizes the consequences of actions taken today on the long-term effect of the organization or patient care, such as the decision of a patient to terminate clinical treatment, can guide thinking about how to balance decision making for quality outcomes.
* •*Recognizing the Dynamic, Complex, and Interdependent Nature of Systems* All things are connected. Patients are connected to families and friends. Together, they are connected to communities and cultures. Communities and cultures make up the fabric of society. The cost of health care is linked to local economies, and local businesses are connected to global industries. Identifying and understanding these relationships helps solve problems with full recognition that small decisions can have a large impact.
* •*Using Measurable versus Nonmeasurable Data Systems* This thinking triggers a “tendency to ‘see’ only what we measure.” If we focus our measuring on morale, working relationships, and teamwork, we might miss the important signals that only objective statistics can show us. On the other hand, if we consider only numbers, (e.g., number of patients seen), we might miss a big perspective, such as lack of engagement in the workplace.

Exercise 1-3

Identify a clinical scenario in which a complex problem needs to be addressed. Who would you include in a network to engage in creative problem solving? How would you go about linking to other social networks if the problem was “bigger than” your immediate contacts? Identify one member of the network and map the potential connections of that individual that could influence problem resolution. Concentrate on the power of these influencing individuals. The patient/family is part of the network. What role would they play in co-creating the resolution strategies? How would you encourage non-hierarchical interaction among workers? Cite instances (personally or professionally) in which a small change in a system has had a big effect.

Tasks of Leading, Managing, and Following

When dealing with theory and concepts, we can lose sight of the practical behaviors that are needed to put these ideas into practice. [**Gardner (1990)**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1479) was the first to recognize this. He described tasks of leadership in his seminal book, *On Leadership*. The purpose of describing tangible behaviors associated with leading, managing, and following is to facilitate an understanding of the distinctions between the tasks and the definitions of leadership, management, and followership presented earlier in the chapter.

Gardner’s Tasks of Leadership

Gardner’s leadership tasks are presented in [**Table 1-1**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid992) to demonstrate that leading, managing, and following are relevant for nurses who hold clinical positions, formal management positions, and executive positions. Note that each role represents the interests of the organization, although the locus of attention is different.

Envisioning Goals

Leading requires envisioning goals in partnership with others. At the point of care, leading helps patients envision their life journey when health outcomes are unknown. It might help a patient envision walking again, participating in family events, or changing a lifestyle pattern. In the case of leading peers (not dissimilar to working with patients and family members), leader competence, trustworthiness, self-assuredness, decision-making ability, and prioritization skills envision crafting solutions to care delivery problems. Imagine leading a change to an electronic health record from a traditional paper record: the leader uses the aforementioned abilities to engage with, convince, or persuade colleagues about the relevance of this change and proceeds with setting direction. Envisioning goals is contingent upon trustful relationships, shared information, and agreement on mutual expectations.

Establishing a shared [**vision**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_044.xhtml#eid33590) is an important leadership concept. “Visioning” requires the leader to

Table 1-1 Gardner’s Tasks of Leading/Managing Applied to Practice, Management, and Executive Positions

|  | **Behaviors** | | |
| --- | --- | --- | --- |
| **Gardner’s Task** | **Clinical Position** | **Management Position** | **Executive Position** |
| Envisioning goals | Visioning patient outcomes for single patient/families; assisting patients in formulating their vision of future well-being | Visioning patient outcomes for aggregates of patient populations and creating a vision of how systems support patient care objectives; assisting staff in formulating their vision of enhanced clinical and organizational performance | Visioning community health and organizational outcomes for aggregates of patient populations to which the organization can respond |
| Affirming values | Assisting the patient/family to sort out and articulate personal values in relation to health problems and the effect of these problems on lifestyle adjustments | Assisting the staff in interpreting organizational values and strengthening staff members’ personal values to more closely align with those of the organization; interpreting values during organizational change | Assisting other organizational leaders in the expression of community and organizational values; interpreting values to the community and staff |
| Motivating | Relating to and inspiring patients/families to achieve their vision | Relating to and inspiring staff to achieve the mission of the organization and the vision associated with organizational enhancement | Relating to and inspiring management, staff, and community leaders to achieve desired levels of health and well-being and appropriate use of clinical services |
| Managing | Assisting the patient/family with planning, priority setting, and decision making; ensuring that organizational systems work in the patient’s behalf | Assisting the staff with planning, priority setting, and decision making; ensuring that systems work to enhance the staff’s ability to meet patient care needs and the objectives of the organization | Assisting other executives and corporate leaders with planning, priority setting, and decision making; ensuring that human and material resources are available to meet health needs |
| Achieving workable unity | Assisting patients/families to achieve optimal functioning to benefit the transition to enhanced health functions | Assisting staff to achieve optimal functioning to benefit transition to enhanced organizational functions | Assisting multidisciplinary leaders to achieve optimal functioning to benefit patient care delivery and collaborative care |
| Developing trust | Keeping promises to patients and families; being honest in role performance | Sharing organizational information openly; being honest in role performance | Representing nursing and executive views openly and honestly; being honest in role performance |
| Explaining | Teaching and interpreting information to promote patient/family functioning and well-being | Teaching and interpreting information to promote organizational functioning and enhanced services | Teaching and interpreting organizational and community-based health information to promote organizational functioning and service development |
| Serving as symbol | Representing the nursing profession and the values and beliefs of the organization to patients/families and other community groups | Representing the nursing unit service and the values and beliefs of the organization to staff, other departments, professional disciplines, and the community at large | Representing the values and beliefs of the organization and patient care services to internal and external constituents |
| Representing the group | Representing nursing and the unit in task forces, total quality initiatives, shared governance councils, and other groups | Representing nursing and the organization on assigned boards, councils, committees, and task forces, both internal and external to the organization | Representing the organization and patient care services on assigned boards, councils, committees, and task forces, both internal and external to the organization |
| Renewing | Providing self-care to enhance the ability to care for staff, patients, families, and the organization served | Providing self-care to enhance the ability to care for staff, patients, families, and the organization served | Providing self-care to enhance the ability to care for patients, families, staff, and the organization served |

engage with others to assess the current reality, determine and specify a desired end-point state, and then strategize to reduce the difference. When this is done well, the nurse and the patient or nurses within an organization experience creative tension. Creative tension inspires the patient and others to work in concert to achieve a desired goal. Shared visioning gives direction to accelerate change.

Affirming Values

[**Values**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_044.xhtml#eid33544) are the connecting thoughts and inner driving forces that give purpose, direction, and precedence to life priorities. An organization, through its members, shares collective values that are expressed through its mission, philosophy, and practices. Leaders influence decision making and priority setting as an expression of their values. People (either patients or peers being influenced by the leader) also use their values to achieve their goals, which are then manifested through behavior.

The word *value* connotes something of worth; intentional actions reflect our values. A leader continuously clarifies and acknowledges the values that draw attention to a problem and the resources in human and material terms to solve it. Values are powerful forces that promote acceptance of change and drive achievement toward a goal.

Motivating

When values drive our actions, they become a source of motivation. [**Motivation**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_044.xhtml#eid32577) energizes what we value, personally and professionally, and stimulates growth and movement toward the vision. Motivators are the reinforcers that keep positive actions alive and sustained, fueling the desire to engage in change. Theories of motivation identify and describe the forces that motivate people. Examples of motivation theory are presented in the [**Theory Box on Motivation on pp. 9–11**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid797).

Managing

The ability to manage is an important aspect of organizational functioning, because management requires determining routines and practices that offer structure and stability to others. This is especially true in certain positions of influence within a clinical setting, such as a nurse manager, clinical nurse specialist, or clinical nurse leader, all of whom share responsibility for creating effective structures that support clinical and organizational outcomes. Being effective as a manager requires behaviors different from those associated with effective leadership, and vice versa. Ideally, those charged with managing are good leaders and followers, because no organizational position is limited to one exclusive set of behaviors over another. Good leaders need management skills and abilities, and good managers need leading skills and abilities, and good followers need both skills too. The tasks of management are discussed on p. [**18**](https://jigsaw.vitalsource.com/books/9780323185776/epub/OPS/loc_004.xhtml#eid1243).