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When should a leader be directive or empowering? How to develop your own situational theory of leadership

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Abstract A situational theory of leadership attempts to match a particular leadership style or type to specific external circumstances. The general idea is that one type of leadership will be effective in one situation, but a different type of leadership will be effective in another situation. Historically, situational theories of leadership have been too abstract to apply to specific situations. Nevertheless, the concept of situational leadership retains considerable intuitive appeal. In this article we draw on our previous research about situational leadership during resuscitation in a trauma center, in order to derive a general strategy of how a leader can best develop his or her own personal theory of leadership which best works for their unique circumstances. The core of the strategic approach involves: (1) defining goals for a specific situation, (2) defining potential leadership types, (3) identifying situational conditions, (4) matching a leadership style to the particular situation, and (5) determining how the match between leadership style and situation will be made. The medical trauma center we profile provided an interesting example of how leaders considered elements of the situation to guide their own leadership.

1. Follow the leader

Q: What style of leadership is best?
A: It depends on the situation!

We've all heard that same old question hundreds of times, just as we've heard that same answer. What we really want to know is how a leader should behave. We want good leaders to lead us, and we want to be good leaders to others in turn.

There is an Old Norse word, *laed*, which means "to determine the course of a ship." We can easily see how our modern word, *lead*, comes from this ancient expression. In our imagination, we may actually picture ourselves standing at the stern, handling the tiller, and directing the rowers as we embark on our great adventure. This is classic leadership, command, and control: giving instruction and

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directions to others to achieve a common goal. We can even visualize the modern version of a leader as the person who determines the course of an organization.

But aren't there other types of leadership? For example, when we think of the charisma that Martin Luther King, Jr. displayed in his "I Have A Dream" speech, we intuitively recognize that as leadership. Moreover, in today's contemporary organizations, the notion of being "empowering" has received wide attention. Is leadership also the capability to empower others?

There are hundreds of definitions of leadership. No single description can completely encompass the concept; however, for the purposes of this article, we define leadership rather broadly as "influencing others." The main idea is that a leader is one who uses a variety of styles or behaviors to influence the behavior and thoughts of others. Further, based on our own research, we believe that specific leadership behaviors can be clustered together to form a "type" or a "style" of leadership.

The notion that a particular type of leadership might be best for a particular situation has been around for a long time. This concept is often called a "contingency" theory of leadership, or is sometimes referred to as a "situational" view of leadership. The fundamental assumption is that a specific type of leadership is likely to be more effective in a specific kind of situation. That is, leadership should be contingent upon the factors within the specific situation. Historical examples of contingency theories of leadership would include Fiedler's Contingency Theory (Fiedler, 1967), House's Path-Goal Theory of Leadership (House, 1971), and—especially in the popular literature—the Hersey and Blanchard Situational Theory of Leadership (Hersey & Blanchard, 1984). These theories have added to the leadership literature; yet, practicing managers often feel a need for more guidance when applying these theories to their own specific situations.

Herein, we deal with this problem by deriving a pragmatic strategy by which individuals can define their own situational theory of leadership to fit their particular circumstances. To accomplish this objective, we will first define five types of leadership which are well grounded in the research and leadership literature. Then, using a case approach based on real life situations, we will demonstrate how these types of leadership have been applied in a situational manner to a particular environment; that is, leadership in a medical trauma center. Finally, we will use the specific example of the trauma center to derive a more general approach so that any leader can define a personal situational theory of leadership.

2. Leadership types

Fundamentally, leadership means influence, or the ability to influence others. This is a broad definition, and includes a wide variety of behaviors intended to influence others. Typically, various kinds of leadership are categorized into typologies. These typologies specify different types of leadership whereby particular leaders' behaviors cluster together to form a type. Over the years, a myriad of leadership typologies have been proposed, and there is a wide variety of theories and typologies that one might choose as a fundamental framework. For example, Yukl (2001) discussed 10 different ways that leadership types or styles could be categorized. The use of types or styles is valuable because it enables all of us to develop a quick way of thinking about leadership. Each of us usually has our own version of leadership type that consists of a label or overall definition of that type, and also some notion of specific behaviors that make up that type. Almost everyone can begin with a simple categorization system that defines a task-oriented type of leadership versus a people-oriented type of leadership. However, most theories in both the academic and popular literature are somewhat more complex than this simple approach.

Currently, the leadership literature is dominated by the transactional-transformational paradigm. This categorization system defines two major types of leadership. *Transactional leadership* depends on the administration of rewards by a leader to influence a follower. In contrast, *transformational leadership* entails inspiration, and the transformation of a follower's motivational state. While there is some debate in the literature, many see charismatic leadership as a part of transformational leadership.

Recently, a theoretical and empirical analysis was conducted by Pearce et al. (2003) which articulated an extension of the transactional-transformational paradigm. Based on the historical literature and their research, they suggested five major types of leadership: (1) Aversive, (2) Directive, (3) Transactional, (4) Transformational/Charismatic, and (5) Empowering. The major contribution of their analysis was to clearly distinguish Empowering as a distinctive type of leadership that focuses on influencing others by developing and empowering follower self-leadership capabilities. The major advantage of using this typology is that it incorporates classical views of leadership (i.e., Directive and Transactional), the dominant contemporary view (i.e., Transformational/Charismatic) and, finally, a newer view (i.e., Empowering) based on modern theories of participation and self-management. We begin by presenting these five main leadership types: the Aversive, the Directive, the Transactional, the

Transformational, and the Empowering. Later, we will focus exclusively on the Directive and Empowering types, because these were the main types of leadership that we observed in our research regarding the actual leadership of trauma teams, which is our main example in this article.

When many think of leadership, the image of Jack Welch organizing and leading his GE troops against competitors may come to mind. This leader is not afraid to knock some heads to get followers to comply. We see a figure larger than life, who leads by commanding others. Often, this type is a combination of aversive and directive types, who uses a position of authority to force others to comply mainly out of fear. If the job is not performed as commanded, some significant form of punishment is delivered to the guilty party. The most common behaviors of the *aversive* leader include threats, intimidation, reprimand, and punishment. The *directive* leader is more benign, but still top-down, expressing leadership through direction, instructions, and command.

The *transactional* leader enters into an exchange relationship with others; he or she influences through the dispensation of rewards in exchange for compliance. The behaviors most frequently utilized and displayed by this leader center around personal and material rewards that are given in return for effort, performance, and loyalty. Followers take a calculative view of their work: "I will do what the boss wants as long as the rewards keep coming."

The *transformational* leader represents the most popular current view of leadership. This leader is characterized by a capacity to create a highly motivating and absorbing vision of the future, and has the capability to energize others to pursue the vision. Apple's Steve Jobs comes to mind as an example of this type. In the eyes of many, this leader is almost larger than life, and sometimes attains a mythic reputation. This is also a top-down type of leadership, whereby the leader is the source of wisdom and direction. The leader's power is based on a facility to generate a commitment from the follower, in response to the leader's vision and persona. This leader uses behaviors such as formulating and communicating a vision, exhortation, inspiration and persuasion, and challenge to the status quo. Often, this leader is seen as charismatic.

The final view of leadership is the *empowering* leader, one who leads others to lead themselves. Manz and Sims (2001) have termed this sort of individual as the "SuperLeader." With this type of leader, the focus is mainly on the followers. In fact, it is the strength of the followers that enables the leader to become "super." The leader's task is to help the followers develop their own self-leadership skills to contribute more fully to the organization. Most of all, followers need information and knowledge to exercise their own self-leadership.

The empowering leader encourages initiative, self-responsibility, self-confidence, self-goal setting, positive opportunity thinking, and self-problem solving. The empowering leader does not give orders, but encourages responsibility. The philosophy of empowerment is a perspective that reaches beyond heroic leadership. In the past, the notion of a leader implied that the spotlight was on him or her; the alternative viewpoint places the spotlight on the follower. These followers, in turn, experience exceptional commitment and ownership of their work. The essence of empowering leadership is the challenge to lead followers to discover the potential within themselves.

While all of these types of leadership can be important, most leaders want to have some sense of when a specific leadership type is likely to be more effective than another. In typical day-to-day situations, leaders often have to make decisions about how best to lead a group. For example, they ask themselves, "Should I be directive or empowering?" This specific question was apparent in our field research at a leading medical trauma center and represents the dilemma of whether a leader's objectives might be best achieved by giving a follower clear directions about how a task should be done, or whether a decision might be delegated to a follower. Overall, the leadership literature provides relatively little guidance regarding how this question might be answered in a particular context. To explore this question further, we will present ideas that were developed in our research on leadership within the medical trauma center. This particular trauma center is an organizational part of a major university medical center/hospital/medical school located in the mid-Atlantic region of the United States, and is generally considered one of the leading trauma centers in the world. It is a relatively large, full-service, and prominent facility, with both teaching and medical care roles.

3. Leadership in the trauma center

The primary purpose of a trauma center is to treat patients who have received some injury or trauma, most often a physical injury caused by a disruptive action such as a fall, car accident, or gunshot. As a secondary purpose, the trauma center serves as a training and educational organization that prepares medical professionals—especially residents—for further professional practice. Leadership is a salient issue in a trauma center. Consider the following hypothetical situation, adapted from

our research, which is relevant for every new attending surgeon that works in a trauma center:

> Tomorrow morning, you start your new job as attending surgeon at the Metropolitan Trauma Care Center. It seems like you've been waiting for this moment forever; first there was medical school, then a surgical residency, and finally, a fellowship. You feel fully qualified, and are excited about reporting for your first shift as an attending surgeon. You think about all the other attending surgeons whom you have encountered over the years, and how different each one of them has been. Certainly, there is no "cookie cutter" leadership approach that every attending surgeon subscribes to. So you think about yourself. Over the coming few months, you will have a choice of how you wish to behave. Your first patient is coming in through the door, and the resuscitation team is looking at you with an air of expectancy. You ask yourself, "*What kind of leader do I want to be*?"

Life in a trauma center ranges from periods of pure boredom to intense crises. A patient comes to the center, typically by ambulance or helicopter, and sometimes is in danger of imminent death. Indeed, despite the best efforts of the team, some patients do die. The main function of the trauma team is to stabilize the patient; that is, to make sure the patient's respiration and other vital life systems are working. This treatment is called resuscitation. Time is of the essence: trauma patients need to receive treatment within an hour from injury, or their body will go into shock and their chances of survival will be seriously reduced no matter what medical treatment is administered after that point.

The central organizational unit of the trauma center is the trauma resuscitation team, which is cross-functional and interdisciplinary. The team is composed of several medical specialists, including an attending surgeon, a fellow (a surgeon training to be an attending surgeon), an anesthesiologist, nurses, technicians (e.g., X-ray), surgery and trauma care residents (MDs training for a specialization), and medical students. The team is a short-cycle intense task force.

Each patient is treated by the trauma team in a sequence of events that is urgent and interdependent. For example, while the surgeon performs primary and secondary surveys of the patient, the anesthesiologist examines the airway and administers medication, the nurse inserts an intravenous line and reports on vital signs, and technicians provide various supporting tasks, such as X-ray. Team composition is fluid; members may come and go as needed, as multiple patients may be arriving and require immediate evaluation and treatment. Treatment is action oriented and under intense time pressure, and the team typically interacts with the patient for a half hour to several hours.

From a leadership viewpoint, the attending surgeon is the key figure on the team: the team leader. The attending is clearly in charge and directs the decision making in regard to the patient, as well as the task activities of team members. The goals of the attending are (1) to ensure a successful resuscitation, and (2) to offer learning opportunities for team members, especially the residents, or the MDs specializing in surgery. These goals—to ensure an optimal outcome for the patient and to ensure learning—can sometimes be in conflict and present a conundrum for the team leader. If one always optimizes patient safety 100%, then the leader—the attending surgeon, who has the greatest skill and expertise—would carry out most procedures. Yet, this would never provide an opportunity for the resident to develop new skills and knowledge. At some point, every resident must undertake a procedure for the very first time. From the leader's viewpoint, these conflicting goals present a challenge of deciding when the resident should be empowered to take charge of a patient.

This issue is not unique to trauma teams. Other urgent situations, characterized by rapid response and high reliability, face the same dilemma: aircraft flight teams, air controller teams, nuclear power operator teams, legal teams, and consulting teams are all examples. When should a leader be directive? When should a leader empower?

In the trauma center the attending surgeon is the formal leader, and can influence the team through various types of leadership. Even though team members may be highly trained in their own disciplines, the attending is the leader who has supreme authority, who organizes and coordinates the team efforts, and who is ultimately responsible for the entire team's performance (Yun, Faraj, Xiao, & Sims, 2003). As colloquially stated by one resident, "It's all on his or her credit card."

During the course of our research, we observed various types of leadership in the trauma center. The results presented here came to light via extensive ethnographic observation and interviews at the trauma center. We initiated our study guided by leadership theories, but without a specific theoretical orientation. The themes we offer emerged from 3 years of field work (see Yun et al., 2003 and Faraj and Xiao, 2006 for more details).

In the trauma care setting, we rarely found transactional leadership. Moreover, we did not find transformational/charismatic leadership. For example, attending surgeons seldom attempted to provide

overt inspiration and extra motivation to team members during resuscitation, perhaps because in this arena all of the team members were already professional, highly trained, and deeply motivated. This is not to say that attending surgeons were not charismatic to some degree, but this mainly stemmed from their position, and respect for their knowledge and reputation, rather than overt charismatic leader behavior.

On rare occasions, because of the stressful and urgent environment—and perhaps because of personality characteristics—an attending surgeon could be quite aversive. Aversive leadership includes yelling and shouting, unpleasant verbal reprimand, obnoxious task direction, and can sometimes entail vulgar language. For the most part, however, this type of behavior was relatively rare.

Much more common was directive leadership, whereby the leader personally determines the diagnosis, has his or her hands on the patient, makes treatment decisions, and gives information and task direction to members of the team. Typically, this leadership is undertaken in a firm and urgent tone, yet is respectful of the team members. This behavior is classic top-down leadership, with the attending surgeon clearly taking charge and assuming the role of centralized decision maker and task giver. Consider the following, as stated by an observer in the trauma center: "You see all kinds [of leadership]. Some of the doctors are very hands-on. . . . They immediately correct, if they see something wrong. . . .So you can see things going on and you know this doctor is going to react to that."

We also found a second type of leadership to be common. This type clearly fit the empowering model we defined earlier. In this leadership mode, the attending surgeon delegated decision making to a resident, who then became the leader of the team for that particular patient. This scenario is described by the trauma center's Chief of Surgery:

> What you really want to do is to get them just when they are getting ready to fall off the cliff and do something bad, and say. . .maybe you should give some thought to "X." When the residents call me and [say] "What do [you] want me to do with this patient?" I say, "What I want you to do is to be a doctor. I want you to go stand by the patient. . .consider the possibilities. . .and tell me what you think. . . .Then, we will discuss whether that is a good idea or a bad idea."

Empowerment of the resident develops over time. At first, the attending would require the resident to stand back and observe the treatment of patients. Often, the attending would speak out loud, describing the situation, the decisions involved, and the rationale for undertaking a particular procedure. This verbal behavior is a form of direction and instruction.

At the next stage, the attending would ask the resident for recommendations: "Dr. Jones, what should we do now?" The attending would listen and give feedback to the resident regarding the correctness and appropriateness of the resident's recommendation, but would still perform the hands-on procedures. In the third stage, the resident would perform the procedures, with the attending standing at the resident's shoulder, monitoring each decision and each task, providing direction and feedback only if necessary. In the fourth stage, the resident would have moderately full responsibility, with the attending surgeon standing back at the edge of the treatment bay, but still observing and then, later, providing post hoc critique and feedback. At the final stage, the resident would be given full responsibility, while the attending surgeon would still be available on the premises, but perhaps in another part of the trauma center. This last stage could be described as relatively full empowerment.

4. When to be directive and when to empower: A situational approach

Overall, we focus here on directive leadership and empowering leadership because these were the main types exhibited by the trauma team attending surgeons we observed. This finding led to the question of why a leader would sometimes be directive, and at other times, empowering. We first used qualitative methods, and then, later, a quantitative experimental approach to investigate this issue (Yun et al., 2003; Yun, Faraj, & Sims, 2005).

In our research, we observed many instances of both directive and empowering leadership on the part of attending surgeons, and noted that the particular situation often determined whether the leader was directive or empowering. The first and most important situational factor was the severity of the patient's injury. Was the patient's injury critical, or less threatening? Was the patient near death? As stated by an attending surgeon, regarding this matter:

> It depends on how critical the patient is. If the patient doesn't seem to be critical, you will see the fellow and the attending kind of roll out of the picture and [back] off, allowing team members to carry things on. But if it gets escalated and [the patient] gets more critical hypertension, you will tend to see the attending and the

> fellow at the bedside, and probably see the attending make all the calls. So, I guess it varies [how] critical resuscitations are. . .You try [and] allow people to learn how to do things.

An attending anesthesiologist raised the safety versus learning tradeoff even more directly:

> I try, with young healthy patients, to give [the residents] more latitude; with people who are sicker, I often warn them ahead of time that I'm going to have a very quick whistle on this one. If you don't get it right away, I'm going to have someone else do it, or I'm going to do it myself. By and large, the residents understand this.

We observed a clear pattern. The closer the patient's condition approached criticality, the more the leader tended to be directive. The logic in this finding is that a more severe injury required the highest degree of expertise that was available, and, that expertise was to be found in the attending surgeon. Moreover, time seemed to be a factor. Severely injured patients imposed more stringent time constraints. In contrast, when the injury was less severe, attending surgeons were much more willing to delegate decision making, hands-on treatment, and team leadership to the resident.

Another situational characteristic found to be an important factor in determining the surgeon's leadership was the degree of experience and expertise of the resident. Residents go through a time honored cycle in terms of the calendar and their learning curve. Typically, residents begin their one-year program on July 1. For the first month or two, their expertise is minimal, and typically they are not empowered to any significant degree. But as time goes by, the residents work hard and are exposed to a wide variety of patients, injuries, and conditions. They observe and receive instruction from the attending surgeons, and are generally eager to undertake decision making and procedures on their own. By the time several months have passed, their expertise has improved considerably, and the attending surgeons become more willing to empower the residents. When June arrives, residents are typically fully empowered, except under unusual circumstances. The main observation was that empowering leadership was critical in facilitating learning opportunities for the residents.

The two situational factors were not equally important in terms of their impact. While both were significant, the attending surgeons tended to emphasize severity of patient injury as the more important situational factor. Even for a long-term medical observer, such as a charge nurse, the specifics of the situation are the drivers: "It depends on the personality of who you are working with and what you need to get done. It just depends. . .on how sick the patient is, what you need to get done with the patient, how strong or weak the team is."

In summary, our research uncovered a contingency theory of leadership that seemed to be specific to the unique environment of the trauma center. When a patient's injury is severe and the resident's experience is low, attending surgeons are more likely to exercise directive leadership. When a patient's injury is less severe, and when the resident's experience is high, attending surgeons are more likely to exercise empowering leadership. This logic is represented by a decision diagram that is illustrated in Figure 1. This figure also represents a contingency theory, or situational theory, of leadership whereby the type of leadership depends on situational characteristics that are specific to a trauma center.

5. A general strategy for defining your own situational theory of leadership

A typical issue in regard to situational theories of leadership is the question of whether the theory is sufficiently useful to be applied in pragmatic situations. As an example, one might question whether the situational leadership theory developed as a result of the trauma center research might apply

Figure 1. How an attending surgeon selects a leadership style

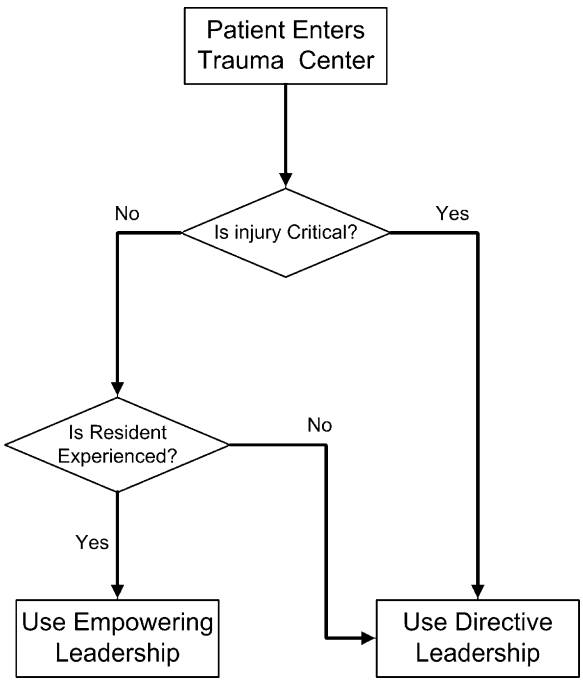

Figure 2. A general strategy to define your own situational theory of leadership

The general approach	The specific case of the trauma center
1. Identify important outcomes	Quality of patient treatment Learning opportunities
2. Identify leadership types/behaviors	Directive leadership Empowering leadership[1]
3. Identify situational conditions	Severity of patient trauma Experience of the team, especially the surgical resident
4. Match leadership to conditions	Use Empowering when: trauma is less severe team is more experienced Use Directive when: trauma is more severe team is less experienced
5. Making the match: How? Change the person in the leadership role to match the situation *or* The leader changes their behavior	 Changing the leader is not feasible in the trauma center The most effective attending surgeons change their behavior to match the situation

[1] Other types might be Transactional leadership & Transformational leadership

elsewhere. While we think the issue of tradeoffs between follower development versus optimal task performance is fairly common, we make no claims that the trauma center model should apply everywhere. However, our findings are likely to apply to similar situations whereby complex knowledge work is organized in teams, training is a core aspect of the process, and the inputs to the task are uncertain. For example, legal and consulting teams are often formed to bring together differentiated expertise. They may work on different projects each time, in the same way that each trauma patient is different. Such teams have differentiated expertise whereby the senior members (e.g., partners) are expected to train and guide the more junior members (e.g., associates). We believe, therefore, that the general strategy that we observed in the trauma center might be applied in other situations. We present a summary of this general strategy in Figure 2, and next describe each step in detail.

5.1. Step 1

Step 1 suggests that any leadership strategy should be dependent on the objectives that the leader wishes to achieve. In the trauma center, the objectives were relatively clear: the primary goal was to save patient lives and provide quality patient care, and the secondary goal was to provide learning opportunities to develop the capabilities and practice of medical professionals. Other situations may have different objectives. For example, we suggest that the objective of a sports team is to win, which in turn is often highly dependent on external motivation of the players. In contrast to the trauma center, some form of charismatic leadership might be quite appropriate in a sports team situation.

5.2. Step 2

Step 2 requires the identification of the types of leadership that might be appropriate in the particular situation. Because of the urgency of care and the potential risks to patient, the trauma center provided a focus on only two types of leadership, directive and empowering. A sales team, in contrast, might benefit from charismatic leadership. A prison situation might require directive or even aversive leadership to control destructive behaviors of the followers (inmates).

Clearly, a research and development situation requires creativity, so an empowering leadership might be most appropriate.

5.3. Step 3

Step 3 involves identification of the salient situational elements in the specific circumstances. In the trauma center, the severity of patient injury and the experience of the resident were the most important situational elements. Other elements might be important in other situations. A virtual team sited in multiple locations might be an important element suggesting a high degree of individual empowerment, yet would still require coordination and internal teamwork leadership behaviors.

5.4. Step 4

Step 4 entails matching a specific leadership style to the appropriate situation. Severe patient injuries and inexperienced residents need to be matched with directive leadership from the attending surgeon. A drill sergeant might also use directive behavior with a squad of inexperienced soldiers. Yet that same sergeant, when leading extremely well trained and experienced soldiers, such as Special Forces, might assign a high degree of autonomy. Special Forces are well known for making use of the most qualified individual, regardless of rank.

5.5. Step 5

Step 5 involves determining how the match between leadership and the situation might be made. In the trauma center, matching the behavior occurred within the individual leader; that is, inside the one person who can change his or her own leadership depending on the situation. In other circumstances, the actual leader might be changed. For example, a multi-divisional corporation might want a division general manager who is more directive in a downsizing or cost control situation. The same corporation might want a more empowering general manager to lead a division that is planning an expansion through the creative use of innovation and new product development.

6. Advantages and disadvantages of different leadership types

Based on the lessons learned from the trauma center, let us now take the five types of leadership and examine how a leader may use a situational approach to selecting a leadership style.

6.1. Aversive

Your objective is to improve the work habits of a problem employee. You have tried different styles of leadership in this situation, from providing clear direction (Directive) to offering rewards for better performance (Transactional). You have rarely used an aversive style of leadership because the disadvantages of this style include low flexibility, strong dissatisfaction, high turnover, rebellion, and low innovation among employees (Ball, Trevino, & Sims, 1994; Pearce et al., 2003; Podsakoff, Bommer, Podsakoff, & MacKenzie, 2006). However, in this situation, you feel that it is important to attract the employee's attention quickly and to emphasize goals that the problem employee must achieve. You have decided to adopt an aversive approach, and must now make the match between this leadership style and your behavior. You will have a private, somber meeting with the employee to let him or her know, in no uncertain terms, that he or she will be fired if there is no improvement. Most of all, during this meeting you will be serious and severe, just short of being gruff. You will make sure that the employee knows that this is a last chance opportunity, and that you will then be prepared to fire that employee if he or she does not change.

6.2. Directive

Your catering company has just landed its biggest contract yet: to provide a large banquet for the attendees of a fundraising auction. You hesitated to accept the contract at first, as the organization has given you short notice and your best line cook is away on vacation. However, you know that a successful outcome will provide excellent word-of-mouth referrals for your company.

You consider yourself, in general, to be an empowering leader, but in this situation you suspect that a more directive approach may be needed. A directive approach is called for when goals are clear, when the leader is considerably more experienced than the followers, and when short-term goals, learning, and compliance are more important than follower development. Similar to the aversive style, drawbacks to directive leadership include low flexibility and low innovation (Judge, Piccolo, & Ilies, 2004; Pearce et al., 2003). You decide to hire a temporary line cook for the occasion. This individual has arrived with strong skills, but is not interested in full time employment with your company. You make the match by providing very specific instructions to the temporary cook. You make it clear as to what you want done, and plan to be hands-on in the kitchen on the day of the event.

6.3. Transactional

You are the manager of a wholesale sales unit that employs a dozen salespeople. Top management has just handed down the target sales for this quarter. You decide that a transactional style of leadership may be the best way for your team to achieve its goals. A transactional style of leadership may be chosen when the leader has control, when turnover is low, and when the followers desire rewards. Disadvantages of this style of leadership include low innovation and emotion, as well as typically moderate motivation since it is dependent on rewards (Avolio, Bass, & Jung, 1999; Bass & Avolio, 1994; Podsakoff et al., 2006). With the concurrence of the Human Resources salary administration department, you set up an incentive program whereby each sales person has an opportunity to win a trip to Bermuda if they accomplish specific benchmarks.

6.4. Transformational/Charismatic

You have been appointed manager of a product design unit that has been riddled with internal conflict, and which is having difficulties with external liaison with other units in the company. You have observed considerable "turf wars" in your first month on the job, and feel that productivity is suffering as a result. An important, immediate goal is to improve relations among the members of your unit, as well as relationships with the other units of the organization. A transformational, or charismatic, style of leadership is called for. This style of leadership can be useful in situations in which high performance is required, or when a crisis looms. A leader will use a transformational style to generate excitement about a project and when a long-term commitment is needed. Unfortunately, followers may lose their motivation when the leader is absent. Also, a charismatic leadership style may lead to incorrect or unethical goals (Bass, Avolio, Jung, & Berson, 2003).

You decide to call the unit together as a group next Monday morning, and you intend to give them a speech and a "mission." In this speech, you will emphasize teamwork: both internal teamwork and external teamwork with the other units with which the product design unit interacts. You will emphasize how much more fun it is to work in an outfit that has strong team cohesion. You will deliberately be more "rah-rah" than you usually are, starting with standing on a stool when you begin the meeting. This is the time to go a bit over the top, to see if you can get a response. Of course, you will need to do a lot of follow-up to assure that teamwork is continually emphasized.

6.5. Empowering

Your research and development division hired two new employees last July. You have concluded that both have good fundamental skills, and a fairly high degree of initiative and internal motivation. You believe that both employees have the capacity to undertake expanded responsibilities and to work more on their own without close direction. To develop their creativity and flexibility, you adopt an empowering type of leadership. With this style of leadership, you expect high long-term performance, high follower self-confidence, high follower development, and very high innovation. Once established, this style of leadership works well in the absence of the leader (Manz & Sims, 1987, 2001; Srivastava, Bartol, & Locke, 2006). Empowering leadership may lead to some initial confusion or frustration. Therefore, with inexperienced followers, you would use empowering leadership only in non-emergent situations. As experience progresses, you may use empowering leadership in more emergent situations. The organizational context must also be considered, as empowering leadership may be at odds with the larger organizational culture.

With these factors in mind, you schedule a private meeting with each employee so that you can plan a program of expanded task responsibilities and self development over the next 6 months. Most of all, you tell yourself that it's time to back off a bit and give them significantly increased opportunities to undertake projects on their own, so that they can learn and gain more experience.

7. A summation

Contingency or situational theories of leadership deal with the notion that different circumstances call for different types of leadership. The general notion of situational leadership certainly has intuitive appeal to anyone interested in leadership. Many generic theories of leadership have been proposed over the years; yet, Podsakoff, MacKenzie, Ahearne, and Bommer (1995) characterized the empirical search for situational elements of leadership as similar to finding a needle in a haystack.

Our research has taken a different approach to situational leadership, mainly by investigating leadership within a specific environment. In the trauma center, our investigation uncovered strong evidence that attending surgeons did indeed differentiate their own leadership depending on the situation. We can speculate as to whether the results of our particular research project might apply to other

situations. The most straightforward linkage would be to organizational situations whereby emergency or crisis issues are salient; for example, fire fighting, cockpit emergency, or public safety. Yet we believe that these issues are also present in non-emergency, everyday organizational situations. In a software development team, for instance, we would expect that the degree of empowerment would depend on how timely and critical the project's due date is, and the experience of the development team. Overall, we would expect that leaders are generally less prone to empower others when subordinates are less experienced and when the particular project or task is absolutely critical to the organization. We would also expect that leaders are more likely to move to empowerment when they have a deliberate agenda to develop the skills and experiences of their followers.

We believe the most important contribution of our research is the discovery of a general approach to defining the specific situational elements within a particular environment, and developing guidelines of how leadership can be optimized within that environment. Any manager can, in fact, develop their own personal model of situational leadership that applies to their own situation. Indeed, there is an answer to whether you should be directive or empowering. Not surprisingly, *"It really does depend!"*

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