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Midlevel Nonclinical Healthcare Leaders' Awareness of Leadership Competence

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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by

Denise E. Wiseman

MBA, University of Phoenix, 2005

BS, Central Washington University, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Management

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Abstract

Effective leadership in healthcare improves the patient experience. Self-awareness drives leadership development, competence, and, in turn, leader effectiveness. The problem addressed by this study was the absence of knowledge regarding how healthcare leaders develop awareness of their leadership strengths and weaknesses: their competence. The purpose of this postintentional phenomenological study was to explore how healthcare leaders develop this awareness. Twelve midlevel nonclinical healthcare leaders from 3 hospitals in the Pacific Northwest region of the United States shared their experiences during semistructured interviews. Participants and their organizations contributed supporting documentation of competence and performance expectations. Following Vagle's postintentional process, data were reviewed holistically and then in detail in multiple iterations. A reflective plan, including a postreflective statement, created prior to data collection and reviewed throughout the study, elevated and abated researcher bias and potential for influence. This plan also served to question the emerging themes and contributed to the trustworthiness of the study. In response to the research question, the necessity of honest and constructive feedback and use of self-reflection to elevate understanding of leadership competence emerged. The shared participant experiences elevated five feedback mechanisms of greatest value: quantifiable results, person–person, recognized capabilities, environmental/relational, and self. Adoption of recommendations for practice, such as an improvement of performance-evaluation processes or the development of a feedback culture, could contribute to social change through the development of effective healthcare leaders. Honest and constructive feedback, with reflection, contributes to gained awareness and identification of developmental needs.

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Dedication

I dedicate this completed study and my efforts to my best friend and my loving supporter – to my husband, Jordan Wiseman. I love you. You challenge me to consider perspectives outside my lived experiences, listen when I talk around and through ideas, and encourage me to see myself the way you see me. You champion me, support me, and believe in me, thank you for your unfailing patience. I am grateful that you are in my life; you make me a better person.

I also dedicate this study to five individuals whose presence in my life brings me great joy. Brooklyn Knox, Ellisa Knox, and Laurel Knox – I love the three of you beyond words. Your futures are bright and I will always offer support and loud cheers as you go for your dreams. Taylor Wiseman and Shae Wiseman – I love you both and know you are capable of achieving great things. Your father and I will always champion your efforts, support your ambitions, and believe in you.

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Finally, I would like to acknowledge and thank friends and family who have supported me throughout this process. Many thanks to my parents, Joe and Judy Bell, and my sister Debra Knox. Your encouragement kept me going. To Diana Asahara, Jim and Amy Levy, Irene Pergamo, and Bill and Michelle Warfield – without your support, your friendship, and the many meals you fed me, this process would have been even more challenging than it was. Thank you.

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Chapter 1: Introduction to the Study

Healthcare systems require competent leadership to achieve positive patient outcomes and performance metrics. Effective leadership in healthcare improves patient satisfaction, reduces patient risk (McFadden, Stock, & Gowen, 2014; Wong, Cummings, & Ducharme, 2013), and maintains or improves the fiscal viability of an organization (Burritt, 2005). Although spending on healthcare in the United States outpaces that of most other developed countries (Squires, 2012), the quality of care is lower (Frakt & Carroll, 2013), increasing concerns for patient safety (Centers for Medicare and Medicaid Services [CMS], 2013). Healthcare in the United States lacks effective leadership (Longenecker & Longenecker, 2014) at a time when the need for effective leadership is increasing, as healthcare becomes more challenging and complex (Institute of Medicine, 2011). Healthcare leaders throughout the system must demonstrate leadership competence for the system to remain financially viable and for patients to receive quality and safe care.

Healthcare systems consist of clinical and nonclinical roles. Clinical roles include physicians, nurses, and ancillary care providers such as those from pharmacy, rehabilitative services, and radiology. Nonclinical job roles support the maintenance of the facility or the needs of clinical-care teams; staff with positions in information technology, finance, environmental services, and security have nonclinical healthcare roles. Healthcare researchers emphasize the importance of competence for clinical leaders (Ancarani, Di Mauro, & Giammanco, 2011; Zhang, Avery, Bergsteiner, & More, 2014), but few address the same for nonclinical leaders.

The focus of this research was the exploration of how midlevel nonclinical leaders recognize their personal leadership competence. This study entailed exploration of the career and life experiences leading to a developed awareness of personal leadership strengths and weaknesses. In this chapter, I cover the purpose of the study, provide a rationale for the social significance of the intended findings, define the meaning of leadership competence, identify the research question, and outline the methodology for data collection and analysis.

Background of the Study

Healthcare Leadership

Leaders influence individuals and organizations. Positive and effective leaders improve the job satisfaction, engagement, and emotional well-being of employees (Kara, Uysal, Sirgy, & Lee, 2013; Ngirande & Timothy, 2014). These satisfied and engaged employees, in turn, demonstrate improved work performance and customer satisfaction to those they serve (Amundsen & Martinsen, 2015; Menguc, Auh, Fisher, & Haddad, 2013). Healthcare leaders have the same influence on employees (Mosadeghrad & Ferdosi, 2013) and, in turn, on patient satisfaction (McFadden et al., 2014). Positive outcomes of effective leadership create an environment conducive to serving the organizational mission.

Improving the health of patients is the mission of healthcare. The positive influence of healthcare leaders on employees improves the healthcare experience for patients (Ancarani et al., 2011; McFadden et al., 2014). This positive experience extends to health outcomes (Price et al., 2014) and these health outcomes further extend to self-care improvement at home (Mehta, 2011). The healthcare experience includes the direct

patient care provided by clinical staff, as well as services provided by nonclinical personnel (Mehta, 2011).

Nonclinical departments provide the underlying support for clinical care (i.e., provisioning supplies, maintaining the building and infrastructure, or managing medical records). Operational failures, such as the unavailability of supplies or equipment, contribute to delayed delivery of care or risk to patient safety (Tucker, Heisler, & Janisse, 2014). Workarounds resulting from these operational failures add to the stress of a nurse's role (Tucker et al., 2014) and may contribute to the workload and stress of nurses that result in increased risk for errors in care delivery (Roth, Wieck, Fountain, & Hass, 2015). Nonclinical personnel also provide services directly to patients (i.e., food service or housekeeping workers) and have the potential to affect patient satisfaction with care (Amin & Nasharuddin, 2013). The healthcare system as a whole, inclusive of clinical and nonclinical subsystems, contributes to the patient experience. Thus, clinical and nonclinical leaders must be competent and effective to support the mission of the organization.

Researchers have demonstrated the need for and described the results of effective clinical leadership, specifically in nursing and physician leadership (Angood & Shannon, 2014; Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014). The behaviors of leaders affect the healthcare experience (McFadden et al., 2014) and patient satisfaction (Manary, Staelin, Kosel, Schulman, & Glickman, 2014). Clinical leadership is a well-supported factor in positive patient care; however, the role of nonclinical leader partners should not be undervalued. The perceptions of service quality from clinical and nonclinical personnel each correlate to patients' evaluations of their overall healthcare experience

(Mehta, 2011). Nonetheless, researchers have failed to explore the extent and method through which nonclinical healthcare roles influence patient-care quality, financial metrics, or regulatory-compliance indicators (Bain & Ward, 2014).

Leadership Competencies

Competence and competency (or competencies) are interrelated but distinct terms. Competencies are the skills, knowledge, or abilities necessary to fill the expectations of a job (Gruppen, Mangrulkar, & Kolars, 2012). Organizations often document these competencies in a job description and assess them during formal performance review. Competence is an individual's ability and motivation to meet these expectations proficiently without conscious effort (Gruppen et al., 2012). For researchers to study leadership competence, they must first understand the competencies of leadership.

The search to define characteristics and qualities of effective leaders has included qualities innate to an individual as well as those learned and developed through experience (Boyatzis, 1982, 2008; Goleman 1998/2004; R. Hogan & Warrenfeltz, 2003). Leading researchers and developers of competency models recognized and created similar categories of competencies (see Boyatzis & Saatcioglu 2008; Hogan Assessment Systems [HAS], 2009; Katz, 1955/1974; Korn Ferry, 2014; Sandwith, 1993). Collectively, these researchers identified the need for leaders to possess competencies in cognitive, technical, management, interpersonal, intrapersonal, and leadership domains; examples of competencies aligned to these domains appear in Table 1.

Cognitive, technical, and management competencies are *hard* skills (Rainsbury, Hodges, Burchell, & Lay, 2002) that rely on intelligence and knowledge of an industry and profession. Management competencies combine cognitive and technical knowledge

or skills and align across industries, differing where industry-specific needs differ. Interpersonal and intrapersonal competencies are *soft* skills; these competencies have been the focus of emotional- and social-intelligence research (Boyatzis, 2011; Goleman, Boyatzis, & McKee, 2013). Interpersonal competencies are those that build and maintain relationships (R. Hogan & Kaiser, 2005). Intrapersonal competencies are those characteristics of an individual that regulate responses, provide internal motivation, or develop an understanding of effect on others (Goleman et al., 2013; R. Hogan & Kaiser, 2005).

Table 1

Six Competency Domains of Leadership and Example Competencies

Domain	Competencies
Cognitive	Critical thinking
	Analytical thinking
	Problem solving
Technical	Time management
	Task-relevant knowledge
	Industry knowledge
Management	Maintaining quality
	Administrative activities
	Staffing/ HR management
Interpersonal	Collaboration
	Relationship building
	Social perceptiveness
Intrapersonal	Initiative
	Adaptability
	Self-awareness
Leadership	Coaching and developing individuals and teams
	Conflict resolution
	Creating a vision

The leadership-competence domain is a high-level domain comprising a combination of hard and soft skills to create the specific actions of a leader; leaders require soft skills to develop and apply hard skills (Weber, Crawford, Lee, & Dennison, 2013). The relationship between the hard and soft skills that create the domain of leadership appear in Figure 1. Collectively, the competencies from the cognitive, technical, managerial, interpersonal, and intrapersonal domains, when effectively blended, define the qualities of a leader.

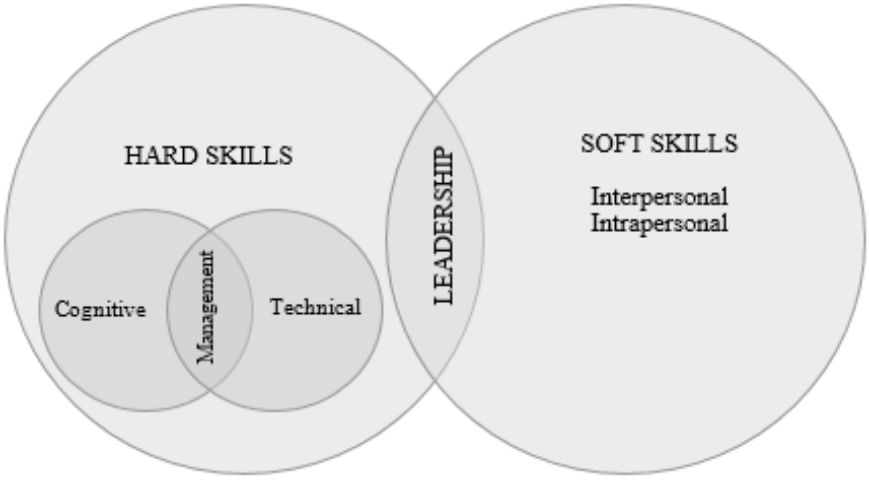

Figure 1. The author's depiction of leadership competency domains represented in the literature.

The management domain is the intersection of cognitive and technical competencies. These three domains are hard skills. Soft skills include interpersonal and intrapersonal competencies. The leadership-competency domain consists of those actions that combine hard and soft skills to create the actions of leadership.

Midlevel leaders require competence in all six domains of leadership (Garman & Scribner, 2011; Garman, Tyler, & Darnall, 2004; Liang, Leggat, Howard, & Koh, 2013). However, those healthcare professionals who transition from a technical or front-line role

to a leadership role are rarely prepared for the responsibilities: developing teams, communicating effectively, or managing change (Briggs, Cruickshank, & Paliadelis, 2012; Stoller, 2014; Townsend, Wilkinson, Bamber, & Allan, 2012). These leaders learn to meet the requirements of leadership through personal experience rather than developmental guidance (Grandy & Holton, 2013a). It is unsurprising, then, that as many as 75% of leaders may lack the necessary skills for their role (Gilley, Gilley, Ambort-Clark, & Marion, 2014; R. Hogan & Kaiser, 2005). However, it is concerning that as many as 89% of leaders believe themselves to be more competent than they are (Erker & Thomas, 2010). Understanding of how healthcare leaders align to this research, especially in light of the suggestion that they are ill prepared for leadership, is worthy of exploration.

Self-Awareness

Self-awareness is an important intrapersonal competency of leadership (Goleman et al., 2013; Korn Ferry, 2014). Self-awareness is the internal process of reflecting on one's performance with information from self-assessment, outcomes of work effort, and feedback from others (Morin, 2011). Improved self-awareness enables one to develop skill, knowledge (Vitello-Cicciu, Weatherford, Gemme, Glass, & Seymour-Route, 2014), and overall leadership competence (Patton et al., 2013). Self-awareness development requires understanding of performance expectations, a realistic self-assessment of performance, honest feedback from others, and internal reflection (Morin, 2011).

The progression of competence development follows a path beginning with gained consciousness of the need for a skill not currently possessed: that is, consciousness of one's incompetence (Manthey & Fitch, 2012). Self-assessment, other-assessment (feedback), and reflection develop this consciousness and identification of

strengths and weaknesses (Morin, 2011). Self-assessment alone is ineffective, as self-ratings of performance align less with actual performance than the ratings of others (Braddy, Gooty, Fleenor, & Yammarino, 2014). Other-assessed performance can assist individuals to improve their ability to self-assess (Krajc, 2008). Self-assessment, other-assessment, experience, and reflection can develop skill proficiency (Manthey & Fitch, 2012). In healthcare, improved individual leader self-awareness and overall leader competence has the potential to extend benefits throughout the system.

Although researchers have defined healthcare-leadership competencies in the literature (Healthcare Leadership Alliance [HLA], 2010a; Liang et al., 2013) and developed tools for the self-assessment of these competencies (American College of Healthcare Executives, 2015), they have not demonstrated that healthcare leaders are aware of or perform in alignment with these competencies. Additionally, researchers explored factors contributing to the development of self-awareness as a competency (Reilly, Dominick, & Gabriel, 2013; Vitello-Cicciu et al., 2014) or referenced self-awareness as critical to the development of other leadership competencies (Patton et al., 2013). However, researchers have not explored the development of an individual's awareness of their leadership competence (those across all domains identified in Table 1 and, more specifically, those in the domain of leadership) outside of a leadership-development program (i.e., in a natural setting).

Researchers described how leaders can develop an awareness of their strengths and weaknesses (Morin, 2011; Ryvkin, Krajc, & Ortman, 2012), but did not describe how an individual leader does develop their self-awareness throughout their career (Turner & Mavin, 2014). Though researchers supported the gained self-awareness from leadership-

development training (Day, Fleenor, Atwater, Sturm, & McKee, 2014), the literature lacks exploration of the experience of gained self-awareness by leaders. Further, healthcare-leadership research has focused on clinical leaders but lacks description and validation of the role of nonclinical leaders in the improvement of employee and organizational performance.

Problem Statement

Nonclinical healthcare personnel contribute directly and indirectly to the quality and safety of care provided to patients. The lack of supplies, malfunctioning equipment, or poorly performing technology hinders care provision and adds to the heavy burden of the nursing team (Tucker et al., 2014). Nurses have an increased risk of errors during care delivery when overwhelmed (Roth et al., 2015) and the contribution from failures in processes increases their workload (Tucker et al., 2014). Effective nonclinical leaders can enhance the performance of the people and processes they lead.

Self-awareness is a competency of leadership (Goleman et al., 2013; Korn Ferry, 2014) and necessary for leadership development (Avolio & Hannah, 2008; Baron & Parent, 2014; Nesbit, 2012; Patton et al., 2013). However, researchers have revealed a common deficiency in performance awareness (Zell & Krizan, 2014) that includes those in leadership positions (Erker & Thomas, 2010; R. Hogan & Kaiser, 2005). Despite abundant research dedicated to healthcare leadership and the development of these leaders, especially clinical leaders (see Ezziane, 2012; Leggat & Balding, 2013; G. P. Martin & Waring, 2012; Stanley, 2012), the literature lacks exploration of how these leaders develop an awareness of their personal strengths and weaknesses, and, specifically, how nonclinical leaders, a subset of healthcare leaders, develop this

awareness. The problem addressed in this study is the absence of knowledge regarding how healthcare leaders develop awareness of their leadership strengths and weaknesses: their competence.

Purpose of the Study

The purpose of this phenomenological study was to explore how healthcare leaders develop an awareness of their leadership competence. Examining this question outside of the confines of a leadership-development program or executive coaching allowed for a deeper exploration of the many paths along which this might occur. The target population for this research consisted of midlevel nonclinical healthcare leaders in midsized healthcare systems in the Pacific Northwest region of the United States. Nonclinical roles in a healthcare system provide the organizational foundation necessary for those in clinical departments to provide patient care. The selection of midlevel-leader participants was important for this study, as these leaders directly affect front-line staff, influencing their job satisfaction, productivity (McDonnell, Connell, Hannif, & Burgess, 2013; Townsend, Wilkinson, Allan, & Bamber, 2012; Yang, Zhang, & Tsui, 2010), and subsequent direct or indirect provision of care to patients (Wong et al., 2013).

This study has the potential to create positive social change, as leaders of local healthcare systems directly influence the communities they serve. These leaders are responsible for the care provided to patients, influence the well-being of those they employ, and offer a source of community economic stability as an employer. Additionally, though these leaders have little direct influence on the overall performance of the national healthcare system, the outcomes of their leadership on care quality and

financial metrics do contribute to the economic performance of the U.S. healthcare system.

Research Question

The research question that guided this study reflects the problem and addresses the purpose for this study: How do midlevel nonclinical healthcare leaders develop awareness of their leadership competence? The search to address this question included an exploration of the leadership skills, knowledge, abilities, and behaviors that midlevel nonclinical healthcare leaders perceived themselves to perform competently and how this perception was developed. The evidence study participants offered in support of their perceptions, through their stories of career growth and development and from exploration of behaviorally anchored responses, helped answer the research question.

Conceptual Framework

The framework for this research rested in the leadership development and effectiveness literature; specifically, in the necessity of self-awareness for personal development and effectiveness as a leader (Day et al., 2014; Leavy, 2016; P. Miller, 2012). Models of leadership development hold that self-awareness is a core competency critical to the developmental process (Korn Ferry, 2015; MacPhee, Chang, Lee, & Spiri, 2013; Nesbit, 2012; Seidle, Fernandez, & Perry, 2016). Self-awareness influences commitment to development of, and overall improvement in, skills and abilities (Karp, 2013; O. J. Sheldon, Dunning, & Ames, 2014; Vitello-Cicciu et al., 2014). Positive or ethics-related leadership theories—authentic, servant, and transformational—strongly correlate with emotional intelligence (Barbuto, Gottfredson, & Searle, 2014; Kotze & Nel, 2015; Ugoani, Amu, & Kalu, 2015). Authentic, servant, and transformational leadership

types correlate with effective leadership (Gotsis & Grimani, 2016), as does emotional intelligence (Lappalainen, 2015; Mills, 2009; Ugoani et al., 2015). Consistent across the research for these theories is the theme of self-awareness as a core element (Avolio & Gardner, 2005; Giolito, 2015; Sturm, Taylor, Atwater, & Braddy, 2014). Self-awareness is key to personal development and a critical component of effective leadership.

Theorists and researchers have frequently debated leader genesis: Are leaders born or made? (Matthews, 2015). Researchers suggest it is both. Genetic traits account for a substantial portion of leader emergence; as much as 32% (Arvey, Zhang, Avolio, & Krueger, 2007). However, environmental, experiential, and learned factors play a larger role (Arvey et al., 2007; De Neve, Mikhaylov, Dawes, Christakis, & Fowler, 2013). Development of leadership competence hinges on the recognition of strengths and weaknesses, purposeful reflection, metacognitive abilities, and self-awareness (Black, Soto, & Spurlin, 2016; Patton et al., 2013; Seidle, Perry, & Fernandez, 2016; Vitello-Cicciu et al., 2014). Self-awareness of performance is a continuous process of evaluation and adjustment based on internal and external cues. Work experience, formal classroom training, coaching or mentoring, and feedback all contribute to developing an awareness of one's own competence (Seidle et al., 2016). This developed consciousness occurs in stages: unconsciously incompetent, consciously incompetent, consciously competent, and unconsciously competent (Jung, Kim, & Reigeluth, 2016; Manthey & Fitch, 2012; Pillen, Brok, & Beijaard, 2013). These stages of development follow a path of awareness: initial awareness of competency and performance compared to expectations, developmental efforts to improve, and gained proficiency.

Leaders can positively or negatively affect their employees' level of stress (Yao, Fan, Guo, & Li, 2014), burnout (Steffens, Haslam, Kershreiter, Schun, & van Dick, 2014), and well-being (Wegge, Shemla, & Haslam, 2014). Also influenced by the quality of leader-employee relationships are employee job satisfaction, organizational commitment, and engagement (Kara et al., 2013; Ngirande & Timothy, 2014; Zhang et al., 2014). Satisfied, committed, and engaged employees show higher performance and productivity (Amundsen & Martinsen, 2015; Degago, 2014; Vogelgesong, Leroy, & Avolio, 2013). The effectiveness of leaders influences the work–life quality for employees and organizational performance.

A search for *effective leadership* in current research repeatedly points to the use of soft skills (Cherian & Farouq, 2013; Hopkins, O'Neil, & Stoller, 2015; Lappalainen, 2015; Taliadorou & Pashiardis, 2015). The soft skills of leadership are personality or behavior traits, influenced by the level of emotional intelligence one possesses. Emotional intelligence consists of self-awareness, self-regulation, motivation, empathy, and social skills (Goleman, 1995, 1998/2004) and is the process of appraising, regulating, and using emotions (Salovey & Mayer, 1990). Ethics-related leadership theories—authentic, servant, and transformational—include the characteristics of emotional intelligence (Barbuto et al., 2014; Kotze & Nel, 2015). The common themes for emotional intelligence, authentic leadership, servant leadership, and transformational leadership are their correlation to effective leadership and self-awareness as a core element (Avolio & Gardner, 2005; Giolito, 2015; Sturm et al., 2014). Self-awareness is a critical component of effective leadership (Day et al., 2014; Leavy, 2016; P. Miller, 2012).

Self-awareness is a strong theme in the study of leadership emergence and development, and other factors influence the development of self-awareness. Though acknowledged as influencing both leader development and effectiveness, these factors are not directly included in the conceptual framework of this study. These other factors include self-efficacy, self-confidence, self-esteem, psychological empowerment, self-determination, leader identity, self-concept, and core self-evaluation (CSE). One or more of these interrelated concepts can hamper or enhance valid perceptions and self-awareness of one's strengths and weaknesses. In this study, consideration of these variables' influence, in conjunction with the primary conceptual framework, were important to the identification and further exploration of themes. Chapter 2 contains an exploration of these other influential factors in addition to more detailed review of leadership development, leadership effectiveness, and self-awareness.

Nature of the Study

Phenomenology was the selected qualitative method for this study. The development of self-awareness of leadership competence is an understudied phenomenon; therefore, an exploration of participants' lived experiences of this phenomenon was appropriate to aid understanding. Competency and self-awareness are dynamic concepts, each shifting with internal (skill development and reflection) and external (change in technology or processes and feedback) variables. The use of Vagle's (2014) postintentional approach, rather than an approach such as the Stevick-Colaizzi-Keen method described by Moustakas (1994), was best suited to my study because of the dynamic relationship of the phenomenon for those who experience it.

Leaders in midsized healthcare systems in the Pacific Northwest region of the United States participated in this study. In these organizations, midlevel nonclinical healthcare leaders were the intended population. The snowball-sampling method created a participant pool that included leaders perceived as competent by other leaders. Inclusion criteria minimized the influence of experience from a prior career outside of healthcare and ensured leaders have had adequate time in a leadership role to achieve a degree of competence.

Interviews served as the primary data-collection method, along with workspace observation and document review. Observation of participants' offices or personal workspaces was part of the in-person interviews. These observations contributed to the data obtained from participant interviews, supporting self-development from visibly displayed resources (e.g., books or certificates), recognition of effective performance (e.g., rewards), or motivational quotations or mementos (Maxwell, 2012). I also collected organizational documents in the form of job descriptions, performance-evaluation forms, and participant résumés. To help identify the competencies participant leaders perceive as their strengths, collected documentation included resumes. Other data sources included field notes, postinterview summary sheets, reflective journaling, and memoranda.

Researcher reflexivity and thick description helped maintain research quality, capturing perceptions and thoughts regarding the data in advance of data collection and throughout the study. This reflective information helped me identify and minimize the impact of my bias, correct research-process errors, and monitor my influence on the study's findings. The use of thick description provided an auditable research flow and added depth of meaning to the analysis of data. In addition, I included recommendations

from Gibbs (2007) regarding research methods to enhance dependability: detailed field notes, quality audio recordings, consistency in the transcription method for each interview, and validation of interview transcripts against audio recordings. Careful documentation of the methodology increased trust in the outcomes of the research.

Definitions

Competence: The possession of the knowledge, skills, and inner motivation to skillfully, and without conscious effort, complete a task or demonstrate a behavior (Boyatzis, 1982; Gruppen et al., 2012).

Competency (competencies): The expected knowledge, skills, abilities, and behaviors required for a role or position in the workplace (Gruppen et al., 2012).

Core self-evaluation (CSE): The evaluation one makes of one's self-worth, abilities, and competence. Self-esteem, self-efficacy, emotional stability, and locus of control comprise this evaluation (Chang, Ferris, Johnson, Rosen, & Tan, 2012; Judge, Erez, Bono, & Thoresen, 2003).

Leader identity: Personally identifying oneself as a leader or perceiving that one demonstrates leadership competence (Day & Harrison, 2007).

Leadership: A process of effectively using interpersonal and intrapersonal skills (soft skills) in combination with cognitive, technical, and management skills (hard skills) to motivate, influence, inspire, and support followers to achieve shared goals (Citaku et al., 2012; Grandy & Holton, 2013a, 2013b; Guo, 2009).

Psychological empowerment: The granted or psychologically perceived sense of having authority or being capable to make decisions or perform actions without oversight (Avidov-Ungar, Friedman, & Olshtain, 2014; Fung, 2014).

Self-awareness: An awareness of personal strengths and weaknesses. Self-awareness entails an internal focus in which individuals compare their performance to the standards or expectations of performance (Silvia & Phillips, 2013).

Self-concept: The perception of current ability based on demonstrations of past performance (Hughes, Galbraith, & White, 2011).

Self-confidence: A belief in one's abilities to perform or meet expectations, even in the absence of direct evidence of such ability (Bandura, 1997).

Self-determination: A theory that autonomy, competence, and relatedness are psychological needs that, when met, can motivate improved performance (Deci & Ryan, 2000).

Self-efficacy: The belief in one's ability to perform a task or demonstrate necessary behavior competently, today and in the future (Hughes et al., 2011).

Self-esteem: The degree to which an individual likes who they are and deems themselves worthy (Hollenbeck & Hall, 2004). Self-esteem results from a judgment of self-worth and the emotional results of that judgment (DeLisi, Jones-Johnson, Johnson, Hochstetler, 2014).

Assumptions

Assumptions are those aspects of a study the researcher presumes will be available or manageable and are necessary for the study to occur or to provide findings of value (Roberts, 2010). In anticipation of this qualitative study, six assumptions emerged. Three could affect the ability to perform this study and three could influence the quality of the findings. First, I assumed that at least two healthcare systems in the Pacific Northwest region of the United States would grant approval for participation in this study.

Then, senior and peer leaders would be able to identify competent midlevel nonclinical leaders and an adequate number of these leaders would meet the inclusion criteria for the study to achieve data saturation.

Of influence to the quality of the study was the willingness of participants to share organizational and personal documents such as résumés, job descriptions, and performance-evaluation tools. Additionally, I assumed participants would be open and honest in their responses to interview questions. The final assumption was that I would be able to minimize my bias or influence.

Mitigation methods diminish the risks of erroneous assumptions. To gain the support of organizations and the participation of senior-leader sponsors, I assured the sponsors that the identities of each organization and individual participant would remain confidential. The use of more than one midsized healthcare system provided an adequate pool of participants. To mitigate risk to the quality of the research, I worked to maintain an interview environment that encouraged open and honest dialogue. Dedicated focus on reflexivity and maintaining an open and phenomenological perspective minimized my influence; that is, seeking unique experiences rather than similarity.

Scope and Delimitations

Delimitations define the scope of the study, clarifying what is included or excluded (Roberts, 2010). The scope of this research study purposefully included only midlevel nonclinical leaders working in midsized healthcare systems. For the purpose of this study, I defined midsized healthcare systems as containing an acute-care hospital licensed for 225 to 450 beds and may include satellite clinics. Participant-selection criteria further delimited the study, using the snowball-sampling method and validation of

each potential candidate against inclusion criteria. The healthcare-system definition and participant-selection criteria reduced variability caused by organization or career dissimilarity. Data-collection methods included two in-person interviews; workspace observation; and document review (résumés, job descriptions, and performance-evaluation processes and forms). To enhance the trustworthiness of the study, I ensured process consistency, thick description, and researcher reflexivity.

Limitations

This study had five known limitations that required consideration of method selection and mitigation efforts to reduce their influence during data collection and analysis: researcher familiarity with the phenomenon (risk to bias), social-desirability bias, false self-assessment of performance (the Dunning–Kruger effect), halo effect from the inclusion criteria, and small study sample. As the researcher for this study, I was the source of the first limitation. My background in healthcare includes leadership roles in multiple nonclinical departments. Having worked in healthcare as a midlevel nonclinical leader, unintended researcher bias risked influencing the findings of this study. To reduce this risk, I documented my beliefs before the study began. Reflective writing during the study assisted in understanding the influence of my bias and identified connections and dissimilarities between my biases and the data from participants. This process helped to question developing themes. Purposeful exploration of findings that differed from the documented preconceptions helped minimize the potential of my influence. A further resource to assist in reducing the influence of my bias was the oversight provided by my dissertation committee. My committee had access to my journals and memoranda to affirm the processes followed and discuss issues.

Social-desirability bias and false self-assessment of performance were probable influences on the trustworthiness of participant responses. Social-desirability bias is the potential for participants to knowingly respond untruthfully to meet social expectations (A. L. Miller, 2012). False self-assessment of performance is the inaccurate perception of performance, typically a false positive perception (Schlosser, Dunning, Johnson, & Kruger, 2013). To mitigate the influence of these potential limitations, I asked participants to provide descriptive evidence of their perceived competence. Additionally, as participants accrued through use of the snowball sampling method, leaders who identified participants were asked to describe the competence of those they recommended. This information provided comparative data. To address socially desirable responses, I gave participants the promise of full confidentiality as a means of encouraging them to provide honest responses to all questions.

A further limitation of this study was the narrowed scope and small study sample. The narrowed scope allowed for depth of data collected from each participant, but also limited the ability to generalize beyond the study participants. The participant sample has importance to broadening understanding of leadership in healthcare; that is, the experiences of nonclinical leaders and the development of competence self-awareness. However, as the participant group was the first to participate in such a study, I had no ability to compare and contrast the findings. This study offers descriptive and interpretive findings of benefit to future researchers; thus, I accepted the limitation.

The final limitation was the halo effect or participant bias that may occur from the study inclusion criteria. The inclusion criteria required each midlevel participant to perceive himself or herself as competent and another leader to perceive them as

demonstrating leadership competence. To mitigate the potential halo effect, I collected multiple sources of data. Additionally, I did not share the explanation of competence provided by the senior or peer leader with the midlevel participant. Further, I explored statements of competence from the individual participants through behaviorally anchored follow-up questions.

Significance of the Study

This study enhances the topic of leadership broadly, and healthcare leadership specifically, by contributing to a greater understanding of how self-awareness of leadership competence develops. This greater understanding contributes to the growing literature focused on leadership development. By narrowing the focus to midlevel nonclinical healthcare leaders, the study contributes knowledge about this understudied population.

Significance to Practice

Technical competence may lead to career advancement into leader-level positions. Technical workers carry different expectations from leaders, and when promoted, often lack preparation and training for the differences (Erker & Thomas, 2010; Spehar, Frich, & Kjekshus, 2012). My study raises an awareness of the leadership competencies that healthcare leaders perceive they possess and identifies leadership-development opportunities. This awareness may further contribute to preparatory efforts in advance of promotion.

Significance to Theory

Much research has focused on the importance of clinical leadership (Angood & Shannon, 2014; Daly et al., 2014; Storey & Holti, 2013), whereas the role of nonclinical

leaders remains understudied. The efforts of those in clinical and nonclinical roles influence patient perceptions of the care experience (Mehta, 2011); Golanowski, Beaudry, Kurz, Laffey, and Hook (2007) declared a need for collaboration between clinical and nonclinical healthcare operations. My study contributes to reducing the gap in the literature regarding nonclinical leadership in healthcare.

Also understudied is the awareness of healthcare leaders to the competencies of leadership and their personal performance to meet these expectations. Self-awareness of one's strengths and weaknesses enhances the development of these competencies (Vitello-Cicciu et al., 2014). In advance of further competence self-awareness research, research is necessary to understand leadership competencies that healthcare leaders believe they possess and can identify. This study contributes to this understanding.

Significance to Social Change

Findings from this study have the potential to contribute to positive social change through the gained knowledge of leadership-competence self-awareness of healthcare leaders. Healthcare leaders influence the performance and financial viability of their organizations. These leaders also influence the well-being of followers. Competent leaders reduce work stress, improve engagement and job satisfaction, and contribute to employees' positive mental state. Further, healthcare leaders influence the medical experience and outcomes of patients. The competent performance of healthcare leaders reduces patient-safety concerns and improves patient-satisfaction and experience measures. Contributing to the knowledge of healthcare leaders' competence self-awareness may influence change in the preparation and development practices of these leaders. This enhancement to healthcare leadership may contribute to the viability of

individual healthcare systems, improve national healthcare measures, benefit employee well-being, and enrich patient care and outcomes.

Summary and Transition

Positive patient outcomes and successful performance metrics require competent leadership throughout a healthcare system. Leaders need self-awareness to develop competence, but many lack this quality; a vast majority of leaders believe themselves to be more competent than they truly are. In a complex healthcare system, competent leaders at all hierarchical levels and across clinical and nonclinical subsystems can best respond to and manage many internal and external pressures. Competent leadership is critical, and competence develops through self-awareness.

This chapter provided support for the completion of this study. The background provided an overview of preceding research that contributes to the identified problem under investigation and purpose of the study. The conceptual framework and intended methodology defined how the study would provide answers to the research question. The following chapters of this dissertation contain a review of the literature and the methodology, a description of the results, and a discussion, concluding with recommendations for additional research and practice.

Chapter 2: Literature Review

Healthcare systems comprise a number of diverse professionals working together to ensure the health of the patients they serve. These individuals include those with direct patient-care responsibilities (clinical professionals) and those with indirect or no patient-care duties (nonclinical). Much research in this area has focused on clinical leadership: Researchers have demonstrated that effective clinical leadership contributes to better organizational performance and improved patient outcomes (Wong et al., 2013). However, equal study of the value of effective leadership by those who lead nonclinical departments was unavailable. Leadership competencies are similar across professions with the exception of industry-specific knowledge and technical skills (Boyatzis, 1982; HAS, 2009; Korn Ferry, 2014). Additionally, researchers have recorded the contribution of effective leadership to employees and organizations across multiple industries and cultures (Mosadeghrad & Ferdosi, 2013; Ngirande & Timothy, 2014; Steffens et al., 2014; Yao et al., 2014). Clinical and nonclinical contexts in healthcare require competent leaders.

Self-awareness is a competency of leadership (Goleman et al., 2013; Korn Ferry, 2014) and necessary for leadership development (Avolio & Hannah, 2008; Baron & Parent, 2014; Nesbit, 2012; Patton et al., 2013). However, researchers have revealed a common deficiency in performance awareness (Zell & Krizan, 2014) that includes those in leadership positions (Erker & Thomas, 2010; R. Hogan & Kaiser, 2005). Despite abundant research dedicated to healthcare leadership and the development of these leaders, especially clinical leaders (see Ezziane, 2012; Leggat & Balding, 2013; G. P. Martin & Waring, 2012; Stanley, 2012), the literature lacks exploration of how these

leaders develop awareness of their personal strengths and weaknesses, and, specifically, how nonclinical leaders, a subset of healthcare leaders, develop this awareness. The problem addressed in this study was the absence of knowledge regarding how healthcare leaders develop awareness of their leadership strengths and weaknesses. The purpose of this study was to explore how healthcare leaders develop awareness of their leadership competence.

This literature review contains sections that define the concepts and theories relevant to the focus of the study and provides support for the conceptual framework. This chapter includes definitions of core concepts of competence, leadership, and self-awareness, as well as the connection between these concepts and their importance in healthcare. The guidance of principal researchers in the field define the competencies of leadership (i.e., Boyatzis & Saatcioglu, 2008; HAS, 2009; Katz, 1955/1974; Korn Ferry, 2014; Sandwith, 1993), validated through analysis of 16 leadership-competency models (see Appendix A). The literature review concludes with a brief overview of integrated concepts and theories in the study of competence: self-efficacy, self-confidence, self-esteem, psychological empowerment, self-determination, leadership identity, self-concept, and CSE.

Literature Search Strategy

The core concepts of this study interrelate and span industries; they are not unique to healthcare. Therefore, this review of literature offers a broad, industry-nonspecific examination of the concepts, in addition to a narrowed focus on healthcare. The broad focus was beneficial, as few studies center on the competence of nonclinical healthcare leaders or the self-awareness of healthcare leaders in general. The keyword and

combination keyword searches included competence, competency, competencies, leadership, healthcare leadership, self-awareness, confidence or self-confidence, self-concept, self-efficacy, self-esteem, core self-evaluation, self-determination, empowerment or psychological empowerment, leadership identity development, and emotional intelligence.

The leading source for the article selection was Google Scholar. This database linked to the Walden University Library and the databases available in ProQuest, ProQuest Dissertations, and Walden University dissertations, found directly in the Walden University Library. Table 2 depicts, for those sources included in this literature review, the category type of literature searched and number of associated documents. I reviewed hundreds of additional resources but did not include them in this literature review due to their lack of relevance, the date of the source (beyond the guideline for research within 5 years of anticipated graduation date), or other exclusionary reasons.

Table 2

Literature Source Categories

Category	Date range	Number of sources
Peer reviewed	Earlier than 2000	7
	2000–2011	67
	2012–Current	144
Not peer reviewed	Earlier than 2000	2
	2000–2011	4
	2012–Current	15
Dissertations	2011	1
Books	Earlier than 2000	6
	2000–2011	3
	2012–Current	3
Other	Earlier than 2000	1
	2000–2011	10
	2012–Current	18

Conceptual Framework

The necessity for self-awareness in leadership development and effectiveness created the framework for this research (Day et al., 2014; Leavy, 2016; P. Miller, 2012). Self-awareness is a competency required for leadership development (Korn Ferry, 2015; MacPhee et al., 2013; Nesbit, 2012; Seidle et al., 2016) and the commitment to develop skills and abilities (Karp, 2013; O. J. Sheldon et al., 2014; Vitello-Cicciu et al., 2014). The ethics-related leadership theories of authentic, servant, and transformational, and emotional intelligence correlate with effective leadership (Gotsis & Grimani, 2016; Lappalainen, 2015; Mills, 2009; Ugoani et al., 2015) and share the theme of self-awareness as a core element (Avolio & Gardner, 2005; Giolito, 2015; Sturm et al., 2014). Self-awareness is key to personal development and a critical component of effective

leadership. Chapter 1 included a concise review of this framework; this chapter elaborates on these concepts and their relevance to healthcare leadership.

Defining Competence

Researchers use the terms competence and competency interchangeably throughout the literature, but the terms have decidedly differing inferences in the study of the skills, knowledge, and abilities necessary for the workplace (Gruppen et al., 2012), justifying the need for clarification. *Competence* is specific to the performance of an individual, whereas *competency (competencies)* is the expected skills or attributes necessary for a job. For example, competencies include the typing speed required for a role as a transcriptionist, the strength of a weld for a position as a welder, or the engagement level of direct reports for a role as a manager. Competence is, in part, the capability to perform job-related competencies, but the possession of knowledge, skill, and ability does not guarantee competent performance. Individuals may possess ability but choose not to perform due to lack of motivation or belief in their ability (Boyatzis, 1982; McDaniel & DiBella-McCarthy, 2012). Ability and motivation combine to produce performance. However, one further element remains to the definition of competence: the level of proficiency demonstrated.

A variety of terms describe the level of proficiency that equates to competence (e.g., adequate, effective, or superior), thereby, suggesting a scale of skill development. Research in the development of competence references distinct stages of learning (Manthey & Fitch, 2012; Pillen et al., 2013). These stages begin with an unconscious lack of skill, followed by an awareness of performance expectations and initial skill development, and conclude with expert and unconscious performance of behavior

(Manthey & Fitch, 2012; Pillen et al., 2013). Therefore, competence is the possession and application of knowledge, skill, ability, and motivation to effectively complete a task or demonstrate a behavior proficiently without conscious effort.

Leadership Competencies

To develop competence, one must first understand the knowledge, skills, and abilities (competencies) of leadership. A job title alone does not define a leader. Rather, possessing and demonstrating the qualities of leadership defines a leader (Sampson, 2011). Citaku et al. (2012) characterized leadership as a "complex multifaceted phenomena that is widely observed but poorly understood" (p. 2). Others (Metcalf & Benn, 2013; Van Wart, 2013) echoed this sentiment. Efforts to define these characteristics have evolved and prompted debate regarding whether leaders are born or made.

Leadership research in the early 20th century sought to ascertain the personality traits possessed by a leader (e.g., the Great Man theory) (Hoffman, Woehr, Maldagen-Youngjohn, & Lyons, 2011), or to associate body type (endomorph, mesomorph, or ectomorph) to leadership characteristics (Sheldon, 1942, as cited by Coffin, 1944) to detect the genesis of leaders. Researchers presumed a leader is an individual "endowed with magic attributes" (Knickerbocker, 1948, p. 24): leaders were born rather than made. Coffin's (1944) assessment of leadership characteristics identified 11 categories of leadership traits in which 83 individual traits resided. These traits included (a) physical (e.g., size and strength), (b) mental (e.g., intelligence and imagination), (c) interpersonal, and (d) intrapersonal characteristics. Though heavily focused on the relationship of body

type to leadership characteristics in the study, Coffin's trait identification initiated a categorization of leadership characteristics.

Researchers began to support the made-rather-than-born argument of leader emergence when exploring leadership behaviors: competence replaced the focus on traits (Boyatzis, 1982; Sandwith, 1993) and the field of research grew in the study of leadership development (see Day et al., 2014 for an overview). However, researchers focused on personality (Colbert, Judge, Choi, & Wang, 2012), physical attributes (Judge & Cable, 2004), and other trait-like characteristics (Cuadrado, Navas, Molero, Ferrer, & Morales, 2013; Walter & Scheibe, 2013). These traits have remained in the literature with evidence to support their influence on leader emergence. In further exploration of an answer to born or made, researchers in studies of twins determined that genetic traits are determinant factors in leader emergence (Arvey et al., 2007; De Neve et al., 2013). These studies also found that environmental factors were influential; thus, environmental conditions can modify the behaviors of an individual, regardless of their innate automatic response (Arvey et al., 2007; De Neve et al., 2013). Trait-like (e.g., personality and intelligence) and state-like (e.g., developed knowledge and skill) characteristics combine to determine the behavior of leaders (DeRue, Nahrgang, Wellman, & Humphrey, 2011; Hoffman et al., 2011). Thus, leaders are both born and made and the expected competencies of leadership will include trait- and state-like characteristics. As Citaku et al. (2012) expressed, the qualities and characteristics of leadership are multifaceted.

Competency Models

Coffin (1944) organized the traits of leadership into categories; similarly, researchers use competency models to categorize the skills, knowledge, and abilities that

define leadership. Competency models provide a method to organize and categorize the knowledge, skills, behaviors, and abilities required for a profession or particular role, grouping those competencies with similar characteristics together. Though each competency model is unique, similarities across competency models for leadership are greater than the differences. A review of the leadership-competency categories presented by principal researchers supports six competency domains: cognitive, technical, management, interpersonal, intrapersonal, and leadership. Table 3 represents the alignment of the domains depicted by each researcher to the six domains defined for this study. Though the domain names differ, the meaning is consistent.

Table 3

Core Leadership-Competency Domains

Leadership competency domains	Katz (1955/1974)	Sandwith (1993)	Boyatzis and Saatcioglu (2008)	Hogan Assessment Systems (2009)	Korn Ferry (2014)
Cognitive	Conceptual	Conceptual/ Creative	Cognitive Intelligence		Thought
Technical	Technical	Technical		Technical	
Management		Administrative			Results
Interpersonal	Human	Interpersonal	Social Intelligence	Interpersonal	People
Intrapersonal	Human		Emotional Intelligence	Intrapersonal	Self
Leadership		Leadership		Leadership	

Principal researchers. The study of leadership competencies from the five principal researchers and their research associates shown in Table 3 spanned more than 50 years. The contribution from these researchers spawned the work of others and furthered understanding of the characteristics that define a leader. The first of these five

researchers, Katz (1955/1974), presented a model of leadership based on three skill categories: cognitive, technical, and human. Researchers continue to reference Katz's work, supporting the value of this early contribution (Peterson & Van Fleet, 2004). Katz concluded, from experience with numerous leaders, that the characteristics of leadership could develop: rather than traits and personality characteristics, effective-leadership qualities consisted of skills developed through experience.

Researchers who followed Katz (1955/1974) expanded on this work. Sandwith (1993) referenced the three skill categories of leadership presented by Katz as the foundation on which to create a more expansive and detailed competency model. This model included five domains, adding administrative (management) and leadership to Katz's model, and excluding intrapersonal considerations. In turn, researchers referenced Sandwith's model, using it in additional competency-model designs or assessments (see, for example, Kalargyrou & Woods, 2011). Sandwith notably identified that the actions of a leader consist of competencies across the five domains; seldom does a leader exhibit competencies in only one domain.

Another influential researcher, Boyatzis (1982), developed a seminal model of leadership competency. Boyatzis researched leadership competencies extensively for more than 2 decades, independently and in cooperation with others (Boyatzis, 2008, 2011; Boyatzis & Saatcioglu, 2008). The initial competency model presented by Boyatzis (1982) consisted of six domains (see Appendix A, Table A4), whereas later work emphasized three: emotional, social, and cognitive (see Boyatzis & Saatcioglu, 2008). This change in focus demonstrated greater appreciation for the value of interpersonal—relational—competencies for effective leadership.

The contributions of Hogan and associates (see J. Hogan, Hogan, & Kaiser, 2009; R. Hogan & Kaiser, 2005) increased awareness of the influence of personality on leadership behaviors and performance. In a collaborative study, R. Hogan and Warrenfeltz (2003) identified four domains of leadership skills: intrapersonal, interpersonal, leadership, and business/technical. HAS (2009) expanded on these four domains in the development of the Hogan competency model, identifying individual competencies for each domain (see Appendix A, Table A9). These four domains are part of the six used in this study, defined in the following section.

The final and most current model featured in Table 3 is the Leadership Architect™ framework from Korn Ferry (2014). Initially created through research and collaboration between Lombardo and Eichinger (1996), this model has been under development since the 1990s. Korn Ferry continued to research and develop this model and in 2014 recategorized the competencies in the framework under four domains titled thought, results, people, and self.

Irrespective of the time between the contributions of these principle researchers, their assessments of the competencies of leadership remain consistent. Cognitive, technical, and management competencies are tactile elements of day-to-day tasks (Beinecke, 2009); I provided examples of these competencies in Table 1. How to perform these tasks while inspiring others to follow and take part in achieving goals requires balanced contributions from interpersonal and intrapersonal competencies (Weber et al., 2013).

Domain definitions. Of the six competency domains, knowledge and intelligence underlay the first three (cognitive, technical, and management); these skills equate to hard

skills (Rainsbury et al., 2002). Cognitive competencies include the ability to think critically, synthesize information, and reason (Amdurer, Boyatzis, Saatcioglu, Smith, & Taylor, 2014; Boyatzis, 2011). This mental capacity enables one to reflect systematically, to see the relationships or interdependence between ideas or processes, and to make decisions (Katz, 1955/1974). Cognitive skills are "threshold competencies" (Amdurer et al., 2014, p. 3; Boyatzis, 2011, p. 92) for leadership. The knowledge specific to an industry or profession comprises the technical competencies necessary for those who hold a job in an industry and for a leader responsible for the completion of work by their staff (Katz, 1955/1974; Sandwith, 1993). The use of knowledge specific to an industry or profession to demonstrate technical competence depends on cognitive abilities (R. Hogan & Warrenfeltz, 2003). The final hard-skill domain—management—involves competencies of task and people management including planning, budgeting, monitoring, and controlling (Guo, 2009). Management competencies combine cognitive and technical knowledge and skills, and are similar across industries. However, management competencies differ where industry-specific knowledge differs. For example, managing a nursing unit requires medical knowledge, whereas managing the hospital engineering department requires an understanding of building maintenance. Although leaders require these hard-skill domains of cognitive, technical, and management competencies, they also require the effective use of soft skills to demonstrate leadership.

The interpersonal and intrapersonal domains contain soft-skill competencies. Effective use of these skills builds relationships and manages internal responses to situations. The competent use of soft skills enables a leader to influence followers toward the attainment of goals (Dearinger, 2011). Katz's (1955/1974) domain of human

competencies included the ability to relate to others, to build relationships, and to demonstrate personal self-management and self-awareness: a blend of interpersonal and intrapersonal competencies. Interpersonal competencies are those behaviors used to build and maintain relationships (R. Hogan & Kaiser, 2005; Sandwith, 1993). Interpersonal competencies rely on intrapersonal competencies: the ability to empathize with others, for example (Boyatzis, 2008; R. Hogan & Kaiser, 2005). Personal and internal motivators, aspirations, and ability to control responses are examples of intrapersonal competencies (Goleman et al., 2013; R. Hogan & Kaiser, 2005).

In the study of emotional intelligence, Goleman (1995; Goleman et al., 2013) also acknowledged the need for self-awareness, self-regulation, motivation, empathy, and social skills (interpersonal and intrapersonal competencies) for effective leadership. By differentiating the original emotional-intelligence competencies into two domains—emotional intelligence (intrapersonal) and social intelligence (interpersonal)—Boyatzis (2008) aligned with researchers such as Hogan (R. Hogan & Kaiser, 2005; R. Hogan & Warrenfeltz, 2003) in identifying the separate but equal importance of interpersonal and intrapersonal competencies. Soft skills are essential competencies of leadership required to develop and apply hard skills (Weber et al., 2013). Therefore, competencies in the leadership domain depend on a combination of hard and soft skills, which together create the actions unique to the behaviors of a leader.

Leadership is the process of effectively using a blend of multiple skills to motivate, influence, inspire, and support followers to achieve shared goals (Boyatzis, 1982; Grandy & Holton, 2013b; Northouse, 2013). Management and leadership are separate concepts and many have clearly distinguished differences (Guo, 2009). For

example, Guo (2009) identified managers as responsible to oversee, monitor, and control, whereas leaders create a vision and inspire and motivate people to share it. Management competencies focus on task and process (Guo, 2009); they rely on technical, tactile, or hard skills. Leadership competencies rely on interpersonal and intrapersonal behaviors in combination with hard skills (Rainsbury et al., 2002; Weber et al., 2013). Strategy and vision are examples of competencies in the leadership domain; each depends on cognitive and technical knowledge to create, and requires interpersonal and intrapersonal competencies to implement. Singularly, demonstrating competence in any one domain (cognitive, technical, management, interpersonal, or intrapersonal) does not equate to leadership. However, when used in combination, the proficient demonstration of knowledge, skills, and abilities from these five domains produce leadership behaviors. This relationship is depicted in Figure 1.

Validation of the six domains. Through the work of researchers beyond those identified in Table 3, further support exists for the six competency domains. Appendix A contains 16 competency models—seven general to leadership, seven specific to healthcare, and two to hospitality services (to reflect leadership in nonclinical areas)—used to validate the six domains. As evidenced by the models in Appendix A, influence of individual researchers produces outcome variations. A careful assessment of these models shows that the similarities are greater than the differences between them.

Researchers of the 16 models were inconsistent in their methods of grouping competencies. Some were categorized to align with desired outcomes, for example, the domain of *fosters positive change* or *communicating* in the model by Garman and Scribner (2011) found in Table A7. Other researchers categorized similar to the six

domains for my study, aligned to the knowledge or behavior category, such as HAS (2009) in Table A9. Because of this dissimilarity, the assessment of the competencies and domains to the six domains in my study occurred in two stages. Appendix A contains a table for each of the 16 competency models, listing the domains, subdomains, and competencies from each source. The final column in each table aligns the competencies from the model to the six domains in this study.

Appendix B then depicts the alignment of the domains of each model based on the competencies in each of the six domains. The combination of soft and hard skills in a domain equates to the domain of leadership; for example, Beinecke and Spencer's (2007) domain of *personal skills and knowledge* consisted of cognitive (hard) and intrapersonal (soft) competencies. Following this guidance, in eight of the 16 models, all domains aligned with the leadership domain in this study (see Appendix B).

In most instances, a clear correlation and similarity emerged among models. The greatest similarity was the representation of all six leadership-competency domains in each of the 16 studies. With few exceptions, the competency models specific to healthcare or hospitality were unidentifiable to these industries. Exceptions included the addition of the word multidisciplinary in conjunction with teamwork in the model by Aitken and von Treuer (2014), because multidisciplinary is a commonly used term in healthcare to indicate collaboration across clinical (and other) professionals. Another exception is the competency of *recovery and other health issues* under the domain of *policy and program knowledge* in the model by Beinecke (Beinecke, 2009; Beinecke & Spencer, 2007). The Academy of Medical Royal Colleges and Institute for Innovation and Improvement (2010) model referenced patients (e.g., *support others to provide good*

patient care under the subdomain of *managing people*) and clinical staff (e.g., *contribute a clinical perspective to decisions* under the subdomain of *making decisions*). Finally, the Suh, West, and Shin (2012) model referenced hospitality-specific tasks and terms.

The removal of these industry-specific references retains the intention of the competency; for example, replacing *knowledge in housekeeping operations* with *knowledge in industry-specific operations* in the Suh et al. (2012) model. Overall, the models created for the hospitality or healthcare industries aligned with the eight non-industry-specific models. The commonality between models suggests a similarity for leadership in general, distinguished by the specific attributes for each industry.

The primary difference in the models was the degree to which researchers identified individual competencies for the cognitive, technical, interpersonal, and intrapersonal domains, rather than defining a leadership-domain competency that relied on a combination of hard and soft skills. For example, HAS (2009) identified a number of single-domain competencies: *initiative* ("takes action without the direction of others;" p. 17), *innovation* ("generates creative ideas and perspectives" p. 17), *safety* ("follows safety precautions and displays safe on-the-job behavior" p. 18), and *work ethic* ("exhibits hard work and diligence" p. 19).

In contrast, competencies listed in Aitken and von Treuer's (2014) model combined hard and soft skills and primarily aligned with the leadership domain. This model included a competency for *communication*:

> The leader possesses a repertoire of communication skills, including an ability to listen and consult, adapt their communication style to suit the needs of the situation and audience, read "what is not being said" in an interaction, and interact

> effectively with the client. Such leaders possess well-developed written communication skills, including an ability to write cogent reports under time pressure. (p. 163)

In addition, Aitken and von Treuer (2014) described competency of *personal integrity, achievement focus, and self-management*:

> The leader operates with integrity and professionalism; demonstrates achievement focus and drive; is self-confident; demonstrates tenacity and resilience; is flexible and adaptable; remains calm and composed in pressured situations; possesses a sense of humour, possesses highly-developed critical thinking and decision-making skills; and undertakes appropriate professional development practices, together with activities to facilitate and support his or her own health and wellbeing. (p. 164)

The Hogan competency model (HAS, 2009) purposefully simplified competencies for clarity and assessment of their individual influence. HAS (2009) perceived that the combination of behaviors or skills to express a complex competency "contaminates" (p. 2) the ability to understand the influence of an individual behavior.

Further study of the competencies necessary for healthcare leadership align with those of the researchers reviewed in Appendix A. The HLA competency model contained five domains: communication and relationship management (interpersonal), professionalism (intrapersonal), leadership, knowledge of healthcare (technical), and business skills and knowledge (technical; HLA, 2010a; Stefl, 2008). When initially created, the competencies aligned to these domains totaled 300 (Stefl, 2008); the updated version contained more than 800 competencies (HLA, 2010a). The domains and

competencies of the HLA model align with those in my study; however, the extensiveness of the model is overly complicated and redundant, reducing its practical usefulness. For example, listed in the domain of *professionalism* and subdomain of *ethics* are the competencies of *consequences of unethical actions, organizational business and personal ethics, professional standards and codes of ethics, adherence to ethical business principles,* and *upholding and acting upon ethical and professional standards* (HLA, 2010b).

In another study, Liang et al. (2013) identified competencies for healthcare leadership roles specific to leader level (i.e., midlevel versus senior) and aligned across each level. Six core competencies spanned all levels: leadership, leading and managing change (leadership); operations, administration, and resource management (management); decision making (cognitive); knowledge of healthcare (technical); and interpersonal communication and relationships (interpersonal). The HLA model and the competencies from Liang et al. offer further support for the six domains in my study and their relevance to healthcare.

In a brief return to the categories of leadership traits developed by Coffin (1944), of interest is the similarities to the competency models of the later researchers identified here. The categories and traits presented by Coffin appear in Appendix C. The third column contains an assessment of the alignment of the trait, where applicable, to one of the six competency domains in my study. Coffin's traits primarily reflect cognitive, interpersonal, and intrapersonal characteristics. Support for these trait-like competencies have consistently remained relevant in the research, but reference to these traits as competencies has changed.

Traits of the individual are influential to leader emergence and effectiveness. DeRue et al. (2011) assessed the contribution of leader traits to effectiveness; these traits included physical (gender, age), mental (intelligence, personality), and leader behaviors (task-, relational-, and change-oriented). Behaviors were more influential to effectiveness than traits; however, DeRue et al. (2011) acknowledged that traits influence behaviors. Personality traits are neurophysiologically linked and trigger automatic responses (Jackson, Hill, & Roberts, 2012). Jackson et al. (2012) connected these traits to subsequently displayed behaviors, identifying that when influential variables remain consistent, individuals respond predictably. When variables change, responses change. Therefore, factors in the environment or in the person can influence the resulting behavior of a leader. Antonakis, Day, and Schyns (2012) also supported the combination of traits and developed competence in leadership skills and abilities. This review offers further support to the argument that the characteristics of a leader are inclusive of trait-like and state-like competencies; leaders are both born and made.

Leadership Competencies Across the Leader Hierarchy

The tasks and responsibilities between the hierarchical levels of leaders differ, but share the requirement of leadership competence (Calhoun et al., 2008; Garman & Scribner, 2011; Katz, 1955/1974; Liang et al., 2013). Additionally, Garman et al. (2004) assessed that half the leadership competencies identified in their study were important to leaders at all levels. Differences between leader levels appeared in the amount to which a leader leveraged competencies from one domain to another. Entry and midlevel leaders have more need for technical competencies; whereas, competencies of strategic

development are of greater importance for senior-level leaders (Garman et al., 2004; Liang et al., 2013).

Senior-level leaders direct the course and set the culture for an organization. The behaviors of the leader at the senior level directly influence organizational culture (O'Reilly, Caldwell, Chatman, & Doerr, 2014). In healthcare, this influence can create a climate of patient safety (McFadden et al., 2014). Though greatly influential, senior-level leaders do not create change without the support and effort of the leaders below them (O'Reilly et al., 2014). Those at the senior level have organizational influence but do not act alone to lead an organization.

Midlevel leaders reside between those who provide front-line supervision, and those who set organizational strategy (Harding, Lee, & Ford, 2014). These leaders share responsibility for oversight of daily operations with front-line leaders; they tend to have close proximity to front-line staff, developing relationships with those who perform the day-to-day work of the organization (Hyde, Granter, Hassard, McCann, & Morris, 2013). Employees view their managers as their immediate leader and depend on them to deliver organizational communication, develop departmental strategy and vision, and inspire and motivate for improved performance (Yang et al., 2010). In this role, midlevel leaders have greater effect on employee performance than senior leaders (Yang et al., 2010), and have direct influence on the commitment, job satisfaction, and retention of employees (McDonnell et al., 2013; Townsend, Wilkinson, Allan, et al., 2012). This proximity results in midlevel leaders acting as the interface between the desires of senior-level leaders and the needs and wants of employees (MacNeil, 2004). Midlevel leaders

disseminate communication, manage performance, and can either support or hinder change.

Healthcare

The U.S. healthcare system suffers from excessive costs and undesirable clinical outcomes for patients. In 2012, the spending on healthcare in the United States was approximately $2.8 trillion (A. B. Martin, Hartman, Whittle, Catlin, & The National Health Expenditure Accounts Team, 2014), and these costs will steadily increase (Frakt & Carroll, 2013). Comparatively, U.S. healthcare spending per capita is more than 50% higher than that of most other developed countries (Squires, 2012). Ranking of care quality for the United States is lowest among these same countries (Frakt & Carroll, 2013). Indicators of healthcare quality, such as readmission posthospitalization, avoidable medical errors, and preventable complications of chronic diseases are high throughout the United States (CMS, 2013; James, 2013; Squires, 2012). James (2013) estimated the annual death rate resulting from preventable healthcare errors to be close to 400,000, and CMS (2013) estimated that 1.7 million healthcare-acquired infections and 770,000 medication errors occur annually. These quality concerns further contribute to the cost of healthcare. Estimated costs of healthcare-related harm exceed $5 billion annually (CMS, 2013). Leadership in individual healthcare systems at the local level can influence these indicators of healthcare costs and quality at the national level.

Individual healthcare systems—those entities that are part of the larger national healthcare system—are themselves complex systems (Martínez-García & Hernández-Lemus, 2013). Local healthcare systems often contain more than one facility, such as an acute-care hospital with a number of outpatient and specialty clinics, and employ

hundreds to thousands of professional and support staff. Numerous interrelated and diverse components influence a healthcare system (Edgren & Barnard, 2012), including the individual clinical and nonclinical subsystems housed within. Each subsystem has different but overlapping and interdependent responsibilities, goals, and business requirements necessary to support patient care.

Internal and external variables contribute to the complexity of local healthcare systems and increase the need for effective leadership (Weberg, 2012). External pressures such as technological advancements and regulatory oversight financially burden healthcare systems and detract from the provision of patient care (American Hospital Association [AHA], 2011; Huston, 2013). Internally, challenges such as the continuous operation of patient care and facility-support departments, staff and clinician shortages, or management of physician relationships further complicate the management of healthcare systems (Balogh-Robinson, 2012; Dobrzykowski & Tarafdar, 2015). The collection of professionals with vastly different educational backgrounds and contributions to the maintenance of the system complicate healthcare leadership: clinical and nonclinical professionals alike.

Governmental leaders in the United States recognized the quality and cost concerns of the healthcare system and that these national concerns improve through the efforts of local healthcare systems. CMS incentivized local healthcare systems to contribute to improved performance through implementation of the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey, with associated pay-for-performance and public reporting of results (CMS, 2015). Members of CMS created and adopted the HCAHPS survey as a nationally used tool after extensive research and

pilot testing (CMS, 2015). The goal of the survey, incentives, and public reporting was threefold. First, create a standard and comparable measurement method; second, create transparency of these performance indicators; and, third, improve the quality of care provided across the United States (CMS, 2015).

CMS has reported hospital HCAHPS survey results since 2008 (CMS, 2015); however, these results have contradictory correlations to quality of care. For example, Stein, Day, Karia, Hutzler, and Bosco (2014) demonstrated correlation with enhanced survey scores and care outcomes, whereas Day et al. (2014) found no correlation. In response to this contradictory evidence, Price et al. (2014) reviewed 34 studies published from 1992 to 2013 (predating and postdating the HCAHPS survey) in which researchers compared patient satisfaction or experience to clinical outcomes. Price et al. concluded that more evidence supports the correlation between perception of patient experience and clinical outcomes than opposes that perception. Therefore, evidence supports the collection and reporting of HCAHPS survey data. To enhance how CMS reports data publicly, the published scores moved to a one- to five-star rating in April 2015 (CMS, 2014a). Consumers have familiarity with the star system to indicate hotel or retail satisfaction; its use in the survey may enhance consumer healthcare-selection decisions (CMS, 2014a). As with retail star ratings, public awareness of prior customer (i.e., patient) experiences may pressure local healthcare systems to make needed improvements.

Improvement in healthcare performance is difficult as national health systems and their localized or community healthcare subsystems are complex (Grigoroudis & Phillis, 2013; Martínez-García & Hernández-Lemus, 2013). The complexity of healthcare

contributes to the overall quality of care issues in the United States (Institute of Medicine, 2011). Faezipour and Ferreira (2013) referred to healthcare as a system of systems; hospitals or local healthcare systems are just one of many contained in the larger national system (Grigoroudis & Phillis, 2013). Internal and external variables contribute to the complexity of local healthcare systems and increase the need for effective leadership (Weberg, 2012). Among the external pressures are regulatory reporting requirements and on-site survey inspections intended to safeguard the delivery of patient care. The government regulates few industries as highly as healthcare (AHA, 2011); regulatory oversight financially burdens healthcare systems and narrows quality-improvement focus (Lipsitz, 2012). External pressures also result from complicated and frequently changing reimbursement structures (Davis, Davis, & Schmelzle, 2013), the challenges and opportunities of increasing use of technology (Huston, 2013), the requirement for disaster preparedness (AHA, 2015), and the increasing life expectancy and resulting population growth of those older than 65 (Dall et al., 2013). The importance of public perception (i.e., HCAHPS survey results) in competition for healthcare market share is one of many external pressures.

Internally, additional challenges complicate the performance of a healthcare system. These challenges include continuous operation of patient care and facility support departments, unpredictable patient volumes, unionized workforces (Balogh-Robinson, 2012), staff and clinician shortages (Balogh-Robinson, 2012), and the management of relationships with internally practicing—but not internally employed—physicians (Dobrzykowski & Tarafdar, 2015). Further, healthcare systems consist of many diverse yet highly connected clinical and nonclinical subsystems (Edgren & Barnard, 2012;

Martínez-García & Hernández-Lemus, 2013). Clinics, patient-care units, and therapeutic and diagnostic departments comprise clinical subsystems. Nonclinical subsystems include support services (e.g., foodservice or facility management), information (e.g., medical records or information technology), and administration departments. Effective healthcare delivery depends on a "diverse spectrum of staff and departments working in a hierarchical inflexible structure wherein several professional groups with different objectives, activities, and subcultures provide healthcare services" (Heyrani et al., 2012, p. 85). The number and diversity of these professional groups contribute to the complexity of leadership in healthcare (Al-Sawai, 2013). Regardless of these differences, the objective to provide quality patient care and services aligns each subsystem and stresses the need for effective organization-wide leadership. Patient care is the purpose of a healthcare entity, but the reality for a complex healthcare system is that the necessities of the business requirements compete with patient care for priority and resources.

Leadership in Healthcare

Effective leaders produce positive results through their ability to inspire, motivate, and influence employees. Several variables influence the work-based experiences and satisfaction of employees, including peer relationships (Basford & Offermann, 2012), organizational culture (Bigliardi, Dormio, Galati, & Schiuma, 2012), and work–life balance (Haar, Russo, Suñe, & Ollier-Malaterre, 2014). The role of the leader is also a powerful component. The study of leadership demonstrates that the quality of leadership positively or negatively affects work stress (Yao et al., 2014), burnout (Steffens et al., 2014), and the well-being and health (Wegge et al., 2014) of employees. Also influenced by the relationship between a leader and their direct reports are job satisfaction (Ngirande

& Timothy, 2014), organizational commitment (Kara et al., 2013), empowerment (Amundsen & Martinsen, 2015; Dewettinck & van Ameijde, 2011), and engagement (Zhang et al., 2014) of these employees. In healthcare in particular, the quality of leadership demonstrated by managers accounted for 28% of the job satisfaction, and 20% of the organizational commitment of employees (Mosadeghrad & Ferdosi, 2013). Additionally, the behaviors of healthcare leaders influences the engagement (Bamford, Wong, & Laschinger, 2013), well-being (Nelson et al., 2014), burnout (Laschinger & Fida, 2013), job satisfaction (Tsai, 2011), and health and absences (Ljungblad, Granstrom, Dellve, & Akerlind, 2014) of healthcare employees. Further, effective leaders improve and sustain critical healthcare financial indicators (Burritt, 2005).

Engaged, satisfied, empowered, or committed employees show higher performance and productivity (Amundsen & Martinsen, 2015; Degago, 2014; Vogelgesong et al., 2013), innovation (Ertürk, 2012), and better service experiences (Menguc et al., 2013). Satisfied employees express a reduced intent to leave (Dewettinck & van Ameijde, 2011; Laschinger & Fida, 2013) and purposefully contribute to the improved performance of an organization (Lin et al., 2011). Wong et al. (2013) supported the positive relationship between leaders, patient experience, and care outcomes in a review of 20 studies. The effectiveness of leaders influences the organizational culture, the work–life quality for employees, and the performance of the healthcare system as a whole. Effective leaders create an environment in which an organization can achieve its mission.

Clinical Leadership

The mission of healthcare is to improve the health of those served. Researchers have studied well the need for effective clinical leadership, specifically in nursing and physician leadership (Angood & Shannon, 2014; Daly et al., 2014; Storey & Holti, 2013). The positive influence of an effective leader on employees improves the healthcare experience for patients (Ancarani et al., 2011; McFadden et al., 2014). Patient-reported satisfaction and experience improve when the leader–employee relationship is positive and employees feel engaged (Boev, 2012; Holder & Ramagem, 2012; Manary et al., 2014). Subsequently, multiple researchers showed that patient experience or perception of care correlated with improved care outcomes (Mehta, 2011; Price et al., 2014). Leader behaviors also positively influenced patients' quality of care (Ancarani et al., 2011), safety incidents (McFadden et al., 2014; Zhang et al., 2014), and clinical outcomes (Wong et al., 2013). These benefits extend beyond the care received in the healthcare facility. Patient perceptions of the care experience also correlated with their improved self-care and adherence to treatment recommendations when home (Mehta, 2011). The actions of leaders influence those of their employees, and the actions of employees responsible for clinical delivery influence the experiences of those in their care. Therefore, the influence of healthcare leaders extends beyond benefit to employees and business aspects of the organization; this influence touches the lives of the patients served.

Healthcare is a complex system and each subsystem influences the system as a whole. Additionally, the healthcare experience includes more than the receipt of care from clinical staff; other organizational variables influence a patient's perception of care quality (Amin & Nasharuddin, 2013; Ancarani et al., 2011). The perception of service

quality from clinical and nonclinical individuals each correlate to a patient's evaluation of their healthcare experience (Mehta, 2011). Clinical and nonclinical healthcare operations must collaborate for patient care to occur (Golanowski et al., 2007). Therefore, the performance of those in nonclinical roles contributes to the overall patient experience.

Nonclinical Leadership

Nonclinical-support service departments affect patient-care quality, financial viability, and regulatory-compliance indicators of a healthcare system. However, the extent to which and methodology in which this influence occurs is minimally addressed in research (Bain & Ward, 2014). Even less research is available regarding the influence of leaders in these departments.

The service provided by nonclinical teams affects the overall satisfaction and experience of care during a patient visit (Amin & Nasharuddin, 2013; Ancarani et al., 2011). Including services provided by nonclinical departments in satisfaction and experience surveys further supports their importance in creating a positive patient experience. Patient-satisfaction surveys from leading vendors (i.e., Press Ganey) include questions exploring satisfaction with services provided by nonclinical departments, commonly those of foodservice and environmental-service teams. Further, questions included in the HCAHPS survey query cleanliness of the environment (CMS, 2014b). Support for the value of foodservice in healthcare is available in the provision of nutrition (Cheung, Pizzola, & Keller, 2013) and correlation to patient satisfaction (see Dall'Oglio et al., 2015). However, the quality of these nonclinical services related to the role of the department leader(s) is unavailable.

Further support for the value of nonclinical teams in healthcare is limited, but their inclusion in a larger exploration of patient-experience factors emerged in a study by Valentine, Darby, and Bonsel (2008). Valentine et al. studied the perceptions of eight nonclinical elements of care on patient experience: dignity, autonomy, communication, confidentiality, choice, prompt attention, social support, and basic amenities. Basic amenities consisted of cleanliness, comfort of the environment, and food quality (Valentine et al., 2008), that is, work performed by nonclinical teams who have minimal contact with patients and provide no direct patient care. Valentine et al. asked participants their perceptions of which nonclinical element was most important: 2% of participants selected basic amenities. Inclusion among the eight elements suggested perceptions of value for nonclinical services. Selection, though by a small group of participants, as most important among the eight, supports this ranking further. Collectively, the addition of satisfaction and experience questions in Press Ganey and HCAHPS surveys, and assessment of importance by Valentine et al. indicated awareness of the importance of services provided by these teams to the overall care-delivery process and patient experience.

Researchers recognized that nonclinical teams contribute to the process of care delivery in studies of nurse workflow or patient experience. Patient throughput, movement from one location to another in a hospital, such as from the emergency department to an in-patient unit, is affected by the efficiency of environmental service teams to turnover patient rooms (Carlton, 2016). Restructuring the environment and workflow in an emergency department for improved patient experience requires the support of teams such as supply management and information technology (Bornemann-

Shepherd et al., 2015). A medication administration process-improvement team recognized the need to include members from environmental services, finance, and engineering, as the system for medication delivery extended beyond nursing and pharmacy teams (Critchley, 2015). Operational failures, such as the unavailability of supplies or equipment, contribute to delayed delivery of care or risk to patient safety (Tucker et al., 2014). In the Tucker et al.'s (2014) study, nonclinical departments that contributed to these operational failures included information technology, food services, central supply, sterile processing, engineering, biomedical equipment, and environmental services. The processes of care delivery is a complex system that expands beyond those teams with direct patient contact. Nonclinical teams play a significant and supportive role.

The contributions from nonclinical departments are diverse and not unique to the healthcare environment. Foodservice, environmental service (laundry, housekeeping, and building cleanliness), engineering, purchasing, information technology, and finance include occupations performed in other work environments or stand-alone facilities (i.e., restaurants, hotels, and banking). The literature supports the influence of leaders in these industries on the performance of employees and organizational outcomes. For example, leaders in the hospitality industry (Kara et al., 2013) and information technology (Syrek, Apostel, & Antoni, 2013) influence the job satisfaction, commitment, and well-being of employees. The effect of leaders on followers remains consistent across industries; therefore, the behaviors and actions of leaders in nonclinical healthcare departments is of similar importance. Caykoylu, Egri, Havlovic, and Bradley (2011) lent further support to this assertion in their study of the variability between nurses, paramedics, and nonclinical staff, and the factors influencing their satisfaction and organizational commitment.

Caykoylu et al. found that the immediate department leader for all three groups influenced organizational commitment, satisfaction with the leader, and feelings of empowerment for employees. Nonclinical teams contribute to the provision of care in healthcare systems and effective leadership enhances the job satisfaction and work performance of these employees.

Defining Self-Awareness

As described in Chapter 1, self-awareness means being conscious of personal strengths and weaknesses, compared to expectations and the effect of these actions on others. This awareness has equal importance to the development of leadership competence (Korn Ferry, 2015) and interacts with emotional intelligence in the development of performance-related self-awareness, allowing an individual to be open to performance feedback from others (Nesbit, 2012). Developing self-awareness entails an internal focus in which individuals compare their performance to expected standards and recognize and acknowledge their personal strengths and weaknesses (Silvia & Phillips, 2013). This inward and conscious assessment of performance occurs with the use of information gained from the external environment, feedback from others, and an internal perspective (Morin, 2011). Reilly et al. (2013) identified this process as introspection (the understanding of self), interaction (understanding one's effect on others), and expansion (personal effort to better understand oneself and others). Those who are self-aware consider their perception of an experience as well as that of others who shared the experience (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). Self-awareness of performance is a continuous process of evaluation and adjustment based on internal

and external cues. This evaluation can only occur if one has an awareness of what competent performance entails.

An individual's gained self-awareness requires a consciousness of expectations and observation of modeled performance, followed by reflection on one's own execution in comparison (Morin, 2011). This developed consciousness occurs in four stages: unconsciousness, consciousness, self-awareness, and meta-self-awareness (awareness of being self-aware; Morin, 2011). Similarly, others defined these stages as unconsciously incompetent, consciously incompetent, consciously competent, and unconsciously competent (Jung et al., 2016; Manthey & Fitch, 2012; Pillen et al., 2013). The initial stage of unconsciously incompetent is the lack of awareness with no demonstration of necessary skill, knowledge, or ability. Consciously incompetent means having awareness, but still, no skill. In the stage of consciously competent, one possesses the skill, but requires thought and purposeful effort for its use. An unconsciously competent individual performs a skill or behavior without thought of doing so. These stages support competence development as following a path of awareness or gained consciousness. Self-awareness develops from reflection on performance in conjunction with feedback from others, effectively synthesizing this information to identify strengths and weaknesses in performance.

Self- and Other-Assessment

Self-awareness is a trait- and state-like competency. This intrapersonal competency is part of one's basic personality, guided by experiences from childhood and throughout one's career (Giolito, 2015; HAS, 2009). One can develop self-awareness (Goleman, 1995, 1998/2004), but this development is a personal action and requires an

individual to actively participate in the process (Beinecke, 2009; Karp, 2013; Nesbit, 2012). Developed self-awareness is an internal process that occurs through reflection on one's performance and achieved outcomes with information from self- and other-assessments (Morin, 2011).

Self-awareness develops as the accuracy of performance self-assessment improves, and self-assessment improves through acceptance of and reflection on received other-assessment. Self-assessment is the judgment an individual makes of their competence, combined with their perception of their ability to improve and develop (Lans, Biemans, Mulder, & Verstegen, 2010). Self-ratings of performance, though of some worth, align less with actual performance than the perception of supervisors, peers, or direct reports (Braddy et al., 2014). Therefore, researchers supported the inclusion of feedback (or other-assessment of performance) for the development of accurate self-assessment (Higgs & Rowland, 2010; Morin, 2011). During reflection, assessment feedback from various sources offers an opportunity to contemplate the differences between self- and other-perception (Morin, 2011).

Those who have greater self-assessment accuracy and who accept constructive other-assessment develop competence and performance effectiveness. Employees' perceptions of leadership effectiveness increase when leader self-assessed performance aligns with that of actual or other-assessed performance (Butler, Kwantes, & Boglarsky, 2014). Conversely, leaders whose estimation of their performance exceeds that perceived by their direct reports reduce the job satisfaction and productivity of these same employees (Amundsen & Martinsen, 2015). Accurate self-assessment is imperative for

leadership development and effectiveness; however, low performers may lack the ability to view their performance with accuracy (Kruger & Dunning, 1999).

Many, especially those who perform least well, do not accurately assess their performance (Schlosser et al., 2013). Erker and Thomas (2010) assessed that 89% of leaders identify themselves as more competent than they are. Top performers assess themselves in greater alignment with actual performance (Schlosser et al., 2013; Simons, 2013) and are more willing to put effort toward improving their performance (Helzer & Dunning, 2012; O. J. Sheldon et al., 2014; Sitzmann & Johnson, 2012). Underperformers tend to overestimate their actual performance, overestimate their performance relative to peers, and are overconfident in these performance assessments (Schlosser et al., 2013; O. J. Sheldon et al., 2014; Simons, 2013; Williams, Kruger, & Dunning, 2013), dubbed the Dunning–Kruger effect (Kruger & Dunning, 1999). The misalignment of self-assessed performance to actual performance restricts the development of self-awareness, diminishing a leader's effectiveness.

Kruger and Dunning (1999) originally proposed that low performers were either unwilling or unable to assess their performance accurately. These individuals were doubly burdened as they performed poorly and failed to recognize their incompetence (Kruger & Dunning, 1999). Further study of the cause and potential solution for this burden led to three hypothesized reasons for self-assessment overestimation by low performers: lack of knowledge, ego or self-esteem limitations, or unrealistic optimism.

Deficient knowledge of performance expectations and performance in relation to others hampers one's ability to self-assess accurately (Ehrlinger, Johnson, Banner, Dunning, & Kruger, 2008). Krajc and Ortmann (2008) proposed that poor performers are

less advanced along the stages of competency; they are unconsciously incompetent. Thus, poor performers cannot perform because they lack necessary knowledge of expectations. In support of this hypothesis, Dunning, Johnson, Ehrlinger, and Kruger (2003) found feedback and training increased the accuracy of performance assessment and reduced overconfidence in these assessments. Further, Krajc (2008) found that feedback reduced the variation between perceived and actual performance with the greatest improvement occurring for those whose performance was poorest. Exploring this further, Ryvkin et al., (2012) reported that feedback positively improved the accuracy of self-assessment against standards, though self-performance compared to peers remained skewed. Ryvkin et al. provided hope for the resolution of inaccurate self-assessment and improvement in performance. However, conflicting evidence suggested the solution may be more complicated.

Feedback should help leaders improve ability to assess performance correctly, moving an individual from unconsciously incompetent to consciously incompetent. Once aware of expectations and their skill level in comparison, an individual can develop through experience, further feedback, and reflection, thereby advancing further along the stages of competency. However, several researchers found that performance feedback did not improve the accuracy of low performer's self-assessment (Schlosser et al., 2013; O. J. Sheldon et al., 2014; Simons, 2013). Schlosser et al. (2013) also found that self-assessment did not improve after experience. Therefore, feedback does not always assist in improving one's ability to self-assess and improve performance. These conclusions necessitated finding alternative reasons for the misalignment of low performer's self-assessment.

The second hypothesis of the Dunning–Kruger effect is that the ego is unable to accept the reality of poor performance, especially as compared to others (Amundsen & Martinsen, 2015; O. J. Sheldon et al., 2014). O. J. Sheldon et al. (2014) found that feedback did not improve the self-assessment of low performers; instead, these individuals questioned the accuracy of the feedback. Similarly, Vazire and Carlson (2011) found that the unwillingness of the receiver to hear a perspective that differs from their own can limit the feedback exchange between the giver and receiver. The need to maintain self-esteem may prevent low performers from accurately assessing and accepting the assessment of others (Amundsen & Martinsen, 2015; Ryvkin et al., 2012).

When low performers accept feedback, their self-assessments improve to a greater extent than their rating of performance in comparison to others (Krajc & Ortmann, 2008; Ryvkin et al., 2012). Ryvkin et al. (2012) offered that lower ranking among peers might be more difficult to accept than absolute rating of performance. Contributing further to the relationship between self-esteem and accuracy of self-assessment, low-performing leaders whose self-assessed performance aligned with that of their direct reports were least effective (Amundsen & Martinsen, 2015). Additionally, poor performers who accurately self-assessed their performance demonstrated a lack of motivation to improve (Sitzmann & Johnson, 2012). Thus, low performers who have little self-esteem may recognize their performance limitations, but fail to be motivated to improve. Low performers may truly be unable to improve because their need to maintain self-esteem (ego-protection) prevents acceptance of constructive feedback and improved accuracy in their self-assessment, or their lack of self-esteem demotivates improvement efforts.

Unrealistic optimism is the final hypothesis for the Dunning–Kruger effect. Lower performers who are aware of expectations, the performance of others, and their own past performance may continue to judge performance inaccurately because they are unrealistically optimistic (Helzer & Dunning, 2012). These individuals may be unable to accurately rate performance because they wish to perform better. Simons (2013) also attributed the lack of improvement in self-assessment after feedback to performance optimism. However, Simons tested the effect of feedback on the self-assessed game performance of bridge players, although the competitiveness of a gaming environment may not equate to professional performance. The three hypotheses for the Dunning–Kruger effect are each logical, but none offers a definitive answer to the problem. The needs (knowledge of expectations) or psychological drivers (desire to succeed) of individual performers will differ; thus, the manner in which they receive feedback (specificity, frequency, or evidentiary) for effective results will also differ.

Though the perception of performance is more accurate from supervisors, peers, or direct reports than from oneself (Braddy et al., 2014), these individuals are unlikely to give honest, constructive feedback in person (Vazire & Carlson, 2011). When an assessor offers feedback, the assessor may withhold their true opinion, either withholding some feedback or reducing the severity of the performance concern (Govaerts, van de Wiel, & Vleuten, 2013). Anonymizing tools such as fully confidential comprehensive feedback surveys can be useful to gain understanding of one's effect on others (Day et al., 2014). However, specific feedback (i.e., example) improves performance better than general feedback (i.e., rating; Krajc, 2008; Krajc & Ortmann, 2008) and even those skilled in providing feedback give less specific feedback in writing than they do verbally (Govaerts

et al., 2013). The quality of feedback is one variable in the feedback-exchange process; the receptiveness of the receiver is another. Those who are feedback oriented tend to have greater motivation to achieve (Braddy, Sturm, Atwater, Smither, & Fleenor, 2013), supporting the Dunning–Kruger effect and the differences between low and high performers.

Effective leaders demonstrate alignment between their perceptions of performance and those of others; when they misalign, these individuals reflect on the differences and take action to improve (O. J. Sheldon et al., 2014). Low performers are either unable or unwilling to accept and grow from feedback; rather, their self-assessments are invalid or skewed (Kruger & Dunning, 1999; O. J. Sheldon et al., 2014). However, those who accept and reflect on feedback, low and high performers alike, obtain benefit from this other-perception (Krajc, 2008; Ryvkin et al., 2012). Feedback is a necessary component of self-awareness development, but its effectiveness occurs only through the acceptance and reflection of other-assessed performance. When an individual willingly reflects on feedback, considering an alternative perspective as well as their own, their self-awareness intensifies and competence improves.

Reflection

In the stages of reflection, awareness comes first; people require awareness for critical analysis and new perspectives to follow (Scanlan & Chernomas, 1997). Reflection includes not only consideration of self-experience, but also the performance of others in comparison and how one wishes to be perceived (Guillen, Mayo, & Korotov 2015; Spaulding, Haley, & Zhao, 2014). Importantly, adaptive and maladaptive self-reflection are different. Adaptive reflection is openness to self and other feedback and the

positive consideration of this information for the assessment of performance and identification of developmental opportunities (Avolio & Hannah, 2008). Adaptive self-reflection generates positive emotional responses (Avolio & Hannah, 2008). Maladaptive self-reflection includes thoughts of self-doubt, blame, and negative emotional responses (Avolio & Hannah, 2008). Self-reflection is beneficial to the development of self-awareness when it is adaptive rather than maladaptive. Therefore, to develop a new perspective, reflection involves critical thought on the meaning of an experience as it pertains to oneself, others, and environmental contributors in an adaptive manner.

People use tools such as journaling to explore behavior or task performance and identify what and how to improve future attempts (Loo, 2002). Reflective tools focus an individual's thoughts on a subject (such as performance assessment), limiting distraction and enabling unbounded evaluation (Janesick, 2011). Those who use reflective methods to improve self-awareness of competence demonstrated improved success in their careers (De Vos, Dewettinck, & Buyens, 2009) and had more effective outcomes from change initiatives (Higgs & Rowland, 2010). Higgs and Rowland (2010) found these leaders actively sought and reflected on feedback, comparing feedback from others to their own perceptions and identifying opportunities for improvement. Leadership-development programs that emphasize the use of reflective practices for behavior change improved participant self-awareness (Vitello-Cicciu et al., 2014). Similar to the findings of Higgs and Rowland, participant leaders proactively requested feedback and used reflection to improve their regulation of emotions and awareness of impact on others (Vitello-Cicciu et al., 2014). Leaders need to use reflective techniques to develop self-awareness. The stages of reflection depend, in a circular fashion, on each other (Scanlan & Chernomas,

1997). P. Miller (2012) referenced this process as double-loop learning: reflecting on self-assessment, other-assessment, and asking questions of oneself regarding how one's performance influenced the perceptions of others and objective outcomes. Leaders use reflection to critically analyze initial awareness of expectations, other-assessment, and self-assessment, similarly aligned to actual performance. From reflection, leaders develop new perspectives. New perspectives generate efforts to change and yield new assessments of performance: the circular path continues.

Leadership Competency Development

Leadership in healthcare is complex (Beinecke, 2009); yet, a lack of desire and preparation for leadership is a common theme. Leaders expressed lack of preparation for the responsibilities of leadership in a management role throughout fields of work (McDonnell et al., 2013) as well as in healthcare (Briggs et al., 2012; Stoller, 2014; Townsend, Wilkinson, Bamber, et al., 2012). R. Hogan and Kaiser (2005) reported that up to 75% of leaders lack skills necessary for their role. Evidence of "managerial malpractice" (Gilley et al., 2014) was found in the placement of unqualified individuals into positions of leadership. These leaders were then not held accountable for poor results and allowed to retain their positions (Gilley et al., 2014). The deficiency of preparation or desire to lead may contribute to this gap. Most leaders in healthcare entered the profession as clinicians; they did not begin their careers with aspirations of holding a management role (Townsend, Wilkinson, Bamber, et al., 2012). Clinicians were promoted based on technical performance (McDonnell et al., 2013), or "fell into the role by accident" (Townsend, Wilkinson, Bamber, et al., 2012, p. 211). These accidental leaders frequently lack preparedness for the responsibilities of a leadership role

(McCallin & Frankson, 2010) and learn to meet the requirements through personal experience rather than developmental guidance (Grandy & Holton, 2013a).

The differences between a technical or staff-level role and that of an entry-level leader is greatest among the hierarchical range of organizational roles (Dai, Tang, & De Meuse, 2011). In a study of nurse managers, participants identified that the skills they demonstrated as competent nurses were far different from the skills they required to successfully transition to a leader-level position (McCallin & Frankson, 2010). Further, the expectations of the role were unclear and the job description differed from actual expectations; the role was demanding and support was unavailable (McCallin & Frankson, 2010). Additionally, development opportunities tend to be more heavily weighted to technical or managerial competencies than to those of leadership (Curry, Taylor, Chen, & Bradley, 2012). Technically competent individuals are promoted into entry- or midlevel leader roles based on demonstrated potential, but fail to develop the potential into competence. Lack of preparation exacerbates the difficulty of this transition.

Senior leaders who actively support the development of their leadership team across the system lead organizations to improved financial and performance measures (Thompson & Kim, 2013). Leadership-development programs require support from senior leaders to produce effective outcomes (Grandy & Holton, 2013b). However, participants in Grandy and Holton's (2013a) study conveyed that their time was spent reacting to issues rather than in reflection and improvement efforts. Researcher-led leadership-development interventions demonstrated that leadership qualities can be developed and, once developed, improve leader performance (Packard & Jones, 2015). Leggat and Balding (2013) supported the integration of leadership development for

clinical professionals throughout the organization. The healthcare leadership team includes clinical and nonclinical representatives; all healthcare leaders must contribute to collaborative and shared goals (Institute of Medicine, 2011). Therefore, efforts to develop healthcare leaders should include all leaders, rather than narrowly focusing on those in clinical roles.

The development of leadership competence extends beyond a requirement for role preparation and leader-development efforts and is not solely a responsibility of senior leaders. Leader development requires a foundation of personal traits and values acquired and developed from childhood through adulthood. Tubbs and Schulz (2005) presented leadership competence as layered in three concentric circles; the inner circles represented personality and values critical to leadership effectiveness. Other researchers supported a foundational level of leadership competencies (Boyatzis, 1982; R. Hogan & Kaiser, 2005; U.S. Department of Labor, 2012). However, what these researchers considered foundational differed.

Similar to the bulls-eye depiction from Tubbs and Schulz (2005), Boyatzis (1982) described demonstrations of competent leadership as a layered circular structure of internal and external factors. At the center are traits and motives of the individual; these influence how other competencies develop and how individuals react to external influences, such as job requirements or work environment (Boyatzis, 1982). Hogan (HAS, 2009; R. Hogan & Kaiser, 2005; R. Hogan & Warrenfeltz, 2003) presented four competency domains (intrapersonal, interpersonal, business/technical, and leadership) and expressed that these develop in stages. Intrapersonal competencies are earliest to develop, followed by the interpersonal domain (R. Hogan & Warrenfeltz, 2003). In

another example, the U.S. Department of Labor (2012) offered a competency model structured as a pyramid. In this model (see Appendix A, Table A15 for details), the foundation blends trait-like competencies of interpersonal, intrapersonal, and cognitive with some non-industry-specific state-like (learned) technical competencies. Consistent for the majority of identified foundational competences are those that are trait-like and innate or developed early in life.

Foundational leadership competencies are unlikely to change over time. Boyatzis (1982, 2008) argued that leaders can learn and develop many competencies of leadership, but trait competencies such as self-control and adaptability are innate and unvarying. Tubbs and Schulz (2005) shared this perspective, identifying that personality rarely changes, and values, though changeable, are unlikely to change over time. The interpersonal and intrapersonal domains develop when one is young and are difficult to change in adulthood (R. Hogan & Warrenfeltz, 2003). Though difficult to change, Goleman (1998/2004) suggested leaders can develop these characteristics included in emotional intelligence. Through training, leaders can develop these qualities (Goleman, 1998/2004; Hayashi & Ewert, 2013; Schutte, Malouff, & Thorsteinsson, 2013), but Goleman also recognized that development occurs through personal experience, stating "there is an old-fashioned word for the phenomenon: maturity" (p. 7). These foundational competencies influence who an individual is and prepare them for future knowledge and skill development.

Leaders can develop leadership competencies, though more so for those beyond the foundational traits (Boyatzis, 1982; R. Hogan & Warrenfeltz, 2003; Tubbs & Schulz, 2005). The stages of competency (unconsciously incompetent, consciously incompetent,

consciously competent, and unconsciously competent) indicate a need for awareness to proceed to development. How one moves from incompetence to competence, once aware of the need to do so, does not occur in one step; through a developmental process one gains knowledge and experience. Developers of the competency model used by the U.S. Office of Personnel Management (n.d.) recognized this need and created a five-level proficiency expectation for their competency model: awareness, basic, intermediate, advanced, and expert. Boyatzis (1982) and Calhoun et al. (2008) also recognized the developmental process in their competency models. Conscious effort to improve and develop leads to a skill or behavior becoming an unconsciously competent action; it becomes natural behavior.

Failure to recognize a need to develop competencies and then to do so can derail a career. Zes and Landis (2013), when studying the causes of derailment for leaders, recognized that unidentified weaknesses when self-perceived as strengths (blind spots) correlate with personal and organizational ineffectiveness. The greater the number of blind spots, the greater the impact on performance. Orr (2012) identified that blind spots are prevalent in that approximately 79% of individuals have at least one. The J. Hogan et al. (2009) finding supported the prevalence of blind spots, reporting that 30–67% of managers fail, stating that “two-thirds of existing managers are insufferable and at least half will eventually be fired” (para 8). Leaders may promote individuals into leadership roles based on positive impressions resulting from a charismatic or extraverted personality; these new leaders may not have the skills appropriate for the role (Dai & De Meuse, 2013; Winsborough & Sambath, 2013). Traits that suggest leader emergence do not guarantee leader effectiveness (De Neve et al., 2013). Career derailment for leaders

results from an incompetent demonstration of leadership behaviors, most typically incompetence with inter- and intrapersonal behaviors (Dai & De Meuse, 2013). Derailment behaviors cause reduced levels of employee engagement and resulting decreased productivity and performance (Inyang, 2013). Derailment occurs through the selection of candidates based on easily identifiable trait-like competencies, whereas leaders require both trait- and state-like qualities to be effective.

To avoid derailment and to grow and develop leadership competencies that produce positive outcomes, one must focus on personal performance. A person can develop leadership qualities, but must exert effort (Beinecke, 2009; Boyatzis, 2008) and have the support and commitment of senior leaders (Grandy & Holton, 2013b; Thompson & Kim, 2013) to do so. Self-awareness positively influences commitment to personal growth and development (O. J. Sheldon et al., 2014; Showry & Manasa, 2014; Vitello-Cicciu et al., 2014); one must be able to identify and accept personal weaknesses (opportunities for improvement) to then develop (Showry & Manasa, 2014). Improved self-awareness enables the development of other individual competencies of leadership (Vitello-Cicciu et al., 2014) and the development of overall leadership competence (Patton et al., 2013). For experience to progress to competence, one must first develop self-awareness.

Baron and Parent (2014) envisioned a five-step process in the development of leadership behaviors. The initial step is the development of self-awareness and identification of the need to change; self-awareness and motivation to improve trigger the developmental process (Baron & Parent, 2014). Avolio and Hannah (2008) proposed that for leaders to benefit from development opportunities, they must be ready to do so

(developmental readiness). Five criteria defined leader developmental readiness in Avolio and Hannah's development model; self-awareness is among these. In the self-directed leadership-development framework, development is a cyclical process beginning with self-understanding (Nesbit, 2012). In Nesbit's (2012) model, self-understanding occurs through an awareness of a gap between current and expected performance, self-reflection leading to self-awareness, and a greater understanding of the gap. Emotional intelligence plays a role in this developmental process. Hayashi and Ewert (2013) suggested that individuals need to have skills for stress management, problem solving, and an ability to adjust to changes in the environment before they can develop self-awareness. Additionally, leaders require emotional self-awareness and self-regulation in the process of development to manage the emotional responses that arise from performance feedback and the change process (Nesbit, 2012). From the gained awareness, the process for change occurs through a motivation to change and a continuing evaluation of performance.

Self-Awareness as a Common Theme for Effective Leadership

Self-awareness is a requirement for leadership-competency development. The ability to honestly assess current performance compared to expectations is the first stage of the developmental process. When self-aware, identification of the need to improve skills and knowledge and the motivation to do so increases (Vitello-Cicciu et al., 2014). The development of the competencies of leadership enhance the performance of a leader. Self-awareness is key to personal development and is a core element of effective leadership (Day et al., 2014; Leavy, 2016; P. Miller, 2012).

A search for *effective leadership* in current research repeatedly points to the use of soft skills and building relationships. This finding spans professional fields; for example, engineering (Lappalainen, 2015), education (Taliadorou & Pashiardis, 2015), banking (Cherian & Farouq, 2013), and healthcare (Hopkins et al., 2015). The soft skills of leadership are personality or behavior traits, influenced by the level of emotional intelligence one possesses.

In the 1980s, Gardner proposed the concept of multiple intelligences: linguistic, logical-mathematical, musical, spatial, bodily kinesthetic, interpersonal, and intrapersonal (H. Gardner, 1991). Interpersonal and intrapersonal are elements of social and emotional intelligence. The definition and initial elevation of the importance of emotional intelligence in leadership occurred through the work of Salovey and Mayer (1990) and Goleman (1995, 1998/2004). In their original work, Salovey and Mayer (1990) defined emotional intelligence as skills that "contribute to the accurate appraisal and expression of emotion in oneself and in others, the effective regulation of emotion in self and others, and the use of feelings to motivate, plan, and achieve in one's life" (p. 185). Later, these researchers developed an emotional-intelligence model that included reflectively regulating or managing emotions, understanding emotions (self and others), using the knowledge of emotions in cognitive processes, and perceiving and expressing emotions (Mayer, Caruso, & Salovey, 2000; Mayer, Salovey, Caruso, & Sitarenios, 2001). Goleman (1998/2004) revised the model and defined emotional intelligence as including five components: self-awareness, self-regulation, motivation, empathy, and social skills. Fundamentally, emotional intelligence is the ability to identify, regulate, and manage the influence of emotions in oneself and in relations with others.

Emotional intelligence has become a significant part of leadership research, though a balance between types of intelligences remains necessary. Boyatzis (2008) and Boyatzis and Saatcioglu (2008) emphasized the combination of cognitive, social, and emotional intelligence as critical for leaders to be effective. MacCann, Joseph, Newman, and Roberts (2014) postulated that emotional intelligence may rely on cognitive intelligence. Leaders need cognitive intelligence to identify and analyze visual and auditory cues; emotional intelligence contributes to how leaders assess the cues and subsequently respond emotionally (MacCann et al., 2014). Goleman (1998/2004) supported the concept that cognitive and emotional intelligences are of importance to leader performance, identifying these as "threshold capabilities" (p. 5), but believed that emotional intelligence is of greater importance and is critical to effective leadership outcomes.

Self-awareness, in the framework of emotional intelligence, is specific to an awareness of the emotional responses of self, others, and the influence of one's actions on the emotions of others (Goleman et al., 2013; Mayer, Salovey, & Caruso, 2008). This is *emotional* self-awareness (W. L. Gardner, Avolio, Luthans, May, & Walumbwa, 2005). Nonemotional self-awareness is the recognition of proficiency in performance-based actions of leadership. W. L. Gardner et al. (2005) distinguished between emotional self-awareness (awareness of values, identity, emotions, and goals) and awareness of skills, abilities, and knowledge. Nonemotional self-awareness has equal importance to the development of leadership competence (Korn Ferry, 2015) and is not disengaged from emotional self-awareness. The development of performance-related self-awareness relies

on the ability to be open to performance feedback from others, which differs from self-perception (Nesbit, 2012).

Researchers supported the relationship between emotional intelligence and effective leadership (Mills, 2009; Ugoani et al., 2015) or leader emergence (Cote, Lopes, Salovey, & Miners, 2010). However, data are inconsistent as the definitions of emotional intelligence and leadership effectiveness vary, study methodologies differ, and numerous variables influence results (Cherniss, 2010). Researchers often equate effective leadership in the study of emotional intelligence with the perceptions of others, rather than with objective measures of results (see Lappalainen, 2015). When including objective results, leaders may not consider other variables of influence (Cherian & Farouq, 2013). Leadership styles that correlate with emotional intelligence have further supporting research for their correlation to leadership effectiveness and contribute to support for the soft skills of leadership.

Ethically based leadership styles such as authentic, servant, and transformational correlate with emotional intelligence (Barbuto et al., 2014; du Plessis, Wakelin, & Nel, 2015; Ugoani et al., 2015) and effective leadership (Gotsis & Grimani, 2016). Authentic leadership means a strong leader–follower relationship created through transparency, trust, and steadfast alignment to values, ethical behavior, and follower development (George, 2015; Giolito, 2015; Turner & Mavin, 2014). Authentic leaders are emotionally intelligent (W. L. Gardner et al., 2005; Kotze & Nel, 2015) and the emotional intelligence characteristics of self-awareness and self-regulation are among the pillars of authentic leadership (Beddoes-Jones & Swailes, 2015). Authentic leaders are self-aware, know

their strengths and weaknesses, and know how these benefit or harm their role as a leader (Avolio & Gardner, 2005; Giolito, 2015; Turner & Mavin, 2014).

Greenleaf (1977/2002) originated and defined the concept of servant leadership. Servant leaders put others first and lead second; meeting the needs of and serving those for whom they are responsible is their primary objective (Zhu, Zheng, Riggio, & Zhang, 2015). These leaders build relationships with their followers based on trust and demonstration that they care (Staats, 2015). Such leaders are motivated to mentor, guide, and develop those they lead (Staats, 2015). Those who demonstrate a servant-leadership style have higher levels of self-awareness (Beck, 2014). The ability to be honest about their strengths and weaknesses—knowing themselves—is foundational to servant leadership (Beck, 2014).

Transformational leadership originated from the work of J. M. Burns (1978) and Bass (1985) and remains relevant today in leadership research. Transformational leadership rests on leader–follower relationships where, among other aspects, leaders are role models (Deinert, Homan, Boer, Voelpel, & Gutermann, 2015; Staats, 2015). Self-awareness of personal performance to model expected behaviors is imperative; thus, self-awareness is a core element in transformational leadership (Malik, Danish, & Munir, 2012).

Similar to emotional intelligence, researchers have also questioned research connecting ethically based leadership styles to effective leadership. Specifically, Andersen (2015) argued that the proposed link between transformational leadership and organizational effectiveness is unclear, stating that the primary concern is a lack of similarity among researchers in defining effectiveness. Andersen raised the argument that

other variables can contribute to performance outcomes and researchers have not yet identified these variables; thus, the effect of leadership style versus other variables is undetermined. The criticism of research linking emotional intelligence or ethically based leadership styles to leadership effectiveness demonstrates a need for greater study, rather than a disproof of the hypothesis. The definition of a leader through the years has included words such as motivating (Citaku et al., 2012), influencing (Northouse, 2013), supporting (Day & Harrison, 2007), and inspiring (Guo, 2009); thus, soft skills, characteristics of emotional intelligence and ethically based leadership styles, are critical to defining the characteristics of a leader.

Consistent across the study of emotional intelligence and authentic, servant, and transformational leadership is the theme of self-awareness as a critical core element (Avolio & Gardner, 2005; Giolito, 2015; Sturm et al., 2014). Self-awareness of strengths and weaknesses affects competency development and emotional self-awareness for the recognition, understanding, and regulation of emotions in oneself, others, and their impact on others. Awareness is a critical factor in a leader adapting their leadership style to a situation and driving a particular outcome (Staats, 2015). Awareness of self, internally, and self in the external environment, enables effective leadership outcomes.

Related Study Concepts and Theories

The study of competence is difficult to limit to just the definitions of competence, competencies, and competency models. One must also consider the interrelated concepts of self-efficacy, self-confidence, self-esteem, psychological empowerment, self-determination, leader identity, self-concept, and CSE. These concepts connect to themes that emerged from this study.

Self-Efficacy

Competence is the *demonstrated* ability to perform and achieve outcomes at or better than the expected level of performance. Self-efficacy is the *belief* in one's ability to perform a task or demonstrate behavior to meet or exceed expectations (K. M. Sheldon & Schuler, 2011). Self-efficacy is not synonymous with competence, but is related.

A leader in the study of self-efficacy, Bandura contributed to the topic beginning in the 1960s. Bandura (1977) developed the concept of positive self-efficacy as occurring through four feedback methods resulting from outcomes of experience. The first feedback method is internal: the feeling of accomplishment and the self-satisfaction of having successfully demonstrated skill or behavior. Verbal support or positive acknowledgement from others is another method, as is the observation of a successfully accomplished task by another (vicarious experience). The final method occurs through the modification of the instinctual reactions that connect to thoughts of performing a task or behavior. For example, one can replace a negative reaction such as fear and anxiety with positive thoughts and emotions associated with successful accomplishment of the task. Bandura's (1977) study of self-efficacy determined that individuals begin or sustain an activity if they feel capable of success; that is, if they believe their performance will demonstrate competence. The perception that an experience has gone well enhances self-efficacy, and enhanced self-efficacy improves willingness to try again and the likelihood of positive outcomes. The opposite is also true: perception that an experience went poorly lowers self-efficacy and decreases willingness to try again.

Studies by other researchers corroborated Bandura's (1977) self-efficacy research (Fay & Sonnentag, 2012) and connected self-efficacy to motivation to lead (Hannah,

Avolio, Walumbwa, & Chan, 2012; Krishnakumar & Hopkins, 2014). Leadership self-efficacy is the perception of ability to perform the tasks necessary to lead others (Ladegard & Gjerde, 2014). The literature supports the link between positive leadership self-efficacy and the performance of the leader individually, as well as the performance of their direct reports (Popoola & Zaid, 2015). Improved leader self-efficacy correlated to an improved leader–follower relationship and reduced turnover (Ladegard & Gjerde, 2014) and a leader's positive self-efficacy beliefs correlated with demonstrated competence (Panc, Mihalcea, & Panc, 2012). The self-efficacy of leaders improves their willingness to attempt the tasks of leadership; personal development occurs from willingness to try and this benefits employees and the organization. Personal development is especially important in light of data suggesting leaders are unprepared for their roles (Briggs et al., 2012; McDonnell et al., 2013). An individual may avoid certain tasks or behaviors of leadership due to undeveloped self-efficacy; instead, they may continue to perform technical skills with which they have proven competence and comfort.

Self-Confidence

Though similar, the concepts of self-efficacy and self-confidence differ. Researchers described self-confidence as judgment of ability or perception of competence and, thus, equivalent to self-efficacy (Hollenbeck & Hall, 2004; Shipman & Mumford, 2011). Hollenbeck and Hall (2004) further described the development of self-confidence as occurring through the experience of success, vicarious experiences, feedback from others, and the emotions generated from the experiences. This is a comparable development path to that described by Bandura (1977) for self-efficacy.

Bandura (1997) articulated the subtle difference between self-confidence and self-efficacy:

> Confidence is a nondescript term that refers to strength of belief but does not necessarily specify what the certainty is about. I can be supremely confident that I will fail at an endeavor. Perceived self-efficacy refers to belief in one's power to produce given levels of attainment. A self-efficacy assessment, therefore, includes both an affirmation of a capability level and the strength of that belief. (p. 382)

Bandura's explanation disagrees with the similarity of self-confidence and self-efficacy provided by Hollenbeck and Hall (2004) and Shipman and Mumford (2011). Although the concepts align, self-confidence is the belief in ability, even in the absence of direct correlational evidence, whereas self-efficacy relies on prior performance in support of a belief in future performance (Bandura, 1997).

In the study of competence and self-awareness, overconfidence is an inhibiting factor. Overconfidence can impede self-awareness and reduce the investment one makes toward their personal-competence development (Ferraro, 2010). Researchers of the Dunning–Kruger effect found that low performers overestimate their actual performance and their performance in comparison to their peers, and are overconfident in these assessments (Schlosser et al., 2013; O. J. Sheldon et al., 2014; Williams et al., 2013). Ehrlinger et al. (2008) expressed that confidence in performance does not equate to competent performance. Therefore, the confidence of a leader should be cautiously trusted until compared to actual performance and results.

Self-Esteem

Whereas self-efficacy is the belief that one will be competent in future performance, self-esteem is the present view of self that develops from prior experience. Self-esteem results from an evaluation and judgment of self-worth and the emotional results of this judgment (DeLisi et al., 2014); self-esteem is the degree to which individuals like who they are and deem themselves worthy (Hollenbeck & Hall, 2004). Self-esteem develops over time and is the perception and value of self, not a judgment of competence.

Self-esteem consists of readily observable or expressed evaluation of self (explicit) and a less readily apparent (implicit) view of self (Randolph-Seng & Gardner, 2013). For example, an individual may verbalize satisfaction or respect for themselves (explicit), but under stress express a negative self-view (internally or externally; implicit). Discrepancy between explicit and implicit self-esteem influences the response of an individual to feedback or stress (Cheng, Govorun, & Chartrand, 2012). This discrepancy may heighten defensive reactions to negative feedback or trigger symptoms of depression if made aware of a misalignment between actual and perceived performance (Cheng et al., 2012). With an optimal level of self-esteem, an individual possesses self-awareness of their strengths and weaknesses and explicitly and implicitly accepts themselves (Randolph-Seng & Gardner, 2013).

Researchers supported consideration of self-esteem as a contributory factor in the Dunning–Kruger effect (Amundsen & Martinsen, 2015; O. J. Sheldon et al., 2014). Protection of self-esteem (ego) may inhibit the ability to accept other-assessment of performance that is less positive than one’s self-assessment (Amundsen & Martinsen,

2015; Ryvkin et al., 2012). Further, those who self-assessed their performance as low in alignment with other-assessment demonstrate a lack of motivation to improve (Sitzmann & Johnson, 2012). Self-esteem protection may prevent the ability to recognize the need to improve, and poor self-esteem can demotivate desire to improve.

Psychological Empowerment

Empowerment is the granted or psychologically perceived sense of having authority or being capable to make decisions or perform actions without oversight (Avidov-Ungar et al., 2014; Fung, 2014). Psychological empowerment is a complex concept consisting of meaning, competence, autonomy, and impact (Degago, 2014; Ertürk, 2012; Singh & Sarkar, 2013). Competence, defined in relationship to psychological empowerment, is an individual's belief in their ability to perform (Ertürk, 2012; Singh & Sarkar, 2013). Given the definitions of competence and self-efficacy used in my study, the term self-efficacy is more appropriate. However, in support of the use of competence rather than self-efficacy, Gullan, Power, and Leff (2013) conveyed that empowerment relies on a proven level of knowledge, skill, and ability; empowerment requires more than the belief in the capability to perform. In addition to competence, an individual must also perceive that the work has value (meaning), believe they have influence over the outcomes of the work they perform (impact), and feel they have a choice about the methods used to complete tasks (autonomy; Ertürk, 2012; Gullan et al., 2013).

Empowered employees have greater job satisfaction (Amundsen & Martinsen, 2015; Dewettinck & van Ameijde, 2011) and commitment (Dewettinck & van Ameijde, 2011). In turn, empowered employees give greater work effort (Amundsen & Martinsen,

2015), have higher performance (Degago, 2014), and are more innovative (Ertürk, 2012). In a review of literature from the mid-1990s through 2011, Maynard, Gilson, and Mathieu (2012) found support for the benefit of empowerment on individuals, work teams, and organizations. Specific to leaders, Solansky (2014) assessed the influence of psychological empowerment on the developmental ability of a leader. Higher levels of psychological empowerment correlated with an increase in leaders seeking experiences and other skill-development opportunities (Solansky, 2014). Additionally, leaders demonstrated employee-empowering behavior in correlation with positive perceptions of competence, meaning, and impact (Havaei, Dahinten, & MacPhee, 2014). Therefore, leaders who are psychologically empowered empower their employees. The positive benefits of psychological empowerment are equally valuable to leaders as to employees.

Self-Determination

Self-determination theory is a motivational theory based on the premise that needs met for autonomy, competence, and relatedness can motivate self-development and improve performance (Deci & Ryan, 2000). Competence, defined in relation to self-determination, affiliates with the definition of self-efficacy in my study: it is the belief in the ability to perform (Deci & Ryan, 2000; Talley, Kocum, Schlegel, Molix, & Bettencourt, 2012). Relatedness is the feeling of connectedness with and love toward others (Deci & Ryan, 2000; Talley et al., 2012). Autonomy is the perception that the activities performed or behaviors demonstrated align with how one views oneself (Reis, Sheldon, Gable, Roscoe, & Ryan, 2000; Talley et al., 2012). Deci and Ryan (2000) equated the needs for autonomy, competence, and relatedness to Maslow's hierarchy, suggesting these are innate psychological needs. Self-determination is a basic human

need, with similar correlation demonstrated across cultures (Church et al., 2012; Hofer & Busch, 2011).

The correlation between self-determination and well-being, job satisfaction, and motivation has a history of associated research. Reis et al. (2000) found that well-being and self-determination correlated positively, though individually the met needs of autonomy and competence had stronger correlation than the need for relatedness. Talley et al. (2012) similarly studied the individual elements of self-determination and found that met needs of competence reliably predicted the psychological feeling of well-being. Autonomy and relatedness influence the perception of competence, though differently in nonwork roles (e.g., parent or spouse) than in a role in the workplace (Talley et al., 2012). Hofer and Busch (2011) found that the stronger the need for feelings of competence, the greater the association with a sense of well-being and job satisfaction when the need was met. Conversely, if the need was unmet, those with the greater need for the feeling of competence expressed a larger sense of loss (Hofer & Busch, 2011). Those with a higher need for achievement demonstrated a greater need for feelings of competence (Schuler, Sheldon, & Frohlich, 2010). When those with a need for high-achievement experienced competence, their motivation, commitment, and progress correlated more positively than for those with a low need for achievement (Schuler et al., 2010). Autonomy and relatedness are influential psychological components to one's perception of competence, with autonomy having greater influence in the workplace. The met need for self-determination, specifically the perception of competence, enhances feelings of well-being and job satisfaction and increases the motivation to achieve.

Leader Identity

Individuals readily shift between multiple identities (e.g., social, personal, or role) (Brown, 2015); leader identity is one of these. Leader identity is the belief that one is a leader and demonstrates leadership qualities (Day & Harrison, 2007). Leader identity and the possession of leadership self-efficacy create a motivation to lead and act as a leader (Key-Roberts, Halpin, & Brunner, 2012). To develop as a leader, one must see themselves as a leader (Murphy & Johnson, 2011). DeRue and Ashford (2010) supported that leadership-identity development occurs through the internal beliefs of an individual combined with feedback from the environment and reinforcement from others. Leader identity occurs through relationships in which returned recognition or validation align with one's self-perception as a leader.

Self-efficacy develops through personal and vicarious experiences, feedback and support from others, and mastery of physiological and emotional states (Bandura, 1977). Komives et al. (2009) identified these same elements for the development of leader identity, supporting leadership-identity development as occurring in six stages: (a) awareness of leadership and of individuals who are leaders; (b) engagement in group activities, such as sports or clubs; (c) identification of hierarchical structures in groups; (d) recognition that leadership behavior does not require a title, and members of groups can share responsibility for leadership behaviors and activities; (e) practice of mentoring and developing others; and (f) recognition of oneself as a leader, with or without a title.

Influences on these stages of development include the changing self-perspective of leadership and leaders, group influences, experiences, developing self-awareness, and modeled behavior (Komives et al., 2009). Murphy and Johnson (2011) supported the

development of a leader identity as occurring throughout life, beginning in childhood and evolving through experiences, feedback systems, and gained self-efficacy. A later case study by Muir (2014) explored the development of leader identity through mentor relationships and found alignment to the six developmental stages of Komives et al. (2009). Muir identified that participants expressed a developed understanding of leadership as well as of themselves as leaders through the mentor-learning program.

Self-reflection and developed self-awareness are core elements in the development of leader identity (Day & Harrison, 2007; Komives et al., 2009). Leadership identity and competence development occur in tandem when in the presence of experiential opportunities and accurate feedback (Lord & Hall, 2005). Reflection and experience develop self-awareness and solidify leader identity (Muir, 2014). Thus, awareness of demonstrated leadership characteristics contributes to the creation of one's identity as a leader.

Self-Concept

The perception of prior performance in relation to current ability is self-concept. Self-efficacy and self-concept are similar notions in that they develop through one's perception of their competence; they differ in past or future view (Hughes et al., 2011). Self-concept is the perception of current competence based on past performance. Self-efficacy is the belief in one's future ability based on perceived current competence. Self-efficacy and self-concept conceptually overlap, as do self-concept and identity. Identity shifts based on the persona being addressed (e.g., social or work role) (Brown, 2015) whereas self-concept is more broadly encompassing of self across identities (Schwartz et al., 2011).

Core Self-Evaluation

CSE is the evaluation one makes of their self-worth, abilities, and competence, consisting of self-esteem, generalized self-efficacy, emotional stability (or low neuroticism), and internal locus of control (Chang et al., 2012; Judge et al., 2003). Self-esteem is the self-appraisal of one's worth (DeLisi et al., 2014). Generalized self-efficacy is the perception of one's ability to competently perform in a number of situations rather than in a specific task or behavior (Chang et al., 2012; Judge, Erez, & Bono, 1998; Judge et al., 2003). Neuroticism is the "tendency to exhibit poor adjustment and experience negative effects such as fear, hostility, and depression" (Judge et al., 1998, p. 170); emotional stability is the opposite. Internal locus of control is the perception one has of their control over the events in their life (Judge et al., 1998, 2003). Judge et al. (2003) categorized CSE as a high-level personality trait identifiable by the characteristics of the four individual traits.

The four traits of CSE interrelate and, together, correlate with job satisfaction (Lemelle & Scielzo, 2012) and performance (Chang et al., 2012; Judge et al., 2003). Researchers suggested that the four traits of CSE, when assessed together, predict the job behavior of participants more adequately than if any one of the four traits were assessed alone (Judge, 2009). However, Chen (2012) questioned the validity and viability of CSE research. Chen acknowledged that prior research demonstrated a relationship between CSE and job performance, job satisfaction, reduced stress, and greater career success. Nevertheless, Chen questioned the inclusion of the four traits rather than other traits, the necessity of the traits in combination rather than as individual influencers of performance

and satisfaction, and the exclusion of other contributory environmental or personal influences on these traits.

Related research supported Chen's (2012) questioning of CSE and other influencing factors (Grant & Wrzesniewski, 2010; Kacmar, Collins, Harris, & Judge, 2009). Grant and Wrzesniewski (2010) suggested that the other orientation of an individual influences the relationship between CSE and performance. Other-oriented individuals are motivated to high performance because of feelings of guilt or gratitude. Individuals with a high other-orientation consider their effect on others. When other-oriented motivated, CSE is more likely to predict improved performance (Grant & Wrzesniewski, 2010). Grant and Wrzesniewski's research had similarity to self-awareness in that the consideration of the effect one has on others is a necessary element.

Environmental factors influence the positive relationship between high CSE and performance (Kacmar et al., 2009). In a highly political environment, where recognition or demonstration of appreciation was low, the performance of participants with high CSE deteriorated (Kacmar et al., 2009). Alternatively, in a positive work environment, participants with a high CSE had positively correlated performance. The meta-analysis performed by Chang et al. (2012) also supported the findings of environmental influence. Chang et al. expressed that those with high CSE thrive when conditions are favorable; in positive, nonpolitical environments, people with high CSE take advantage of opportunities.

Summary and Conclusions

This literature review provided an exhaustive overview of the core concepts of competence, leadership, self-awareness, and interrelated themes. The evolution of

understanding of these topics and the gained awareness of the complexity of each has developed since the early 1900s; the available research on these topics, individually and in combination, is vast. Leaders are both born and made; that is, the qualities of leadership are a combination of innate characteristics and learned behaviors. These characteristics and behaviors make up the six leadership-competency domains: cognitive, technical, management, interpersonal, intrapersonal, and leadership.

This chapter also addressed the critical need for effective leadership in healthcare. Competent leadership is necessary to support the financial viability of local and national healthcare systems and, more importantly, the lives of those served. Though research on all topics addressed in this literature review is abundant, researchers failed to adequately serve the population of nonclinical healthcare leaders. Additionally, a theory for how competence self-awareness develops in midlevel healthcare leaders is unavailable. Midlevel nonclinical leaders lead those who provide foundational support for local healthcare systems to function and serve their mission. This study contributes to filling the gap in the research for this population on the topic of self-awareness development.

Chapter 3: Research Method

The purpose of this study was to explore how healthcare leaders develop an awareness of their leadership competence. In this chapter, I define the research methods used in the collection, organization, and analysis of data that contributed to answering the research question and achieving the purpose of the study. This chapter also addresses the rationale for selecting the phenomenological approach, the role of the researcher, and the methods used to enhance the trustworthiness of the data and protect the confidentiality of participants.

Research Design and Rationale

The following research question guided this study: How do midlevel nonclinical healthcare leaders develop an awareness of their leadership competence? The search to address this question included an exploration of the skills, knowledge, abilities, and behaviors of leadership that midlevel nonclinical healthcare leaders perceived themselves to perform competently and the experiential evidence they offered in support of their perceptions. The connection between self-awareness, development of leadership competencies, and leadership effectiveness establish the conceptual framework for this study.

Researchers use qualitative methods to collect and explore the perceptions and experiences of participants. Researchers use the qualitative approach of phenomenology to explore the lived experiences of participants. Examining the themes that emerge from this exploration enables researchers to gain an enhanced understanding of the phenomenon under study. In this study, I used Vagle's (2014) postintentional phenomenological approach to underlie exploration of the experiences and perceptions of

midlevel nonclinical healthcare leaders regarding their leadership-competence awareness. I selected Vagle's method over that of other researchers, such as Moustakas (1994), because of the dynamic relationship of the phenomenon for those who experience it.

Van Manen (2014) detailed the historical development of the phenomenological method. Two philosophical researchers, Husserl and Heidegger (van Manen, 2014), provided the early development of the study of lived experiences (phenomenology), enhanced and influenced by a number of philosophers and researchers. Prephenomenology philosophers include Descartes, Kant, Hegel, and Nietzsche, and contributors following Husserl and Heidegger are many (see van Manen, 2014). Influenced by all who contributed to the development of phenomenology, Vagle (2014) introduced the approach of postintentional phenomenology. I used Vagle's philosophy and methods in this study.

Postintentional phenomenology contrasts with the Husserlian and Heideggerian approaches to phenomenology. Husserl's approach was descriptive and epistemologically focused (Dowling & Cooney, 2012; van Manen, 2014), searching for and describing the "essences of lived experiences" (van Manen, 2014, p. 89) and developing a full understanding of the phenomena. Vagle's (2014) perspective on Husserlian phenomenology was that it is the study of *of-ness*, the connection or relationship among the subject (participant) and object (phenomena). Heidegger's approach was interpretive (hermeneutic) and ontological (Dowling & Cooney, 2012; van Manen, 2014), searching for the "nature of being" (Dowling & Cooney, 2012, p. 24). Heideggerian phenomenology is the study of *in-ness*, the intersubjective relationship of subject and

object such as to describe the relationship of an individual (subject) and emotions (object/phenomena) of love (in-love) or pain (in-pain; Vagle, 2014).

Whereas Husserlian phenomenology is the study of of-ness and Heideggerian phenomenology the study of in-ness, Vagle's (2014) approach is the study of *through-ness*. Postintentional phenomenology is descriptive and interpretive and focused on the nature of becoming (Vagle, 2014). In describing this pictorial representation of through-ness Vagle (2014) stated,

> I imagine the lines of this image being permeable and malleable: they are not rigid, nor are they finite. Like intentional meanings, they shift and change in and over time, through ever changing contexts. The lines of overlap and grey areas signify some salient, partial, fleeting, temporary, unstable intentional meanings. In this sense, the "of-ness" and "in-ness" of intended meanings are at best glimpses of possibilities. (pp. 40–41)

Intentional meanings are a significant concept in phenomenology and Vagle emphasized their importance in postintentional phenomenology.

Van Manen (2014) defined intentionality as the lived experience between the subject and the object: it is "the intentional ways that the phenomenon gives itself, shows itself, or appears in consciousness" (p. 63). Dowling (2011) explained intentionality as "the internal experience of being conscious of something" (p. 56). Intentionality is neither the subject nor the object, but, rather, the relationship between (Vagle, 2014). Vagle's (2014) postintentional phenomenological approach accepts and seeks the intricacies of multiple and shifting relationships. This approach allows and encourages an exploration

of phenomena from different angles to gain a full understanding of all potential differences or similarities.

Postintentional phenomenology was an ideal approach for this study, as self-awareness and competence are both complex and shifting concepts. Self-awareness rests on internal insights developed from external and internal assessments and recognition of influence on others (Morin, 2011; Reilly et al., 2013; Silvia & Phillips, 2013). Self-awareness shifts with the addition of new knowledge or insights. Competence is a developmental progression that alters as processes, technology, knowledge, self-awareness, or other variables (external and internal) assert influence. The intricate nature of these phenomena (objects) and their relationships with leaders (subjects) are best studied with postintentional phenomenology.

Vagle's (2014) postintentional phenomenology follows a defined process containing five steps. Step 1: Identify the phenomenon "in its multiple, partial, and varied contexts" (Vagle, 2014, p. 121). The identification of the study phenomenon occurs throughout Chapters 1, 2, and 3. Step 2: Define the data-collection process (Vagle, 2014); I meet this step in this chapter. Step 3: Create a postreflective plan (Vagle, 2014); the instrumentation section of this chapter contains this plan. Step 4: Read the transcripts and collected data, reflect on what stands out from the material, and then read the content again (Vagle, 2014). Vagle provided a clear process for this task, whole-parts-whole, defined in the data-analysis section of this chapter. Step 5: Write the analysis of the findings from the tentative manifestations (themes) (Vagle, 2014).

Role of the Researcher

In qualitative research, the researcher is the data collector and the interpreter responsible for creating meaning from the data (Vagle, Hughes, & Durbin, 2009). Accordingly, the researcher should be open to the possible themes and relationships that develop from the data by remaining neutral and minimizing the influence of personal bias or prior knowledge. Vagle et al. (2009) recognized that a researcher selects a phenomenon to study based on personal interest. Thus, it is not a question of "whether we are influencing the phenomenon, but in what ways we are influencing" (Vagle et al., 2009, p. 348). Researchers should disclose their potential influence on the research, as I do here.

My background in healthcare leadership had the potential to bias this study. Beyond the risk of bias, no threat to invalidation of findings existed from conflicts of interest, power relationships, or uses of incentives. I have worked in healthcare for the past 18 years. My leadership career path began in a 40-bed community hospital in a dual role as clinical dietitian and foodservice manager, directly after graduating and obtaining my dietetic registration. "I was hardly a dietitian, let alone a manager" is how I often describe my preparedness to lead, a sentiment of personal inexperience in my early career, underscoring the basis for this research. Life changes, advancements into larger healthcare systems, progressively advanced leadership roles, and a career change into healthcare information technology provided me with many experiences. These opportunities allowed for observation of differences in and between healthcare systems and leaders. Personal reflections on leadership competence led me to immerse myself in the study of leadership with the intent to develop my own competence as a leader.

In this study, I was involved in and responsible for all aspects of the research. My previous professional experience as a midlevel leader in a healthcare system, combined with personal and academic interest, influenced the selection of the topic for this study and had potential to bias the data collection and analysis. A positive potential benefit of my prior experience was that it afforded me the unique ability to understand the business perspective and language of participants.

I carefully addressed my prior relationships with the study sites or potential participants throughout the study. For example, one site fitting the criteria of the study was a healthcare system where I worked for 8 years. My knowledge of the organization and its culture and my relationship with the leaders in the organization could risk invalidating this study; thus, I did not include this site. My personal knowledge of the remaining organizations available for use in the study was minimal with the exception of one where I worked over 10 years ago. The intervening time since my employment minimized the potential influence of my experience. To reduce risk further, no potential participants with whom I had direct working or personal relationships were included in the study, regardless of my experience with the organization for which they currently work.

Husserlian phenomenology includes the use of bracketing and reduction to remove the influence of the researcher's bias, preconceptions, and perceptions (Dowling & Cooney, 2012; Tufford & Newman, 2010). Thus, Husserlian phenomenology is descriptive: the researcher describes but does not interpret participant experiences. Heidegger did not support the belief that the influence of the researcher could be removed (bracketed); instead, the suggested approach was to provide an interpretive (hermeneutic)

perspective of the participant experience (Dowling & Cooney, 2012; Tufford & Newman, 2010). For Heidegger, the researcher is an unavoidable participant in the study (Tufford & Newman, 2010). To manage the influence of the researcher on the collection and contemplation of participants' expressed experiences, the researcher documents preconceptions prior to data collection and maintains a reflective practice throughout the study (Converse, 2012; Wilson, 2014). Vagle's (2014) approach aligns with that of researchers who blend the practices of Husserl and Heidegger (Dowling & Cooney, 2012; Tufford & Newman, 2010). Vagle's approach is descriptive and interpretive and uses bridling to gain awareness of researcher influence.

Bridling includes practices for bracketing and reduction, but allows for interpretive thought, if fully explored (reflective practices), for alignment to the experiences of the participant (Vagle, 2014). The researcher documents bias, perceptions, and preconceptions at the beginning of the study and reflects and elaborates on them throughout to minimize (bracket) their influence (Vagle, 2014). The practice of bridling encourages reflection and self-questioning to validate understanding or interpretations and exploration of participant experiences.

To minimize the influence of my biases, experience, assumptions, and preconceptions about the study phenomenon, I used bridling and reflection. Vagle's (2014) five-step process for postintentional phenomenology includes the creation of a reflective plan. A later section of this chapter details the reflective plan for this study.

Methodology

Participant-Selection Logic

The broadest definition of the population intended for this study of the competence self-awareness of healthcare leaders could include all healthcare leaders, but I chose to narrow the population of the study to that of midlevel nonclinical healthcare leaders who work for midsized healthcare systems. Three factors supported this decision: this population is important because they support the foundation of a healthcare system, this population is understudied, and the scope of the study is manageable. Considerations of my time and budget during the data-collection process, and the desire for in-person interviews, guided the decision to select which healthcare systems to include. This selection narrowed the available healthcare systems and, thus, the participation population, to a region within a 50-mile radius of Covington, Washington, my home city.

Three definitions clarify the intended population for this study. *Midlevel leaders* are those with titles of manager or director who have a team of five or more people reporting to them. These leaders have a more senior leader to whom they report, and may have junior leaders, such as supervisors, who report to them. *Nonclinical* departments contain professionals and staff who do not provide medical care to patients. Examples of such departments include foodservice, maintenance, finance, and information technology. *Midsized* healthcare systems contain an acute-care hospital licensed for 225 to 450 beds and may include satellite clinics.

Senior-level leaders (sponsors) and midlevel nonclinical leaders participated in the study. The study focused on data obtained from the second group. Sponsors provided approval for the organization and its midlevel leaders to participate in the study. Selection

of senior-leader participants occurred through purposeful sampling, based on their role in the organization and response to my inquiry of the organization. Identification of midlevel nonclinical participants occurred initially from the sponsors; the snowball-sampling method created the remaining participant pool. I selected snowball sampling as the sampling strategy because other-assessment of performance (i.e., peers and supervisors) is more accurate than self-assessment (Braddy et al., 2014). Thus, the first criterion of participation for midlevel nonclinical leaders was their competence, identified by a senior-leader sponsor or peer.

The use of inclusion criteria assisted in selecting participants who had a shared knowledge and experience with the phenomenon under study. These criteria required participants to (a) be employed (not a contractor) by one of the selected healthcare systems, (b) hold a position as a midlevel nonclinical leader, (c) be perceived by another leader as demonstrating competence in more than one of the leadership skills or behaviors aligned to the leadership domain (example of leadership domain competencies are listed in Table 4), (d) have 5 or more years of work experience in healthcare, (e) have greater than 2 years in a midlevel healthcare leadership role, and (f) perceive themselves to be competent in one or more leadership skills or behaviors aligned to the leadership domain. These criteria helped ensure the collection of data reflected healthcare experience, rather than influence from a prior career outside of healthcare, and that adequate time in a leadership role had created an impression or perception of competence to develop. I included an additional criterion, permission to record the interviews, for method consistency.

Table 4

Example of Leadership Domain Competencies

Competencies
Coaching and developing individuals and teams
Change management
Communication skills
Conflict management/resolution
Creating a vision
Delegating
Empowering
Inspiring
Mentoring
Motivating
Negotiating
Organizational awareness
Politically savvy
Role modeling

The sample size for a phenomenological study does not have clear definition or agreement in the research community. In qualitative research such as grounded theory, data saturation indicates adequate sampling (Glaser & Strauss, 1967). However, van Manen (2014) emphasized that a phenomenological researcher is not in search of commonalities among participants (data saturation) per se. Phenomenologists search for insights unique to the participants that contribute to a richer understanding of the experience (van Manen, 2014). Vagle (2014) supported that a clear identification of sample size is difficult in advance of the study and depends on the study phenomenon. The sample size may be small if the researcher will collect a large amount and varied data (interview, observation, or other) from each participant; less time spent with and data collected from participants increases the necessary sample size (Morse, 2015; Vagle,

2014). Further, excessive data can impair the researcher's ability to perform deep analysis (Marshall, Cardon, Poddar, & Fontenot, 2013) and inhibit adequate reflection (van Manen, 2014). Ultimately, the researcher must determine if they have included an adequate number of participants. However, identification and justification for a minimum sample size in advance of data collection is necessary.

A number of researchers (see Table 5) have provided guidance and rationale for an ideal sample size in a phenomenological study. Using this guidance, the minimum sample size for this study was 12 participants. I shared the rationale to stop interviewing with my committee; their advice and support guided the final sample size.

Table 5

Sample Size in Phenomenological Research

Researcher	Sample size	Rational
Smythe (2011)	12–20	Stated amount for a doctoral study
Gentles, Charles, Ploeg, & McKibbon (2015)	< 10	If large amount of data is collected (multiple interviews or other collection methods)
	> 30	If less data collected
	~12	If descriptive phenomenology
Guest, Bunce, & Johnson (2006)	~12	70% of codes identified within the first six interviews and over 90% by the 12th

Note. Guest, Bunce, and Johnson (2006) spoke to grounded theory and to phenomenology; their focus was on reaching data saturation.

Instrumentation

This study explored the lived experiences of participants' developed awareness of their leadership competence from in-person interviews, observations of participants' personal workspaces, and organizational- and participant-specific documentation. To investigate this phenomenon fully, it was necessary to explore the individual components

of leadership, competence, and self-awareness separately and in relation to each other. Verbal participant responses (interviews) may not have sufficed; Vagle (2014) advised openness to and inclusion of a number of data sources, as potential insights may accrue from unexpected sources. Visual cues from the observation of participants' personal workspaces, documentation of performance expectations (e.g., job description or performance-evaluation forms), and personal résumés enhanced understanding of role expectations, personally expressed competence, and skill-development methods. Field notes, postinterview comment sheets, original recordings and transcripts, and reflective journaling supplemented these primary data sources. These methods are secondary data sources and enriched my understanding of the primary data. Collectively, the primary and secondary data-collection sources and instruments provided depth of data for a robust analysis. I have presented the alignment of each data-collection source to the research question in Table 6.

Table 6

Alignment of Primary Data Collection Sources to the Research Question: How do Midlevel Nonclinical Healthcare Leaders Develop an Awareness of Their Leadership Competence?

Document source	Rationale/alignment
Interview	Verbal exploration of participant's lived experience; perception of skills, knowledge, abilities possessed that align to role; and perception of professional-self.
Workspace observation	Observation and discussion of visual cues in the workspace in support of participant's prior statements (from interview) or that offer further exploration. The cues may include books, awards, quotes, or other items.
Résumé	Professional tool used to share prior experience and statements of competence.
Job description	Statement of role and performance expectations. Implied assumption of competence alignment to expectations.
Performance evaluation process/form	Statement of role and performance expectations. Implied assumption of competence alignment to expectations.

Interview guide. A semistructured interview format allows researchers to develop a predetermined list of questions or themes, but the order in which researchers ask these questions or the exact wording of the questions may change from one interview to the next. In this interview format, the line of inquiry may vary based on information obtained from the interviewees that warrants further elaboration, but the base structure retains consistency across each participant interview. Researchers ask clarifying or unanticipated questions based on comments contained in participant responses. Vagle (2014) supported using a semistructured interview format, declaring that an unstructured format risks distraction from the purpose and research question. Semistructured interviews also provide method consistency and help maintain the trustworthiness of the study (Bevan, 2014; Høffding & Martiny, 2015; Vagle, 2014).

The creation of the interview guide followed the recommendations of Bevan (2014), Vagle (2014), and van Manen (2014). Van Manen emphasized that phenomenological interviewing avoids asking questions of perception, interpretation, or belief; rather, questions should remain focused on descriptions of the lived experience. Vagle (2014) added that each interview question should clearly link to the research question and researchers should actively listen during the interview for those moments when they need to ask additional clarifying questions. The intent of the questions is to collect the prereflective experiences of participants (Høffding & Martiny, 2015; Vagle, 2014). Prereflective experiences are the aspects of an experience not fully in the participant's consciousness (Høffding & Martiny, 2015); thus, questions of differing formats that seek greater depth and clarity of understanding help raise these experiences to the conscious level (Bevan, 2014; Høffding & Martiny, 2015; Vagle, 2014).

Bevan (2014) recommended the use of three domains of questions for phenomenological interviews: contextualization, apprehending the phenomenon, and clarifying the phenomenon (p. 138). Contextualization questions are descriptive, tell me how … or tell me about …; initial questions in the interview guide should consist primarily of contextualization questions. Apprehending the phenomenon questions help validate or clarify understanding of participant statements. These questions tend to be structural (directly asking for clarification) or descriptive to gain further elaboration for the narrative. Apprehending the phenomenon questions are typically unique to each participant and not part of an interview guide; they serve to clarify the narrated experiences. Clarifying the phenomenon questions use "imaginative variation" (Bevan, 2014, p. 141) to further clarify an experience or identify previously unshared aspects.

These questions retain elements of the original experience, but ask for an alternative consideration. For example, in the case of this study, if a participant expressed a lack of mentoring relationship in their career, I might ask, "if you had a trusted mentor, what effect might that have for you?" This questioning format is contrary to van Manen's (2014) instruction to avoid asking for perceptions or views not directly related to describing the experience. I used imaginative variation carefully so as not to cross the boundary from actual experience to the what-if scenario, and to encourage a different way to describe an experience or feeling.

With the research purpose and question in mind and following the recommendations of Bevan (2014), Vagle (2014), and van Manen (2014), I created the interview guide found in Appendix D. Each question and the rationale for its inclusion follow. In these questions, I purposefully avoided reference to the individual as a leader or as competent to remove inferred expectations that may unintentionally influence responses.

Interview Question 1. Tell me about your career path, how did you get where you are today?

Interview Question 1 elicited a personal story from each participant. This question served to begin the explorative conversation of the phenomenon through the participant's lived experience. This is a descriptive question; the participant's responses prompted unscripted structural or descriptive questions for clarity and understanding.

Interview Questions 2. Tell me about the skills, knowledge, and abilities you possessed when you first began your career. How have these changed? What contributed to this change?

Question 2 sought elaboration to the response from Question 1. If the prior response alluded to changes in skill, knowledge, and ability of the participant since their early career, Question 2 helped to clarify. Question 2 is descriptive and had behaviorally anchored and structural follow-up questions.

Interview Questions 3. Tell me about the skills, knowledge, or abilities required for your current role. How do your skill, knowledge, and abilities align to those you listed? How do you know this?

Question 3 built on the developing conversation and moved the focus to the participant's current role. Question 3 is descriptive and had behaviorally anchored and structural follow-up questions.

Interview Question 4. What words would you use to describe yourself in your professional life? Tell me why you describe your professional-self in these words.

Question 4 served to disassociate participants from the skills, knowledge, and abilities (competencies) for their role, moving to a descriptive exploration of the individual in the professional setting. This variation in the questioning opened investigation of professional identity.

Interview Question 5. If you were to equate how you feel in your role to a musical style (classical, heavy metal, alternative, etc.), what would you choose and why?

Question 5 is an imaginative-variation question (Bevan, 2014). Phenomenology often uses creative means (participant writing or artwork) to explore subconscious connections to experiences (Vagle, 2014). By asking participants to equate how they feel in their role to a musical style, I opened an alternative perspective to the conversation.

Interview Question 6. How would you define: leadership; competence; self-awareness?

Questions 1 through 5 purposefully preface this final question so as not to bias responses from participants in those questions. Interview Question 6 collected the definitions of leadership, competence, and self-awareness from participants' perspectives. These words may have had different meaning for each participant and may have differed from that defined in this study. An important process in phenomenology is the validation of meaning to remove influence from researcher bias or unverified assumptions (van Manen, 2014; Vagle, 2014). Because the words leadership, competence, and self-awareness are central to this study, I asked this structural question of each participant.

Interview Question 7. I would like to observe your office (or personal workspace), and ask questions about what I see or do not see. Can you tell me about … ?

Question 7 began a conversation about participants' workspace to gather data that may have contributed to an understanding of their experience in a leadership role or personal leadership development. Other than Maxwell's (2012) assertion that the content of an individual's personal workspace offers insight to who the person is and what matters most to them, no definitive correlation exists between content in a personal workspace and leadership development or competence. However, Vagle (2014) encouraged inclusion of multiple data sources and the conversation during this observation may have offered a unique insight.

After Questions 1 through 7 concluded, the participants were asked to refer peer leaders they perceived to be competent. I also collected an explanation for their perception of this leader's competence. This response was contributory to the

participant's response to prior questions, specifically Question 6, and to the responses from the referred leader if they were included in the participant sample.

Documentation collection. A number of pieces of documentation from participants and host organizations augmented the data obtained during the interviews. From each participant, documents included a demographic-information form and résumé. I sent the demographic-information form, modeled on those used by Dearinger (2011, p. 223) and Johnson (2013, pp. 178–179), to each participant in advance of their scheduled interview. This form enabled me to collect information about the participant such as gender, age, current job role, years at the current organization, and years of experience in healthcare. A copy of the demographic-information form appears in Appendix E.

An individual's résumé may contain statements of competence and indicators of personality (G. N. Burns, Christiansen, Morris, Periard, & Coaster, 2014; Lipovsky, 2013) and should be defensible during job interviews. However, Wang and Yorks (2012) identified that individuals write résumés to gain access to an interview; they may feel disconnected from the content contained in the document as they lack self-awareness of their skills as they align to the listed achievements. The focus of this study was on individual leaders' self-awareness of their competence; the information participants included in their résumés provided insight into this phenomenon. I reviewed participants' résumés after my first interview with them to prevent influence on my perception of their skill, knowledge, and ability. I used the contents of the résumés to generate questions for the second interviews.

Documents collected from organizations included sample job descriptions and performance-review process and forms, and other tools used in the clarification of job roles and expectations. Document collection occurred during or subsequent to the meeting with the senior-leader sponsors or participants. Reviews of these documents assessed use of leadership-competence statements versus technical- or management-competence statements in the setting and assessment of role expectations. Review of these documents followed the first interview with a participant to prevent influence on my perception of role expectation. I created questions for the second interview from this review.

Field notes and postinterview comment sheets. Audio recordings do not capture all data elements of relevance from interviews, such as nonverbal cues and researchers' perceptions. These data elements contributed to understanding the primary data and benefited the research. Methods to enhance the data collected from the interviews included field notes and a postinterview comment sheet.

I took field notes during the interviews on a printed copy of the interview guide. These notes included observations of the office or workspace, nonverbal cues from participants when responding to questions, and other impressions. During interviews, I focused on participants and building rapport, rather than on collecting detailed field notes. Thus, I reviewed and added clarity to these notes directly after leaving the participant and before exiting the building. Kvale (2007) suggested researchers set aside time directly after each interview for reflection on the interview and to document impressions, while memory of the entire interview remains clear in the researcher's mind. Documenting directly after each interview prevented the loss of data or confusion of data between

interviews. These postinterview additions to the field notes captured details specific to the content of the interview.

In addition to adding content to the field notes, after each interview I completed a postinterview comment sheet (see Appendix F). Following Wickham's (2012, p. 86) example, this tool captured the tone of the interview, my reaction to participant responses, strengths and weaknesses of the interview, and any concerns or other relevant documentation. The postinterview comment sheet captured specific details on the data obtained from the participant as well as the quality of the interview. This tool helped gather immediate impressions I then used for memoranda and journal entries.

Reflective plan. One of Vagle's (2014) five steps for the postintentional phenomenological approach is the creation of a plan for reflection. The plan for this study included the creation of a postreflective statement, revisiting this statement to review and add further insights at regular intervals, maintaining a reflection journal, and memoing. I captured the postreflective statement through my responses to questions developed from recommendations offered by Vagle (2014) and Tufford and Newman (2010; see Appendix G). This statement also captured my responses to the questions in the interview guide to document my own experience with the phenomenon. I indicated the dates of my original responses and tracked additions or modifications during the research with the date and rationale. As the themes from the analysis of data began to emerge, I compared these to my postreflective statement to question the true nature of the themes rather than the influence of my preconceptions.

Incorporating reflective journaling into the research methods helped reduce the influence of my perceptions and bias in the collection and analysis of data. Researchers

use this method to raise awareness of personal influence on the research, to reflect on performance, and to explore thoughts about the research process (Janesick, 2011). Reflective journaling helps researchers identify their perceptions to minimize influence on the research (Chan, Fung, & Chien, 2013; Tufford & Newman, 2010). Evaluating performance serves to recognize a need to modify methods or improve skills and identify limitations or unintended influences on the data. I kept a journal throughout the research process.

Memoing is a form of writing similar to journaling, but focused specifically on the data. The use of memoing provides researchers an unstructured method of thinking about the data (Tufford & Newman, 2010). Using memoing, researchers gain awareness of connections and patterns in the data, and can freely sort and manipulate these patterns to make further connections (Engward, 2013). When memoing, researchers focus on the data, a specific thought, a category, or an event while free-writing. To enhance the thoughts captured in memoranda, I reviewed each multiple times during data analysis and rewrote them in a new version (saving the original) as I obtained additional data. The resulting memoranda became part of the collected data, even as they were a tool for data analysis.

Recording. I audio recorded interviews with the permission of each participant, using digital-recording devices. In preparation for time with each participant, I tested the equipment and ensured that each device was fully charged. Directly before meeting participants for their interview, I made a short recording identifying the date, time, name of the participant, and location of the interview.

Procedures for Recruitment, Participation, and Data Collection

I solicited senior-leader sponsors in the potential participating organizations for approval to use their sites and interview members of their leadership teams. Data obtained from the American Hospital Directory (2015) helped identify healthcare systems meeting the study's criteria. To maintain confidentiality of the organizations and participants in this study, I withheld the names of the organizations from this written document. Each organization provided an official letter of cooperation (see sample found in Appendix H).

Data collection commenced after receiving approval from the Walden University Institutional Review Board (approval number 09-13-16-0259632). I initiated the study in participating organizations through a meeting with the sponsor. Each senior-leader sponsor signed an informed-consent prior to the interview commencing (see Appendix I). The purpose of this meeting was to collect referrals for midlevel nonclinical healthcare leaders who they perceived to be competent in their roles. I also collected descriptive statements regarding why these leaders were perceived as competent.

Multiple referrals were collected to increase the likelihood that at least one midlevel leader meets the study criteria and agrees to participate. Midlevel leader participants also provided up to five peer referrals. The batch nomination again allowed for disqualification based on inclusion criteria, nominee declination, or duplicative referrals.

I initiated requests for participation from candidates through telephone conversations in which I explained the study and reviewed expectations for their participation. Validation of criteria matching followed participants' preliminary

acceptance of participation. I scheduled interviews after confirmation that the candidate met the inclusion criteria and had provided their verbal agreement. An e-mail serving as the invitation letter (see Appendix J) with an attached consent-to-participate form (see Appendix K) and demographic-information form (see Appendix E) followed. The invitation letter and consent form provided written explanation of the purpose of the study, restated participation expectations and the interview process, and provided my contact information.

Interview process. The primary data-collection method was in-person semistructured interviews with sponsors and participants. Meetings with sponsors occurred before interviews with participants from the same organization. These interviews served to gather organization-specific documents (job descriptions and performance-review process and forms) and to identify initial participants. The intent of this study was to collect the experiences of midlevel nonclinical participants; thus, the sponsor interviews were brief. Appendix L contains the process and questions used for these interviews.

To collect data directly from each participant, I completed two in-person interviews. The first interview included an observation of the participant's office. I determined I would need two interviews, because multiple contacts with participants achieves depth (Morse, 2015; Vagle, 2014). In-person interviews provide an opportunity to observe unspoken elements of communication allowing greater opportunity to establish rapport, creating a comfortable and relaxed atmosphere resulting in a more open exchange (Irvine, Drew, & Sainsbury, 2012). In-person interviews took place in participants' offices or workspaces to allow for privacy and observation of the work

environment. I recorded each interview; acceptance of this process was one of the participation criteria. Confidentiality and comfort of participants was a primary consideration; therefore, if participants shared a workspace, the interview took place in a private location. If a separate interview location was necessary, I observed the participant's workspace subsequently.

All initial participant interviews, including those with senior-leader sponsors, began with an explanation of the study, review of the informed-consent form, and discussion of the purpose of their participation. I began each interview after participants verbally stated their readiness and willingness to proceed and had signed the informed-consent form. I scheduled 30 minutes for interviews with sponsors, and 90 minutes with participants.

At the conclusion of each participant interview, I answered participants' questions regarding the study purpose, process, or other topics. At the end of the first interview, I explained the process for follow-up interviews and reviewed the methods used to collect, analyze, store, and maintain confidentiality of the data. When the second interview concluded, I notified participants that data collection had concluded and thanked him or her for their contribution. I reviewed data retention and confidentiality a final time. Each participant expressed the desire to receive a summary of results; I will deliver this by e-mail following the successful defense of my dissertation. I provided my contact information once again for any future questions or needs.

I notified sponsor participants by e-mail when data collection had concluded. This e-mail thanked them for their contribution and explained the data retention and

confidentiality process once again. My contact information was included for any further questions or needs.

Observation. The observation of the personal workspace for each participant occurred during the first interview; Question 7 in the interview guide prompted the conversation that occurred during the observation. The contents, organization, and cleanliness of a participant's personal workspace may speak to their personality or leadership style. Researchers have demonstrated links between the personalization of a workspace and the personality of the individual (Wells & Thelen, 2002). Maxwell (2012) stated "the books on the shelves, sayings on the walls, memorabilia in the displays: They are windows into that person's leadership style, the sources of his or her inspiration, the values that drive his or her decisions" (para. 4). Beyond the observation from Maxwell and the link between personalization of workspace and personality from Wells and Thelen, no available research correlated the content in a personal workspace and leadership development or competence. However, Vagle (2014) encouraged inclusion of multiple data sources to enhance understanding of the phenomenon under study. The exploratory conversation during the observation of participants' workspaces assisted in creating depth of understanding.

Data-Analysis Plan

No clear division between phases of data-collection and -analysis exists in qualitative research, inclusive of phenomenology (Vagle, 2014). Following the first interview, the data-analysis process began. Following the phenomenological perspective of Vagle (2014), my study included descriptive and interpretive analysis. Vagle's fourth step in the five-step approach to phenomenological research is to read the transcripts and

collected data, reflect on what stands out from the material, and then read the content again. Vagle provided a clear process for this task using the six-step whole-parts-whole approach. This approach aligns with the guidance provided by van Manen (2014): holistic reading of the data, followed by a selective review, and then a detailed reading. During this process, the researcher deconstructs the data, considers for interpretive meaning, then reconstructs in themes of meaning (van Manen, 2014). Vagle's recommendation to follow the whole-parts-whole analysis method aligns and offers elaboration to van Manen's process. Step 1: Holistic reading of entire text; Step 2: First line-by-line reading; Step 3: Follow-up questions; Step 4: Second line-by-line reading; Step 5: Third line-by-line reading; Step 6: Subsequent readings (Vagle, 2014, pp. 98–99). Between Steps 3 and 4, the second interviews occurred, prompted by the initial review of the data and identified need to seek clarification.

Transcription. The method used to transcribe an interview influences the analysis of the data. A transcript of an interview is a translation or interpretation of the originally obtained data (Gibbs, 2007; Gibson & Brown, 2009; Lucas, 2010) that can change the meaning of the primary data (Kvale, 2007): "Transcriptions are impoverished decontextualized renderings of interview conversations" (Kvale, 2007, p. 3). Decisions made regarding the selection of transcription method can influence the resulting analysis of the data (Oliver, Serovich, & Mason, 2005). The data from interviews include more than the stated words. Meaning sits in the participant's pauses, gestures, and expressions during the interview (Kvale, 2007). Modification of grammar, the use of punctuation, removal of colloquialisms, and omission of verbal and nonverbal cues in the transcription of interviews all have the potential to affect the interpreted meaning.

The transcription method can be focused or unfocused, or fall somewhere between. Focused transcription contains all details of the interview, including identification of the length of pauses, speech overlaps, use of response tokens (for words or utterances such as um, yeah, like, and ah), and notation of sounds or verbal/nonverbal cues made by the interviewee or interviewer (Oliver et al., 2005). Focused transcription includes what the participant said and how they said it. The elements included in the focused transcription, however, can confuse understanding, and the effort to document the details can lengthen the transcription process (Oliver et al., 2005; Skukauskaite, 2012). Unfocused transcription removes most details and corrects the language and content (Oliver et al., 2005). The intent of unfocused transcriptions are to provide the meaning of what participants said, rather than a detailed documentation of what participants said or how they said it (Gibson & Brown, 2009).

The focused transcription method was unnecessary for this study as the time required to add this detail would be prohibitive, and the added content would not contribute to the analysis. The transcripts for this study retained the words the participants used with punctuation added and grammar corrected. Communication consists of verbal (words, tone, and utterances) and nonverbal (pauses, posture, and facial expression) cues (Luciew, Mulkern, & Punako, 2011). Therefore, bracketed comments in the text identified verbal or nonverbal cues deemed important from recorded interview, field notes, and postinterview documents. If believed beneficial to understanding a participant's meaning, the transcript also included notation of pauses, pitch, or use of response tokens. I modified the content for readability, but retained the original statements and meaning of participants.

Researchers retain value by completing the transcription of interviews themselves; immersion in the data enables a greater depth of understanding (Lucas, 2010). However, transcribing interviews can take a minimum of 4 to 6 hours per hour of interview; more if adding unspoken detail (Lucas, 2010; Sullivan, Gibson, & Riley, 2012). I planned to use a transcription service for the initial transcripts, followed by a personal review and edit of the transcripts. This process would reduce my time for transcription while still affording time to gain familiarity with the data obtained. Additionally, a second individual reviewing transcribed material would enhance reliability of the data (Kvale, 2007). This transcript review would occur while listening to the recorded interview and as part of the first step in the whole-parts-whole process.

As part of Step 2 of the whole-part-whole process, I move the transcribed content into an Excel spreadsheet. Each question resided on its own row of the spreadsheet and I added columns titled researcher, participant, passage highlights, codes, and reflection. I placed the questions asked in the researcher column, and participant responses (verbal and nonverbal) in the column entitled participant. Those questions correlating to the interview guide had reference numbers aligned with the guide. This transcription tool enabled me to highlight passages, identify codes, and document thoughts during the transcript review. This process reduced the need to move between documents to note this information while working. I saved this initial version as a memorandum entry. A few days after completing this review, I again listened to the interview while reading the transcript. I added new, empty columns for highlighted passages, codes, and reflection to the transcript (removing the earlier entries) prior to listening and, while listening, added highlight passages, codes, and thoughts about the content in the appropriate columns. I

saved the modified document as a new memorandum. This second review, without immediate influence from the earlier review, enabled a fresh perspective and source of reflection on differences in passage highlights and reflection comments.

Software. I used two software applications during the data-collection and -analysis phase of this study. Microsoft Office applications, Word and Excel, aided in transcribing interviews, documenting notes, and organizing data. I also used Excel to manipulate coded sections of transcripts for a perceptual shift in the review of the data. I considered the use of applications for qualitative research, such as NVivo, but avoided them, favoring the immersion approach of reading the transcripts multiple times and writing (Vagle, 2014; van Manen, 2014).

Issues of Trustworthiness

Trustworthiness in phenomenological research is unlike that in other qualitative research methods (van Manen, 2014). Researchers assess a phenomenological study for validity based on the quality of the research question, that the collected data include descriptions of experiences rather than opinions or perceptions, and that the analysis contains rich descriptions providing experiential depth (van Manen, 2014). The research question met van Manen's (2014) first criterion and this section describes the methods I employed to meet the other two and enhance the trustworthiness of the findings.

Credibility

Researchers achieve credibility, confidence in the findings from research, through transparency in the research process, such as the disclosure of and rationale for selected methods. This chapter provides details of the methods and includes the intent to adhere to Vagle's five-step process. Key to this process is the use of reflexivity. Reflective

journaling improves researcher self-awareness (Janesick, 2011). Journaling helps researchers understand their role in the data-collection process and the influence of their biases, experiences, and perceptions. I wrote impressions in a journal throughout the data-collection and -analysis process to minimize the influence of my perceptions and biases. Additionally, the postreflective statement captured my predata collection perceptions of the phenomenon, expectations of what the data may reflect, and beliefs of how I could influence the responses of the participants.

Transferability

Researchers conduct phenomenological research to gain understanding of a phenomenon from the experience of those who lived it. The purpose is not to generalize the experiences beyond the study sample; "the only generalization allowed in phenomenological inquiry is 'never generalize'" (van Manen, 2014, p. 352). I employed the practice of thick description and semistructured interviews to enhance the validity of my methodology.

I used thick description to document research methods, development of themes, and other practices performed throughout the research process for clarity of process and rationale (Pandey & Patnaik, 2014). I also used thick description in Chapter 4, including the words of participants and their nonverbal cues to add to the interpretation of meaning (Denham & Onwuegbuzie, 2013; Luciew et al., 2011). This method provided a clear audit trail throughout the research process.

I conducted interviews using a semistructured format; following the interview guide found in Appendix D for the first interviews with each participant. I conducted each interview. Consistency in the method of interviewing strengthens research validity

(Høffding & Martiny, 2015) while maintaining the nature of phenomenological-research process. The interview guide redirected the conversation back to the consistent structure across all initial participant interviews, while allowing each interview to include unique qualities that more fully explored individual experiences.

Dependability

Methods that improve dependability enhance research quality. Qualitative researchers identify many methods to ensure dependability (Elo et al., 2014; Gibbs, 2007). In my study, the methods used included documenting decisions made during research, taking detailed field notes, maintaining consistency in the interview-transcription method, and validating interview transcripts against the audio recording during the analysis process.

Confirmability

Personal bias, an inappropriate participant sample, and lack of methodological transparency risks weak confirmability in qualitative research (Wester, 2011). I included reflective journaling and detailed field notes as secondary data sources to strengthen confirmability. Elo et al. (2014) offered that the use of direct quotations from participants when sharing the analysis of findings further strengthens confirmability. In addition, careful and thorough consideration and description of sampling methods, and transparency of research methods through thick description in Chapters 3 and 4, further contributed to this study's confirmability.

Ethical Procedures

Careful consideration of the methods used, clarity of the study purpose and processes, and collection of informed-consent documentation helped protect the

confidentiality of participants. When soliciting membership in the study, I provided prospective participants a verbal review of study objectives, details regarding their involvement in the collection of data, description of how I would maintain their confidentiality, and notification of the 5-year retention of data. An e-mailed copy of this information followed candidates' verbal acceptance to participate (see Appendices I and J for examples). Before the start of each interview, I once again reviewed the information and obtained the participant's signature on the consent form to indicate their understanding and voluntary involvement in the study. The informed-consent form (see Appendix K) included the purpose of the study, expectations of participants, guarantee of confidentiality, voluntary nature of participation, risks and benefits of the study, and researcher and university-representative contact information. The form also included the selection method for participation and the ability of the participant to withdraw at any point during the study.

To safeguard the confidence of participants, interview questions did not request the disclosure of sensitive information, and I conducted all interviews in a private location. I maintained all data on my personal laptop computer, which is password protected and securely stored in my home office. Additionally, I did not use participant and organization names in the submitted study documentation. Descriptive and detailed data collection and presentation in a qualitative study may affect the ability to maintain an individual's privacy (Gibbs, 2007). I took care to prevent the ability of published participant comments to link to an individual participant. Removing mention of organization names and carefully considering what material to quote in the study reduced this risk. If I had concerns regarding the lack of anonymity of the data, I planned to

request the review and approval of the individual, organization, or both. I acquired Institutional Review Board approval (#09-13-16-0259632) of my plans to safeguard the protection of all participants following the successful defense of this dissertation.

Participants were free to withdraw from the study at any time. If participants departed, I would remove and destroy collected data. I would also adjust or remove themes generated or supported by the participant as necessary.

Data Organization, Security, and Storage

I worked to ensure the privacy and integrity of all collected data, and to protect the identities of all participants, storing documentation received directly from participants in a secured location. I identified each participant through a numbering system, using the letter P for participant or S for sponsor and then a number: for example, P1 indicated Participant 1, P2 for Participant 2, and so on. Each document name contained the participant identifier, the data type, and the date I created the file. For an interview, the document name was P1-Interview-MM.DD.YY, where MM is the numeric month, DD the day, and YY the year. For example, I named the transcribed interview P1-Transcript-MM.DD.YY. Versions contained an additional identifier such as .V2; for example, P1-Interview-MM.DD.YY.V2.

I assigned each participant an electronic folder in which I stored the original digital interview, transcribed interview, collected documentation, interview and postinterview notes, and any subsequent pertinent documentation or data. A spreadsheet tracked each individual participant's name, identifier, participating organization, contact information, consent-form receipt, date and time of each interview and observation, and other data-tracking elements. I protected this spreadsheet with a password and maintained

sole access to it. At the conclusion of this study, I destroyed this spreadsheet; thus, there is no indicator of who participated in the study.

I scanned paper versions of documentation, including printed copies of transcripts used during manual-coding efforts and signed consent forms, storing them electronically. I shredded the physical hard copies of all written material following the analysis, retaining data and research work on my laptop computer with backup copies saved to external media devices, such as USB flash drives, during the research process. The laptop computer used for all project-related work is my personal device and was password protected and kept secure in my home or directly with me when carried outside the home. Upon completion of the study, I deleted the data remaining on my laptop computer and will retain all material stored on external media devices in a locked container for 5 years. After 5 years, I will delete the data from these external media devices.

Summary

This chapter provided an overview of the design and methods for this study. The phenomenological approach contributed to understanding how midlevel nonclinical healthcare leaders develop self-awareness of their leadership competence, thereby filling a gap in the research. The reflexivity practices central to Vagle's (2014) approach helped account for the potential to influence the data, due to my personal experience, knowledge, and interest in the study topic.

The targeted population for this research included midlevel nonclinical healthcare leaders from midsized healthcare systems in the Pacific Northwest region of the United States. Purposeful sampling identified senior-leader sponsors, and the snowball technique

identified midlevel nonclinical participants. Inclusion criteria determined fit of each participant to the study population.

Data accrued through interviews and observation, and from documentation collected from organizations and participants. Reflective journaling served to identify my bias or influence on the collection or analysis of data and in developing my research skill. Analysis followed the whole-parts-whole process defined by Vagle (2014) and identified themes responding to the research question from the participants included in the study sample. Thick description and researcher reflexivity contributed to the quality of the data and analysis. Described methods and assurance that participation was voluntary safeguarded participant confidentiality and emotional safety. In Chapter 4, I present the analysis of data.

Chapter 4: Results

The purpose of this qualitative, phenomenological study was to explore how healthcare leaders develop an awareness of their leadership competence. This study successfully provided content that responds to the research question—How do midlevel nonclinical healthcare leaders develop awareness of their leadership competence?—and provides additional insights to the connection between leadership development and competency self-awareness. In this chapter, I provide pertinent information regarding my interviews with 12 midlevel nonclinical healthcare leaders from three hospitals in the Pacific Northwest region of the United States. This information includes an overview of the research setting, demographics of the participant group, data-collection and -analysis procedures, outcomes and results from the analysis, and evidence of trustworthiness.

Research Setting

The physical setting for each interview was in the participant's office in all but one instance. Participant 1 (P1) shared an office with a supervisory team who were present at the time of the first interview; thus, for this interview, we met in a small conference room in the department. For Question 7 of the interview, in which I observed the participant's office, we moved to the office. We held the second interview in the participant's office, as the supervisors were not present. There were no other variations in setting during the study.

Multiple priorities and time constraints challenge healthcare leaders. This was evident when I sought permission from senior leaders to include their organizations and leaders in this study. I gained approval to include three healthcare systems. Senior leaders from two of these systems expressed their desire to minimize impact on their leaders. For

one healthcare system, a careful review of the study methodology and expected requirements of leader participants took place in advance of approval. The second hospital limited participant involvement to two leaders. These senior leaders understood the challenges of their leadership teams and strove to protect them.

I scheduled the interviews with each participant based on their availability and need to attend to higher priority responsibilities. One participant expressed an elevated level of stress when we met for their initial interview, as a regulatory agency was on the premises conducting an inspection. Though I offered the ability to reschedule, this participant opted to retain our time together. I noted no apparent influence on the quality of data collected during this interview. Another participant shared toward the conclusion of the second interview the participant's nervousness in advance of the first interview. This nervousness was not apparent to me during our time together. Instead, when I assessed the quality of each interview using the postinterview comment sheet, I noted that there was a relaxed atmosphere and engaged dialogue during each. During my time with the participants, I did not observe any concerns regarding influence of job stressors or organizational environment that could influence study results.

When completing the postinterview comment sheet to gather initial thoughts regarding the content and quality of the interviews, two interviews required the greatest reflection. The first was the interview with P1. This was my first interview and I purposefully took additional pains to analyze the quality of the interview for improved future performance. From this reflection, I recognized a need to have greater awareness of body language and allow silence. More than once, I began to speak before P1 had concluded his statement. If I were observant and patient, there were cues that P1 had

more to say. Additionally, I identified the need to ask more follow-up questions to validate my understanding before progressing to the next question.

I spent considerable time reflecting on my interview with P6. The tone of this interview differed markedly from that of the interviews with prior and subsequent participants. In reflection, I noted these differences and considered the influence on the overall results. I retained this participant in my sample because the participant met all inclusion criteria, including that of self-perceived competence in one or more leadership competencies. Additionally, the different viewpoint of this participant provided me with a discrepant case during the data analysis and deepened my reflective consideration of the data collectively and from each participant.

Demographics

From senior and peer-leader referrals, I invited 17 participants to join this research study; 12 met the inclusion criteria and agreed to participate. Table 7 contains the participant demographics. Comparison demographics for the same population (midlevel nonclinical healthcare leaders) or for the leader population at each of the three healthcare systems was unavailable. Additionally, because this study sample met defined inclusion criteria, comparison demographics for leaders who also met these criteria would not be possible.

Two characteristics of this group contribute to the leadership development research. First, these leaders each gained their initial role as a leader in their 20s or 30s. Thirty is the average age for a first leader-level role (Zenger, 2012). Second, researchers contend that individuals gain their first leader-level roles in advance of formal leadership training (Briggs et al., 2012; Stoller, 2014; Townsend, Wilkinson, Bamber et al., 2012;

Zenger, 2012). Zenger (2012) stated that the provision of formal training typically occurs in leaders 40s, after their first leader-level role. The leadership related training received by the participants in this study is in Table 8. Only two participants received training prior to their first leader-level role and both shared that the degree did not prepare them for leadership, but, instead, enhanced their technical or managerial knowledge. For each of the 12 participants, and in support of Zenger's contention, formal leadership training occurred after their first leader-level position.

Table 7

Demographic Data

Demographic category	Number of participants	Average years
Gender		
Male	7	
Female	5	
Age		
25–35	3	
36–45	5	
46–55	2	
> 55	2	
Position		
Manager	5	
Associate Director	1	
Director	5	
Controller	1	
Years in Healthcare		15.8
<=5	3	
6–12	2	
12–19	2	
>=20	5	
Years with Current Organization		7.1
<=5	6	
6–12	4	
12–19	1	
>=20	1	
Years in Current Role		6.4
<=5	7	
6–12	3	
12–19	1	
>=20	1	
Years of Leadership Experience		15.3
<=5	2	
6–12	2	
12–19	3	
>=20	5	

Table 8

Leadership Development Format and Occurrence with First Leader-Level Role

Participant	Training	Occurrence: Before or after first leader-level role
P1	On-the-job	After
P2	Formal, non-work related, program	After
P3	Advanced degree	After
P4	Advanced degree	Before
P5		
P6	Advanced degree	Before
P7	On-the-job	After
P8	On-the-job	After
	Enrolled in advanced degree program	After
P9	On-the-job	After
	Advanced degree	After
	Extensive self-sought development	After
P10	Enrolled in advanced degree program	After
P11	Extensive self-sought development	After
P12	On-the-job	After

Data Collection

Three senior leaders, one from each participating hospital, engaged in one in-person interview. The purpose of these interviews was to collect referrals for midlevel nonclinical healthcare leaders who they perceived to be competent in their roles. I also collected descriptive statements regarding why the senior leaders perceived those they referred to be competent. From these first referrals, I obtained seven study participants. Using the snowball sampling methodology, from the first seven participants I added the remaining five participants to the study.

Participant interviews spanned 47 days. The initial interviews began on September 19, 2016 and concluded on October 27, 2016. Follow-up interviews began on

October 27, 2016 and concluded on November 4, 2016. The length of time required for the initial interviews was 30 days longer than that of the follow-up interviews, as data analysis was occurring concurrently to identify codes and elevate themes.

Initial interviews were in-depth and followed a semistructured interview guide. Before turning on the audio recorder for the initial interview, I explained the study, the purpose of their participation, and reviewed the informed-consent form. The interview then followed the interview guide (see Appendix D). Question 7 of the interview guide included an observation of the participant's office. I collected the majority of the data during the initial participant interviews.

I used follow-up interviews to confirm information obtained during the initial interview, supplement information gaps, and present the developing themes for validation. The follow-up interviews began by asking if participants had any contributory thoughts about the questions or content from the first interview. I followed this with a high-level review of the competencies identified by the statements in the prior interview. I then asked questions about assumptions I had made of the collected data or to explore the participant's prior statements. Next, I asked the participants, as I had in the first interview, how they knew themselves to be competent. This review enabled me to validate, augment, or clarify content. To end the interview, I listed the developing themes garnered from the collective participant group to validate alignment to their experience. This final step contributed to the list of themes and to my awareness of those themes that resonated for each participant.

I recorded and transcribed each interview for use in data analysis. I used two digital recording devices during the interviews: a Dennov VR-BK6 digital voice recorder

and a voice recorder from Green Apple Studio installed on my Android phone. Interviews were transcribed in full following the unfocused transcription methodology described in Chapter 3. A transcription service transcribed the first three interviews. The time to return these transcriptions exceeded 2 weeks; thus, I made a change to the transcription plan and personally completed all subsequent transcripts within 72 hours of the interview.

Three discrepant cases emerged from the data collection. The first two pertain to P6. From the interviews with this participant, I identified 40 competencies; this was far fewer than for the other participants. The amount of interview time with this participant was 80 minutes for the initial interview and 30 minutes for the follow-up. Interviews with P6 were longer than the average. The interview process and questions with P6 were no different from those with other participants; however, the collected content contained fewer competencies. P6 also failed to provide a copy of a résumé, though I made three requests (once during the participant-identification phone call and again during each interview). After reflection, I determined that the lack of this information did not jeopardize my data. The third outlier was the low number of competencies identified from P5's résumé. P5 explained that there had been no necessity to update the résumé, outside of having a copy on file during a reorganization of departmental leadership, in the participant's many years of tenure with the hospital. Thus, the content of P5's résumé was minimal.

Data Analysis

I analyzed the data following Vagle's (2014) postintentional phenomenological approach. This included listening to the recorded interview while reading the transcript to catch errors or note contributory information obtained from tone or other sounds.

Following transcript validation, I reviewed all collected data holistically for each participant, without identifying codes or highlighting passages (other than mental identification or *ah ha* thoughts; I was unable to prevent the coding or highlighting my mind wanted to make). The next review of data was a line-by-line review with codes noted, sections highlighted, and my comments. I concluded these reviews in advance of each participant's follow-up interview.

After I concluded the follow-up interviews and transcribed the content, I completed subsequent iterations of line-by-line review for each participant's data. Each review occurred on a fresh copy of the raw data; this reduced influence from the earlier review and enabled a fresh perspective on the data. I repeated this process multiple times for each participant. I identified all 20 subthemes following the completion of the fifth interview. The subsequent interviews elaborated on these subthemes and raised awareness of those with greatest relevance to the overall participant group.

The original analysis process concluded after three iterations of line-by-line data review. However, I had an unsettled feeling as I was writing the analysis section of this chapter. Upon reflection, I recognized that the last review had raised further evidence in support of the identified subthemes or other contributory content. Because this review cycle had contributed to the analysis, I felt there might be further elements yet unseen. Thus, I performed the line-by-line review again for each participant. For eight of the data sets, I identified no further contributory content. For the remaining four, I performed this review again. With the fifth review, I identified nothing new and my data review concluded. No new themes arose from the additional review, but I made connections and deepened my understanding of the themes and participant experience.

A key element of Vagle's (2014) postintentional phenomenological approach is the creation of a reflective plan. Following Vagle's guidance, I created a postreflective statement in advance of data collection to capture my personal perception of the study topic and expectations from the research. This statement included my responses to the questions found in the Interview Guide (see Appendix D) and the questions in Appendix G. During data collection and analysis, I revisited this statement and added further insights. As the themes from the data analysis began to emerge, I compared these to the postreflective statement to question the influence of my biases and preconceptions on the identification of themes. This practice was beneficial as I caught instances where I had made inferences not fully supported by the data.

I also used memoing during data analysis to explore the data conceptually. I used this method of free-writing to consider patterns from coded content and to explore thoughts elevated during review of the data. After I initially analyzed all data for themes, I purposefully reviewed Chapter 2 to consider the concepts included in the literature review (self-awareness, competency development, self-efficacy, self-confidence, self-esteem, psychological empowerment, self-determination, leader identity, self-concept, and core self-evaluation) and their relationship with the data. Through memoing, I worked to remove my predata preconceptions and biases from my prior research for the literature review to clearly see connections or identify gaps.

Competency Identification

I conducted an evaluation of the competencies identified by each participant to develop an awareness of their perception of competence aligned with the six domains of leadership. This was important for exploring their rationale for how they know they are

competent. I garnered these competencies from statements in the interviews as well as those shared in résumés. During the interviews, participants expressed 40 to 136 unique competencies. They communicated these competencies either directly, such as in response to Interview Question 4—"What words would you use to describe yourself in your professional life?"—or indirectly during the interviews. I then aligned the listed competencies to those from the core researchers reviewed in Chapter 2 and listed in Appendix A. This enabled analysis of the alignment of participant competencies to the six competency domains.

Following the same process used for the interviews, I also identified the competencies from résumés and performance expectations. From participant résumés, 7 to 35 unique competencies emerged. I identified 39 to 57 competencies from the performance expectations (performance review forms and job descriptions) for each participating hospital. The individual competencies identified by participant and source (interview, résumé, or performance evaluation) appear in Appendix M. The inclusion of a competency does not validate that the participant is skilled; likewise, the exclusion of a competency does not imply they are not skilled. This analysis is simply an indication of the competencies expressed by participants during the data-collection process.

This analysis of the competencies expressed by the leader participants was valuable for two reasons. First, it raised awareness of the leadership competencies healthcare leaders perceive they possess and may be beneficial for future leadership-development consideration. I address this as a potential for further research exploration in Chapter 5. Second, understanding the competencies, specifically those in the leadership-

domain, leader participants perceived they possessed enabled a focused exploration of the research question. This exploration led to the identification of multiple themes.

Theme Identification

The combination of deep immersion in the collected data, repeated review and addition to the postreflective statement, and thorough exploration of the data while memoing, elevated a number of themes beyond the scope of this study. I made purposeful effort to remain focused on the research question and themes pertaining directly to this question. However, as expected, an intricate relationship emerged between leadership development and the themes in response to the research question. In some instances, subthemes of competency development were also subthemes that informed participants they were competent. Therefore, I included these subthemes in the list presented in Table 9. I have categorized the subthemes by their alignment to the research question (knowledge) or development and provided a description.

Table 9

Recognized Subthemes by Category and With Description

Subthemes	Category	Description
Results	Knowledge	Quantifiable metrics for the achievement of goals.
Extra responsibilities	Knowledge	Asked to participate/lead a committee, manage a project, or have interim responsibility for another department.
Offered advancement	Knowledge	Offered a promotion or job without having applied.
Culture	Knowledge	The feeling of positive energy in the department; witnessing smiles or laughter; peers helping each other accomplish tasks.
Relationship with team	Knowledge	Employees trust they can share information; gifts from employees; feeling of genuine like and respect.
Mentoring others—their success	Knowledge	Seeing those mentored succeed.
Feel respected	Knowledge	Feeling that employees, peers, or others in the organization have respect for the work they do, knowledge they have, or their general person.
Director is recognized	Knowledge	A supervisor receives recognition for the performance of the department.
Innate quality[a]	Knowledge[a]	An awareness of leadership competence occurring through no recognizable developmental process.
Self-assessment and reflection	Knowledge and development	The assessment of the strengths and weaknesses in comparison to perceived expectations. Reflection is an active element for the assessment of competence (knowledge) and in identification of need for development.
Solicited feedback	Knowledge and development	Positive feedback supports knowledge of competence. Negative or lack of feedback may prompt reflection and personal development. Feedback may be verbal, nonverbal, or written.
Unsolicited feedback	Knowledge and development	Positive feedback supports knowledge of competence. Negative or lack of feedback may prompt reflection and personal development. Feedback may be verbal, nonverbal, written, or presented as awards or gifts.
Performance review	Knowledge and development	Performance reviews may contain quantifiable metrics of performance (objective feedback) or subjective feedback. Factors evaluated on a performance review and ranked high in support knowledge of competence. Lower scores or feedback may prompt reflection and personal development.

Table continues

Subthemes	Category	Description
Professional groups/boards	Knowledge and development	Membership or leadership in a professional group/board may support knowledge of competence such as, nominations for a leadership role (president) or recognized for accomplishments. This subtheme overlaps with others (offered advancement, extra responsibilities, results, and feedback). Networking with similar professionals provides a developmental opportunity.
Self-development	Development	Focus on improving personal performance in various leadership competencies.
Observing others	Development	Witnessing the positive or negative behaviors or outcomes of another and recognizing a desire to adopt or avoid those behaviors.
Mentors/trusted individuals	Development	Advice, support, guidance, and feedback from experienced and trusted individuals.
Overcome personal challenge	Development—driver	Events when young that caused personal emotional scars or temporary medical issues resulting in inability to work.
Competition—personal	Development—driver	Pushing oneself for improvement against past performance, a set goal, or the results of others.
Doubt/feeling like a fraud	Development—driver	Ranges from minor questions of ability due to the unknown to thoughts of inadequacy that are more pervasive.

Note. Knowledge refers to how one knows they are competent. Development indicates themes of personal leadership development.

[a] Innate quality is a unique subtheme in that participants agreed that "just knowing" or having always felt as though they are a leader is a reason for their knowledge of competence. However, an innate quality is not a tangible indicator of competence.

To assess which subthemes had greatest relevance, I assigned a value based on the strength of participant alignment. Level 0.0 meant a participant did not mention the subtheme or denied it as a reason for knowing why they are competent. Level 1.0 reflected low alignment; 2.0, moderate; and 3.0, high. I also assessed average response rate based on level, number of responses for each assessed at Level 1.0 or more, and the overall number of participants for whom the subtheme was part of their experience. Table 13 depicts this assessment. A visual depiction of the number of participants who identified a subtheme and the average ranking of each subtheme is in Figure 2. This analysis led to the findings discussed in the results section.

Table 10

Subthemes by Participant and Ranking

Subthemes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	Ave	3's	2's	1's	Count
Results	3.0	1.0	3.0	3.0	1.0	3.0	3.0	3.0	3.0	3.0	3.0	2.0	2.6	9	1	2	12
Extra responsibilities	3.0	0.0	3.0	0.0	3.0	1.0	3.0	3.0	3.0	3.0	3.0	1.0	2.2	8	0	2	10
Offered advancement	3.0	2.0	0.0	2.0	0.0	1.0	3.0	1.0	1.0	0.0	0.0	2.0	1.3	2	3	3	8
Culture	2.0	3.0	3.0	3.0	3.0	0.0	3.0	3.0	3.0	2.0	3.0	2.0	2.5	8	3	0	11
Relationship with team	2.0	1.0	2.0	1.0	3.0	0.0	3.0	3.0	2.0	1.0	1.0	2.0	1.8	3	4	4	11
Mentoring others—their success	1.0	0.0	0.0	0.0	2.0	0.0	0.0	3.0	1.0	0.0	0.0	2.0	0.8	1	2	2	5
Feel respected	2.0	0.0	0.0	0.0	2.0	0.0	3.0	0.0	0.0	2.0	0.0	0.0	0.8	1	3	0	4
Director is recognized	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	1	0	0	1
Innate quality	3.0	3.0	3.0	3.0	3.0	0.0	1.0	3.0	3.0	3.0	3.0	3.0	2.6	10	0	1	11
Self-assessment and reflection	3.0	3.0	3.0	3.0	3.0	1.0	3.0	3.0	2.0	2.0	3.0	2.0	2.6	8	3	1	12
Solicited feedback	3.0	3.0	3.0	3.0	3.0	0.0	0.0	3.0	3.0	2.0	3.0	2.0	2.3	8	2	0	10
Unsolicited feedback	1.0	3.0	1.0	3.0	2.0	0.0	3.0	3.0	3.0	2.0	2.0	2.0	2.1	5	4	2	11
Performance review	0.0	0.0	2.0	2.0	2.0	1.0	1.0	1.0	0.0	1.0	1.0	1.0	1.0	0	3	6	9
Professional groups/boards	0.0	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.3	0	1	1	2
Self-development	2.0	3.0	3.0	2.0	2.0	0.0	3.0	3.0	3.0	3.0	2.0	3.0	2.4	7	4	0	11
Observing others	2.0	2.0	2.0	3.0	0.0	1.0	0.0	3.0	3.0	3.0	3.0	2.0	2.0	5	4	1	10
Mentors/trusted individuals	3.0	1.0	3.0	1.0	2.0	1.0	2.0	2.0	0.0	1.0	3.0	1.0	1.7	3	3	5	11
Overcome personal challenge	1.0	0.0	3.0	0.0	0.0	1.0	3.0	0.0	3.0	0.0	2.0	2.0	1.3	3	2	2	7
Competition—personal	2.0	0.0	0.0	2.0	1.0	0.0	2.0	0.0	0.0	2.0	1.0	1.0	0.9	0	4	3	7
Doubt/feeling like a fraud	0.0	1.0	3.0	0.0	0.0	0.0	2.0	0.0	3.0	0.0	0.0	0.0	0.8	2	1	1	4

P1 to P12 indicates individual participant responses.

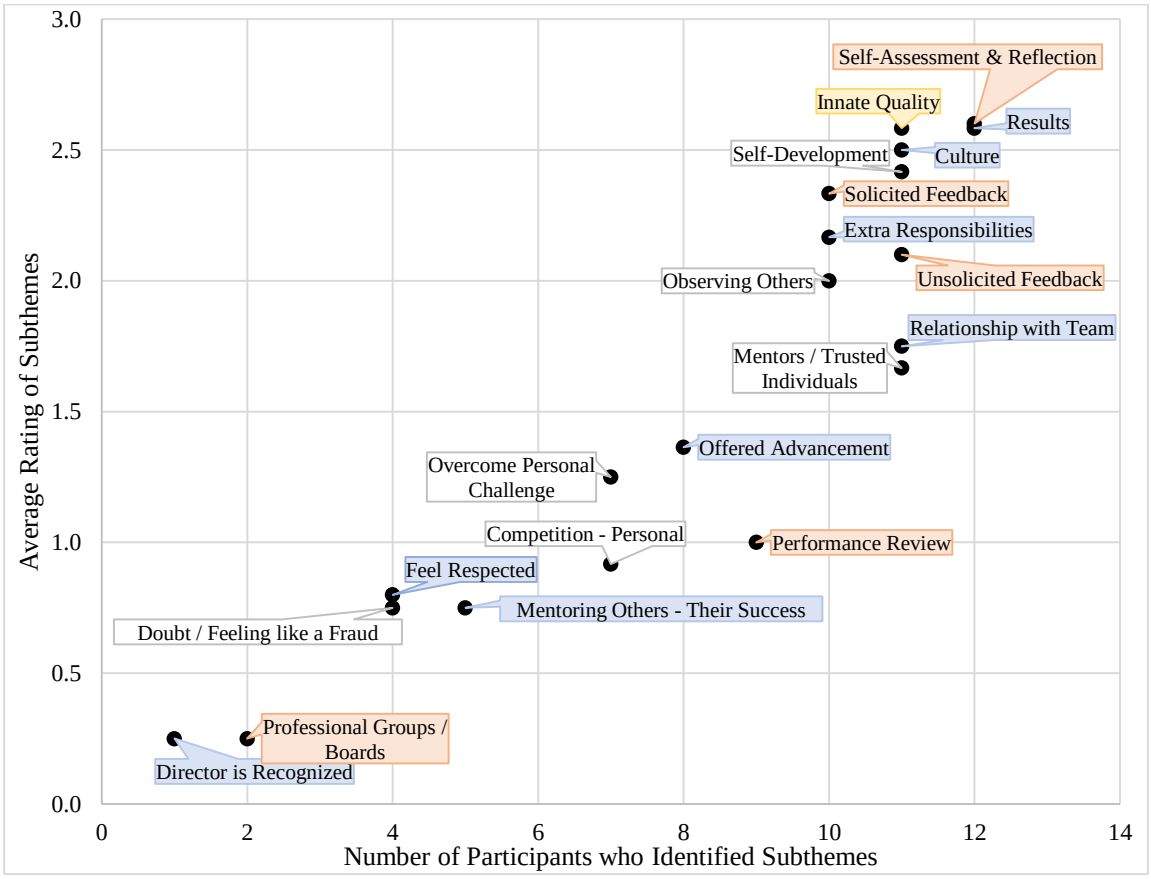

Figure 2. Visual representation of strength for each subtheme.
Subthemes in blue fully align to the research question (how participants know they are competent). Subthemes in orange align to the research question and influenced personal development of leadership competence. White are development subthemes. Yellow, innate quality, is a unique subtheme with partial alignment to the research question.

Evidence of Trustworthiness

Credibility

Researchers achieve credibility, or confidence in the findings from research, through transparency in the research process. Transparency includes actions such as sharing the rationale for method selection (see Chapter 3), disclosing variance in practice from planned methods, and reporting anomalies in the data. I have reported these variations and anomalies in this chapter.

The inclusion of reflective journaling improves researcher self-awareness (Janesick, 2011) and research credibility. I wrote impressions in a journal throughout the data-collection and -analysis process to minimize the influence of my perceptions and biases. Additionally, I created a postreflective statement that captured my predata collection perceptions of the phenomenon, expectations of the data, and consideration of my potential to influence the responses of the participants. I reviewed and contributed to this statement throughout the data-collection and -analysis process.

Transferability

Findings from phenomenological research have little transferability. Instead, this research methodology adds to the understanding of a phenomenon from the experience of those who lived it. To enable replication of the methods used in this study, I have used thick description when documenting the data-collection and -analysis process.

Dependability

I used four methods to strengthen the dependability of the study. First, during data collection, I took detailed field notes. These notes documented elements of the research

experience not directly captured in the primary data sources. Second, I documented decisions made during research, such as the change from using a transcription service and retention of P6 in the participant sample. Third, I maintained consistency in the interview-transcription method, with the exception of a necessary change after the third interview. The final method was the validation of interview transcripts to the audio recording during the analysis process.

Confirmability

Methods used to strengthen confirmability included reflective journaling and detailed field notes as secondary data sources. Direct quotations from participants when sharing the analysis also strengthened confirmability. Many of these statements are included.

Study Results

The conceptual framework for this study identified the intricate relationship between the research question—How do midlevel nonclinical healthcare leaders develop awareness of their leadership competence?—and leader development and effectiveness. My study also demonstrated this relationship; thus, I present these results in two sections. The first section provides an identification of the themes and subthemes in direct support of the research question, the second responds to the conceptual framework. Also included in this section is mention of the discrepant case: P6.

Results Pertaining to the Research Question

The response to the research question did not become fully apparent until I reviewed my postreflective statement with the 20 subthemes in mind. I had reviewed and modified this statement numerous times during data-collection and -analysis with the

intent of removing my influence from the study. However, when reviewing my postreflective statement with the data from the participant group in mind, it helped to illuminate the answer. I had written

> Without the insights of others, I may never have gained an awareness of how others have perceived or been affected by my actions or behaviors. In many cases, how my actions or behaviors had an unintended detrimental effect. One of my greatest challenges during my career has been the lack of honest and constructive external feedback. Even when I have attempted to solicit it. I have occasionally received feedback of value, but it has been a rare gift. When I have received feedback, it has typically been positive. I am confident there is unshared constructive feedback. My personal growth and development weighs on my shoulders. Including developing awareness of my weaknesses and the knowledge of how to overcome them. The competency development path begins with unconscious incompetence. Contribution from external feedback is required to go to the level of conscious incompetence. From conscious incompetence, development can begin.

How do midlevel nonclinical healthcare leaders develop awareness of their leadership competence? From the provision of honest and constructive external feedback.

After making this connection, I explored the reasons why participant statements aligned 5 of the 14 subthemes to both the category of knowledge and development. Here I recognized connection of themes: participants had identified that they reflected on the feedback. There were instances where a participant expressed their acceptance of feedback without reflection; they accepted feedback as fact. I categorized this as

knowledge. However, there were also instances when participants did not accept feedback as a source of knowledge without prior reflection. This reflection prompted identified developmental actions. I categorized these participant experiences as knowledge and development. Therefore, reflection on honest and constructive external feedback is a contributory element to gaining awareness of competence and identifying developmental needs.

To explore the 14 subthemes responding to the research question, I used the assigned values given for the strength of participant alignment in the analysis section (see Table 10). Eight of these subthemes were strong indicators due to the inclusion of one or a combination of multiple factors from Table 13: average participant rank of Level 2.0 or greater, majority of participant rankings at Level 3.0, or recognized as a subtheme by ten or more participants. I included two additional subthemes for specific reasons. The subtheme of performance review was included because this subtheme aligns to both results and feedback, and nine participants identified it as a source. Offered advancement is a unique subtheme. To have demonstrated a level of performance for which a job offer or advancement is then presented (without having applied for the position) is uncommon. Additionally, this type of performance recognition is similar to that of extra responsibilities; both are a recognition of capabilities. Table 11 contains the five final themes and correlating subthemes.

Table 11

Themes Identified With Correlating Subthemes

Theme	Subtheme
Quantifiable results	Results
	Performance review[a]
Person–person	Unsolicited feedback
	Solicited feedback
	Performance review[a]
Recognized capabilities	Extra responsibilities
	Offered advancement
Environmental/relational	Culture
	Relationship with team
Self	Self-assessment and reflection
	Innate quality

[a]Five participants identified goals with measurable metrics as criteria in their annual performance review; the remaining participants with this subtheme referenced feedback received through written comments or during discussion of the review.

Theme 1: Quantifiable results. All 12 participants supported results, or performance against measureable goals, as indicators of their leadership competence. Nine participants strongly supported this subtheme. Quantifiable results are tangible and unquestioning evidence of achievement to goal. One may infer that achievement of goal is an example of possessing the competence to do so. In hindsight, goal achievement as evidence of performance and, thus, competence, has obvious correlation to knowledge of competence. Nonetheless, I had not considered this as a theme in advance of this study. A search to explore a thematic reason why results would give evidence of competence is not required. As noted by P8 when validating this theme, “yup, some things are tangible. Easy to put your finger on.” Excerpts from two participant interviews offer their perceptions of this theme:

> P7: Financial, patient satisfaction, and employee engagement goals—we are doing exceptionally well in all those areas. We typically do and we typically lead the hospital in employee satisfaction. We are outperforming every other hospital in this region in terms of HCAHPS patient satisfaction; outperforming state average, and the national average. We are on pace financially. So there is that, the tangible objective goals.

> P9: Well, there are objective and subjective components for how or why I know I am competent. Objectively, I meet the tangible results expected of me: productivity numbers, budget, patient satisfaction, etc. My ability to focus on those expectations, to focus the work of my team on those, and to achieve the necessary results is a clear indicator of competence.

Examples of measured metrics included patient satisfaction, employee engagement, finance/budget, productivity, and unique departmental measures. Goals were set at an organizational level by senior leaders, departmentally, or as personal goals created by the participants themselves. Results outside of tracking for annual performance expectations were communicated through organizational or departmental dashboards, reports of HCAHPS results or other reporting sources, or manually tracked and reported by departments or individuals.

The majority of the metrics were lagging, meaning a delay emerged between when the act occurred (patient-satisfaction or employee-engagement actions) and when results were reported. For example, a 4 to 6 week lag exists between the date a patient is discharged and the reporting of their perception of experience for that admission. Two

participants identified leading metrics: those tracked and available to report in timely proximity to the action. These participants created tracking methods to create awareness of current performance to anticipate the results of associated lagging metrics. Tracking leading metrics allowed for more timely recognition of issues and adjustment in performance.

Five participants identified performance reviews as tools to identify tangible metric goals and achievement of goals. Participants shared that these goals were set at the beginning of the fiscal year and reviewed infrequently. Additionally, P4 noted that metrics on P4's performance evaluation were outside the participant's span of control (goals set for the organization or unrealistically set by someone else). Thus, participants rated the usefulness of performance reviews to reflect competence moderate to low.

Theme 2: Person–person. Of the 12 participants, 11 identified feedback from others as a source of leadership-competence knowledge. This feedback was either solicited or unsolicited, and could include body language. Indicators of unsolicited feedback included awards, notes written on pieces of paper or in cards, e-mails, verbal comments, or gifts from peers or staff (signs of appreciation). Participants identified these sources of feedback as indicators of their positive work or leadership competence. Only P11 identified unsolicited feedback as a source of constructive criticism.

Three participants recognized the value of body language when interacting with others. Body language could accompany solicited or unsolicited feedback. This feedback source enabled perceptive judgment of the reactions or feelings of those with whom they engaged.

Ten participants described their practice of soliciting feedback from their supervisor, employees, or peers. P1 shared that, following the disappointment of not receiving a promotion, the participant solicited feedback to learn why. The resulting information was valuable, changing the participant's perspective of the skills needed to advance into leadership and helped to shape P1's future career. Three participants indicated rounding at regular intervals with their employees, purposeful one-on-one meetings, as a regular practice. During this time, each leader included questions such as "how can I be a better leader for you?" (P8). Feedback solicited from peers served two purposes: P8 scheduled time monthly to make rounds with other department directors to assess the status of in-process projects, proactively identify issues, and build relationships. P2 and P3 indicated peers as a source of feedback regarding performance; for instance, P2 stated, "if I think things didn't go well [in a meeting], I'll reach out to someone."

Two additional forms of solicited feedback were the annual employee-engagement survey referenced by most participants and, for some, the annual performance-review process. The leader does not directly solicit feedback from the employee-engagement survey per se, but solicits this information through the organizational process of annual evaluation. P5 indicated that the rating for each question was a method of feedback in addition to the comments. P4 shared that the organization's annual performance-review process allows self-identification of peer and employee reviewers. This participant indicated a purposeful selection of individuals from whom feedback could be personally valuable: "I chose a lead in the department who had not been very happy with operations before, so it was important for me to get her feedback."

P5 also shared that feedback received during a performance evaluation from a supervisor was valuable:

> It has been helpful with my boss, who I think is willing to tell me things. He and I are pretty well on the same page [regarding] where my strengths and weaknesses are. He is definitely willing to call me out on the weaknesses during my performance review. It is good to have that honest feedback from him.

An excerpt from the interview with P2 provided a generalized example of the value of feedback:

> Feedback has helped a lot, honestly. Feedback is huge. I underestimate how helpful that is. Whether it is solidifying your own thoughts or even recognizing how people view you. Which is often different than how you view yourself. You have to be able to listen and recognize what others are saying about you. Even just side comments, whether it is good or bad, that is how people are viewing you.

Theme 3: Recognized capabilities. Extra responsibilities included leading committees, leading a high-profile organization wide project, or acting as interim director for an additional department. Examples of offered advancements included advancement to higher level roles in their organization without having first requested the promotion, or offer of a job when filling a consultant role. These feedback mechanisms are examples of recognized capability and a positive acknowledgement of demonstrated current and perceived future competence. Ten participants had extra responsibilities as a subtheme, eight had been offered advancement, and six of these had both forms of recognized capabilities.

Extra responsibilities.

P5: I have filled in on interim basis in varying degrees in different roles for, thankfully, short periods of time (laughter). I have helped provide oversight for our purchasing area, our patient financial services, our billing office, our contracting area. I have been involved with our risk management. Things that are truly outside of my role. [Asked if this supported knowledge of his competence]. I would say that the additional responsibilities would definitely be a reflection of my competency. I do not think I would have been asked to do the number of things I have done along the way if folks did not think I was competent enough.

P7: How do I know I am competent? It is my reputation; it is being invited to participate in many different committees across the hospital. I think I am on 10 different committees and I think I have valuable input for each of those. If I was just sitting there twiddling my thumbs, or did not really have anything to offer, or was not respected, I do not think I would be. I think you prove yourself time-and-time-again. It is the respect from my peers, respect from my employees, and the reputation and credibility that I have built up over the years.

Offered advancement.

P7: I then worked as a [removed specification of role for confidentiality] in addition to being lead when the supervisors were not there. I guess they were impressed enough. The manager approached me and offered me their vacant night supervisor position. Later I was moved to an assistant manager position at that

> same hospital. Then, about another year, year and a half later I was offered this job.

Theme 4: Environmental/relational. For 11 participants, environmental or relational feedback was expressed through the culture of their department and relationship with their teams. Culture was a strong indicator; I ranked this as a Level 3.0 for eight participants. Relationships with team members was an element of the departmental culture; the strength of the leader–employee relationship contributed to positive environmental energy. Phrases such as "the morale has changed" (P2) indicate relationship and culture. P3 expressed "it is about creating the right culture, it is about creating an environment that allows people to be successful, do what they are best at. To break barriers down." P5 stated "creating a work environment that people feel valuable in, and that encourages them and makes them want to do the best job they can." P2 added that by empowering the team to make decisions, they have become owners of the work.

In response to Question 5 on the interview guide (if you were to equate how you feel in your role to a musical style, what would you choose and why?), P1 identified jazz. When asked why, P1 explained:

> There are times here where things are very soothing, like the sound of music. When you hear the chatter of the staff, when you hear everyone say good morning, [and] when someone trusts you and they come to the office and say hey, I got a problem. When you hear the celebrations when we score well. When you hear the sound when we did not hit as well as we should. It can be the sound of sweet jazz around here. And that is a good sound.

This description of how P1 felt depicts the culture in P1's department. Further excerpts from participant interviews regarding the importance of culture follow:

> P2: I try to tune into people and their behavior. When I hear a supervisor leading a huddle and they are laughing and having a good time. To me, that is success. Everybody's moral is up and they have a good rapport. That is one way I measure success as a leader.

> P4: The culture is the most important thing to me. That shows [me] I am successful. I do not know if taking credit is the right word, but when people are happy and things are going well, I feel very much that this is my success coming through.

> P9: Culture is vital. You can feel it when you walk in. Are people happy and you can feel the positive energy, or is the energy heavy and negative? I am an effective leader if I create a culture where my staff want to work, where barriers are removed to enable them to be effective, and where they know they are appreciated.

Theme 5: Self. All participants mentioned self-assessment and reflection either directly or indirectly during their interviews. Four participants expressed active use of reflection as a method of self-awareness; one of these mentioned journaling. Others mentioned they think about their performance, feedback, or mistakes and how to improve. For example, P5 mentioned "internal self-checking" and P3 said "look in the mirror and be honest with yourself, then be teachable."

Indirect examples were lessons learned from past outcomes. P4 shared an example of having pushed a change too quickly and without building support from the team. P4 reflected on the experience, engaged a trusted advisor (spouse), and identified the error and what should be done in the future. When next presented with a process change to implement, P4 used this experience and did not repeat the mistake. P2 offered a similar example when feeling unwilling to back down on a set decision and failed to listen when a team member raised concerns. Afterward, P2 reflected on the encounter, "heard" the viewpoint of the employee during this reflection, and modified the decision. The outcome and employee relationship improved.

For these participants, self-assessment and reflection identified opportunities for improvement as well as recognition of competence. P11 shared that journaling helped the participant develop leadership skills: "it is still a work in progress, will always be, but I have definitely developed skill and competence as a result of this work." Recognition of their work and skills to achieve quantifiable results and filtering of received feedback (validating against self-assessment) were instances where reflection led to validation of competence. I offer further evidence of this subtheme below.

> P1: [In regards to a request for feedback after not receiving a promotion] I would say yes, at that point in my career I may have been a little flamboyant. I knew I was the best candidate, I knew I could do all the technical stuff, I knew I could do all the supervisory stuff, but I did not recognize—being possibly full of myself—that there was another element I was missing. Inquiring about that and considering the feedback did several things. It taught me not to be full of myself,

> which has helped me to have a humble spirit. Being passed over taught me to look at the details.

> P5: Knowing and understanding your own strengths and weaknesses, and actually thinking about them. Consciously thinking about [your strengths and weaknesses], and how you use them. I think about self-awareness, I think a lot about it, especially on the weaknesses side more than the strength side. [Self-awareness] is knowing what those weaknesses are and how to address them. Being aware of how biases influence decisions and viewpoints of the world.

Innate quality. The identification of an innate quality of leadership known to them or perceived by others was a strong subtheme identified from interviews with participants. Ten participants strongly identified this subtheme as aligning to how they know they are competent. When I asked P9 how the participant could assess personal competence, the initial response was, "I don't know, I just know. You know?" Further exploration of this statement elevated awareness early in the participant's life of how others treated P9: seeking advice, assigning leadership roles on school or sport teams. Additionally, P9 recognized that support and guidance offered by others occurred to groom P9 for a leadership role. For the participant group, it was a foundational understanding that they are leaders resulting from subtle and overt feedback, often since youth. These participants expressed this assessment as an innate quality.

Of the participants in this study, 11 identified they were recognized as leaders either early in their career or in childhood. Five were unable to identify when or how they began to know they were leaders. P2 shared not wanting to be a manager and resistance

when first asked to take a promotion. P2 now believes others recognized skills before the participant personally understood the qualities of leadership: “I feel a lot of it is innate. It is just in me and I do not know necessarily where it comes from.” P3 and P7 articulated that early in their careers they were told of their demonstrated leadership abilities, and P5 was “pushed” into leadership roles when in high school because “people realized that I was a good leader.” P1 and P4 were told when they were very young that they were leaders. P1 shared that the participant’s father and grandfather were leaders in the military and stated, “there is a lineage of leadership in our family. Personally, I think you are born with that.” Four participants recognized that, though they have innate skills, competence required reflection and effort through the years to hone these skills and learn those that were not innate characteristics, such as the technical aspects of their roles. Examples of statements regarding the subtheme of innate quality from three participants follow.

> P4: People just acknowledged that I was a leader. My dad, he saw a lot of his personality in me, or projected it, one of the two. He was always like “you are a leader, people follow” so I was always thinking that growing up. This is my personality. This is who I am.

> P12: I have always felt like a leader. I did not know how to put it into words when I was younger, but ever since that first job, straight out of school, where I was placed into a management job I have known that is what I want to do.

Results Pertaining to the Conceptual Framework

In the conceptual framework for this study, I explained that my research was rooted in the leadership development and effectiveness literature. Self-awareness is a key component of both; thus, to answer the research question, I would need to untangle an intricate relationship. The conceptual framework contained five core elements: leadership development, leadership effectiveness, leader genesis, leader influence on employees, and those psychological factors of influence on the development of self-awareness. The subtheme of innate quality addressed leader genesis and the theme of environmental/relational addressed influence on employees. These themes support participants' awareness of their leadership competence; I address the remaining three elements of the conceptual framework and connection to the data here.

Leadership development. The data supported leadership development in 11 of the 20 subthemes (see Table 9). Development and knowledge were elements in five of these subthemes. I addressed four of these in the prior section, as they were strong indicators for the participants.

Feedback from solicited, unsolicited, and performance-review sources provide other-assessment of performance and may validate one's awareness of competence. These feedback sources may also provide content that, with reflection and motivation to change, may drive self-development efforts. Examples from two participant statements support this self-development focus: Regarding performance feedback from peers, P4 said, "I had two pieces of feedback that were not positive, and I had 55 that were positive. And, of course, I focused on the two." This participant went on to describe how they

reflected on the feedback, used a confidant to deepen the reflection, and what they have incorporated into their leadership practices since, in response.

> P11: Results are good for identification of where I stand as compared to expectations, but I find feedback to be far more valuable. There are many nuances of interactions with people, or with differences between how I perceive myself and how I am perceived by others, that I cannot really understand without the insights from others. I have received some very candid and constructive feedback in the past both via email and in a letter. I learned the most from those, but ouch, it hurt to hear in the moment! [She later described her journaling process; how she reflected on this constructive feedback to drive self-development].

Self-assessment, especially when compared to other-assessment from feedback, was a theme participants identified. P7 provided an example of an experience in which the participant's perception of their presentation of a need to resolve an issue (tone and passion for solving this problem) supported organizational values. However, the perception of some in the same meeting differed. "I now try to be aware of things like that and think before I speak and how are others going to perceive it" (P7). An example of improved self-awareness emerged from P7's experience; recognition that tone and passion, as inferred by others, was perceived as negative rather than championing a need for change. P7 also became cognizant of the political environment.

The participant group strongly rated two developmental subthemes: mentor/trusted individuals and observation of others. Three participants shared they benefited from formal mentor relationships. Eight participants shared that trusted individuals, such as sport coaches, supervisors, or teachers, had provided guidance or

advice that helped direct their leadership development. Frequently mentioned was the self-development that occurred from having observed the behavior or skills of someone else. P4 shared implementation of learned behavior after observing a higher level leader's behavior:

> I am fascinated, it is almost artful how she communicates things in a very optimistic way, but careful; it is not over promising, it is not over excited. It is very supportive, but she also can convey boundaries in the same words. I am very impressed by her and would love to emulate that. She says "think Yes," that is her motto. So I have tried to incorporate that, especially here. This is a really dynamic [department] that has a lot of asks that are outside of the box, so really trying to think of how I can support people. So thinking yes, watching her and thinking yes has released tension for me because I wonder why I hold onto something in thinking no. … [Described an interaction with her team in a meeting] I felt myself very defensive and frustrated. Felt these walls come up. Then asking why and [began to think] yes. I physically felt that things were opening up for me just by being curious and thinking yes rather than having my defenses up.

Four participants identified self-development efforts to improve leadership competence outside of self-assessment, reflection, and solicitation of feedback. P2 was selected to participate in a leadership-development program and expressed examples of how this program motivated reflection on P2's future career. P8 and P10 had begun advanced degrees with a focus on leadership; P10 specified the intent to improve personal leadership competence. P11 shared the use of reflective journaling to develop self-awareness.

Leadership effectiveness. The assessment of effectiveness for the participant leaders was outside the scope of this study; though it was suggested by the senior or peer leader referral, based on perceptions of competence. Positive or ethics-related leadership theories—authentic, servant, and transformational—and emotional intelligence correlate to effective leadership (Gotsis & Grimani, 2016; Lappalainen, 2015; Mills, 2009; Ugoani et al., 2015). Comments from 11 participants supported characteristics of these theories. For example, P2 changed the reporting structure of the department and the roles of the supervisors to create shared leadership. P2 then trained, coached, and empowered these supervisors to own decisions and the performance of the department. Moving from a hierarchical decision-making and leadership structure to a team or shared-leadership approach transformed the culture of the department. Similarly, P1 focused on the development of supervisors by empowering them to make decisions, using the outcomes of these decisions as learning opportunities in a positive nonjudgmental manner (thanking them for making a decision, regardless of outcome) and giving up privacy in a large office to provide leadership guidance. P1 shared this decision to share an office in this way:

> I made a decision a few months ago that for others to grow, for new leaders to grow, I moved in with some new leaders. So I gave up my privacy, ability to think and talk freely, to be able to nurture others. My operational leader is fairly new and he does not have the experience, but he is highly intelligent. So between my experiences and his youth, [I am] trying to steer that in the right direction.

Psychological factors of influence on the development of self-awareness. The factors acknowledged as potential influencers to valid self-awareness of one's strengths

and weaknesses and, thus, of potential interest in this study included self-efficacy, self-confidence, self-esteem, psychological empowerment, self-determination, leader identity, self-concept, and CSE. The nature of this study, the purpose and narrowed scope, did not create an environment that deeply explored these concepts. Themes that arose in relation included self-esteem and self-worth (developmental-driver subtheme of doubt/feeling like a fraud), leader identity (subtheme of innate quality), and the interrelated theories of self-concept, self-confidence, and self-efficacy in numerous participant statements contributing to the subthemes. None of these requires exploration beyond this mention, as they are elements of earlier thematic discussions, or I did not recognize them as significant factors for the participant group.

Discrepant Case

The data from my interviews with P6 served as a discrepant-case example in comparison to the other 11 participants. Reflection on the data obtained for this participant identified that I had a preset bias regarding what defined an effective leader. As explored in the conceptual framework and Chapter 2, my perception of effective leaders are those who have an authentic, servant, or transformational leadership style. These leaders also demonstrate emotional intelligence. P6 challenged my preconceptions of effective leadership because a senior leader believed P6 had leadership competence (inferred as effectiveness), but did not demonstrate the characteristics I expected.

The only subtheme that strongly aligned for P6 was results. P6 stated, “for me it is bottom line productivity, collecting the case, [accounts receivable], registration. The details do not really matter to me. It is the results. The means of getting there are inconsequential.” P6 shared that feedback from performance reviews and individuals had

supported P6's ability to achieve metric-based results. These same feedback sources also identified interpersonal relations as an area in need of improvement. Notably, the metric-based results strength and interpersonal relations weakness aligned with statements from the referring leader. Thus, the referring senior leader based the definition of leadership competence on the ability to get results, in contrast to my definition of an effective leader. I retained this participant for three reasons: P6 shared evidence of self-awareness, P6's statements of competency included those in the leadership domain, and P6's data provided a discrepant case and enhanced my reflection on the collective data.

Summary

This phenomenological study explored the lived experiences of 12 healthcare leaders to answer the research question: How do midlevel nonclinical healthcare leaders develop awareness of their leadership competence? I analyzed the data using Vagle's (2014) postintentional phenomenological approach. Through the detailed process of repeated review and reflection on the data, the response to the research question became clear. Leaders develop awareness of their leadership competence through feedback. Specifically, through honest and constructive external feedback. When the leader then uses self-reflection, this feedback can generate awareness of strengths and weaknesses.

Data analysis elevated the feedback sources most strongly connected to the experiences of the participant group. I categorized these feedback sources into five themes consisting of 10 subthemes. These themes are feedback mechanisms inclusive of quantitative and qualitative sources: quantifiable results, person–person, recognized capabilities, environmental/relational, and self. The theme of self-development also emerged from the data analysis with four of these subthemes overlapping with the themes

in response to the research question. As defined by the conceptual framework for this study, I anticipated an overlap between development and knowledge themes. In Chapter 5, I provide an interpretation of the findings regarding the themes and subthemes relating to the research question and the interrelated theme of self-development.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this phenomenological study was to explore how an understudied subpopulation of healthcare leaders, midlevel nonclinical leaders, develops an awareness of their leadership competence. Self-awareness is a leadership competency and necessary for leadership development. Researchers supported this contention (Avolio & Hannah, 2008; Baron & Parent, 2014; Goleman et al., 2013; Korn Ferry, 2014; Nesbit, 2012; Patton et al., 2013). The exploration of how leaders develop an awareness of their personal strengths and weaknesses—how they know they are competent—has not been well researched. In this qualitative phenomenological study, I explored the lived experiences of 12 leader participants to answer the research question: How do midlevel nonclinical healthcare leaders develop an awareness of their leadership competence?

From three midsized hospitals in the Pacific Northwest region of the United States, 12 midlevel nonclinical healthcare leaders participated in this qualitative study. Vagle's (2014) postintentional phenomenology was the selected approach. Vagle described this approach as the study of through-ness or the nature of becoming. Self-awareness and competence are both complex and shifting concepts; changing with new knowledge or other variables. The intricate nature of these phenomena and their relationships with leaders are best studied with postintentional phenomenology.

I collected data through two in-person interviews, demographic information forms, résumés, job descriptions, and performance-evaluation documents. During the interviews, leaders described their leadership experience from early career to their current position. Participants shared their perceptions of the competencies they possess. They also contributed evidence in support of their knowledge of competence. These leaders were

open in their sharing of experiences and collectively contributed to the emergence of an answer to the research question.

Midlevel nonclinical healthcare leaders develop an awareness of their leadership competency through honest and constructive external feedback. Self-reflection on this feedback enhances understanding and verification of strengths or weaknesses. Among this participant group, shared experiences with five themes of feedback arose: (a) quantitative results, (b) person–person, (c) environmental/relational, (d) recognized capability, and (e) self. In this chapter, I provide an interpretation of these themes and their intricate relationship with self-development. I also present recommendations and implications from these findings.

Interpretation of Findings

This study confirmed and extended the research on self-awareness. The intertwining of development and knowledge subthemes confirmed the intricate nature of the phenomenon. In the cycle of development, awareness of strengths and weaknesses begins with initial consciousness of performance expectations. The expected knowledge, behaviors, skills, and level of performance. Development efforts to improve, input from feedback sources, and reflection leads to gained proficiency (Jung et al., 2016). My study extends the research through a broadened understanding of how leaders know they are competent. Understanding the ways leaders develop the knowledge that they are competent, the mechanisms that provide feedback regarding their strengths and weaknesses, is critical for the cycle of development.

The five themes identified by this research pertaining directly to the research question are feedback mechanisms. Visually represented in Figure 3, the themes of

quantifiable results, person–person, recognized capabilities, and environmental/relational provide feedback directly to a leader and offer validation of their strengths or weaknesses. Self-reflection may filter this feedback; the dotted line represents the potential inclusion of self-reflection. The theme of self consists of the subthemes self-assessment and reflection, and innate quality. Self-reflection directly connects to aspects of this theme; thus, the visual connection and bidirectional arrows.

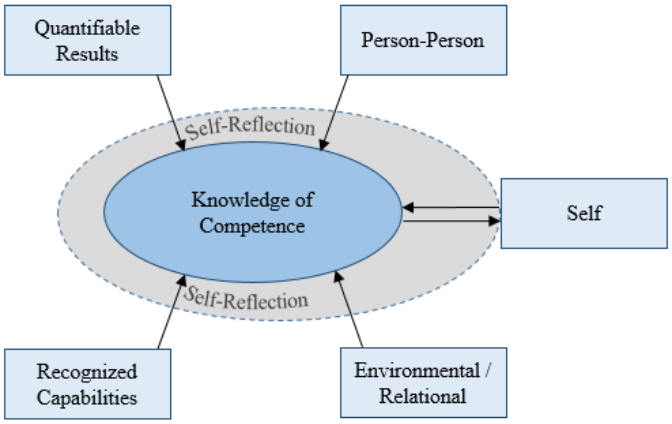

Figure 3. Thematic model of feedback mechanisms contributing to knowledge of competence.

Developing self-awareness, or knowledge of competence, entails an internal focus in which individuals compare their performance to expected standards and then recognize and acknowledge their personal strengths and weaknesses (Silvia & Phillips, 2013). This inward and conscious assessment of performance occurs with the use of information gained from the external environment, feedback from others, and an internal perspective (Morin, 2011). The purpose of this study was to identify how leaders know they are competent. This study identified information sources pertinent to participant leaders.

The thematic model offers an explanation from the shared experiences of participant leaders. Incorporating this information in a discussion of the conceptual

framework that guided this study demonstrates its value to the literature. I represent this incorporated perspective in a visual representation of the cycle of development in Figure 4. The left-hand side is the relationship depicted in Figure 3: feedback mechanisms supplying leaders with sources of knowledge. Feedback or judgments of performance outside of oneself are necessary (Higgs & Rowland, 2010; Morin, 2011; Showry & Manasa, 2014). However, one must be receptive of this feedback for the cycle of development to begin (Braddy et al., 2013; O. J. Sheldon et al., 2014). One can deny this feedback, accept it as fact, or use reflection to develop understanding (Manthey & Fitch, 2012; Morin, 2011; Nesbit, 2012). Development occurs through the identification of a desire to change, reflection, and readiness for change (Avolio & Hannah, 2008; Baron & Parent, 2014; Black et al., 2016). Support, guidance, and resources then assist in the process of development (Patton et al., 2013; Seidle et al., 2016). External motivation or internal achievement motivation drive persistence (Baron & Parent, 2014; Braddy et al., 2013). Feedback from development efforts continue the cycle.

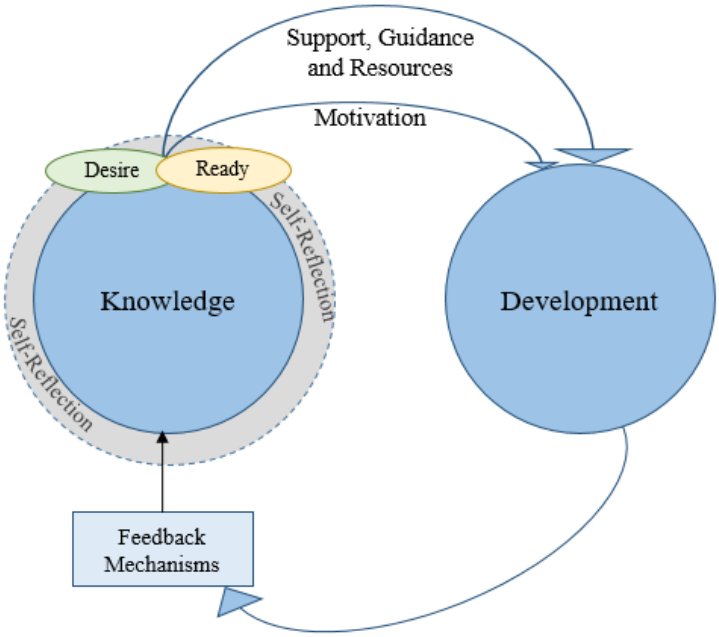

Figure 4. Relationship of feedback mechanisms in the cycle of development.

Participant data also contributed to understanding the cycle of development outside the response to the research question. Three subthemes, indicated as development drivers, identified motivation (see Table 9). Examples of support and guidance shared by participants created the subtheme of mentor/trusted individuals. The subtheme of observed others is an example of resources; learning experiences gleaned from assessment of others' behavioral example. A few participants shared additional effective resources: the decision to go back to school for an advanced degree, organizational development opportunities, leadership-development programs, or self-sought sources (books or podcasts).

Figure 4 represents an inference that the cycle of development is clean, without challenges. This is not the case. Research demonstrates that a number of personal and external variables can benefit or block the cycle (Bandura, 1977; Ferraro, 2010; Lord &

Hall, 2005; Randolph-Seng & Gardner, 2013; Schuler et al., 2010; Solansky, 2014). I mentioned these as potential influencers in the conceptual framework: self-efficacy, self-confidence, self-esteem, psychological empowerment, self-determination, leader identity, self-concept, and CSE. Participants' shared experiences included elements of these influential variables; these were either included as part of identified themes, or were not recognized as significant factors for this participant group. Further exploration of these influencers was beyond the scope of this study but is worth mentioning to forestall the inference that the cycle of development follows an uninterrupted path.

Limitations of the Study

Five limitations of potential influence accrued in the analysis and findings of this study. I recognized these limitations in advance of data collection and the study methodology attempted to mitigate their effect. The first limitation was my familiarity with the phenomenon (risk to bias) through personal experience as a midlevel nonclinical healthcare leader. The creation of a detailed plan for reflection elevated my awareness of preconceptions and biases. Purposeful examination of the developing subthemes compared with my documented expectations of the data reduced this influence.

Three limitations were participant influences: social-desirability bias, false self-assessment of performance (the Dunning–Kruger effect), and the halo effect. Social-desirability bias may have influenced the data if participants failed to respond truthfully to meet an expectation they perceived I, or others, had (A. L. Miller, 2012). False self-assessment—identification of competencies they do not possess—may also have occurred if participants had inaccurate perceptions of their performance (Schlosser et al., 2013).

I managed the potential influence of these recognized limitations by asking for descriptive evidence of perceived competence. The participant-selection criteria also reduced the influence. Further, I shared my plan for full confidentiality of participant inclusion in the study to encourage open sharing of experiences. The selection criteria—participant and referring leaders' perceptions of competence—introduced the halo effect as a limitation. I mitigated this possibility by asking for descriptive evidence of perceived competence. The collection of multiple sources of data further mitigated the influence of the halo effect.

A further limitation for this study was the narrowed scope and small study sample. I accepted this limitation as it allowed for depth in the collection of data from each participant. Further evidence of acceptability of this limitation occurred, as no new subthemes emerged after the fifth interview.

Recommendations

A number of recommendations for future research can be generated from this study. This study was a small sample phenomenological exploration of the experiences of midlevel nonclinical healthcare leaders in one specific region of the United States. Replication of this study with similar leaders in different regions, with leaders from different industries, or with a larger sample size would contribute further depth to answer the research question.

Beyond replication of this study, I would recommend exploration of the feedback mechanisms themselves. This study produced identification of feedback mechanisms, but did not explore the direct influence of these themes or subthemes. A study with narrowed focus on individual subthemes for identification of their scale of influence may further

validate or negate their contribution. Alternatively, exploring the influential variables on specific subthemes may contribute to further a systematic understanding of the cycle of development.

Performance reviews were a subtheme of the quantitative results and person–person themes. However, participants rated the value of this subtheme, the process or tool, moderate to poor. Researchers have studied performance-evaluation processes across industries, yielding a shared perspective of improvement opportunity (Ingram, Anderson, & Pugsley, 2013; Kromrei, 2015; Society for Human Resource Management, 2014). Self-awareness requires an understanding of performance expectations and honest, constructive feedback (Morin, 2011); the performance-evaluation process has the potential to contribute to both. Specific exploration of the performance-evaluation processes in healthcare to enhance understanding of the advantages and challenges of existing practices may help identify opportunities for improvement.

Of the participants, 11 expressed they were receptive of feedback from their supervisors, peers, and employees. Though I captured some of their experience with feedback, this study did not explore the content or quality of feedback or the specific nature of its influence on their leadership performance. Exploration of the frequency, source, content, and quality of person–person feedback could offer enhanced understanding of this feedback mechanism. Connection of this information to specific influences on leadership performance would be a further contribution to the literature.

During data-collection and analysis, I identified 186 competencies from participant interviews and résumés. There were 83 competencies found in my review of the performance expectation documents. Participant-identified competencies did not align

with four of these performance expectations. The purpose of this study was not to compare competencies expressed by leaders to the expectations for their role. Additionally, this study did not serve to validate leader's performance for those competencies they perceived themselves to possess. However, future research exploring leaders' perceived competencies in either of these manners would enhance cognizance of developmental opportunities.

The demographic information for this participant group mirrored the literature regarding selection for a leader-level role in advance of preparedness for leadership (Briggs et al., 2012; Stoller, 2014; Townsend, Wilkinson, Bamber et al., 2012; Zenger, 2012). Only two of the participants in this study sample had formal training, the receipt of a Master in Business Administration degree, in advance of their first leader-level role. Each participant expressed that this training prepared him or her for technical or managerial expectations of their role, but not for leadership. Expanded exploration of the timing of formal leader training and influence on the competence of leaders would be another opportunity for future study.

Implications

Research from R. Hogan and Kaiser (2005) and Gilley et al. (2014) suggested that many leaders lack critical elements of leadership competence. The findings from my study contribute to an understanding of how leaders develop awareness of their leadership competencies. Understanding the importance of these feedback mechanisms in the cycle of development enables recommended actions to improve the development, and thus effectiveness, of leaders. Adoption of such recommendations would result in positive social change for individual leaders, those they lead, and the organizations they

serve. For the individual, this understanding would more effectively prepare them for advancement into leadership or to higher level roles. This preparation could enhance self-efficacy and other psychological characteristics that further benefit the cycle of development. Leaders influence the well-being of their followers (Kara et al., 2013; Ngirande & Timothy, 2014). Thus, enhanced development and effectiveness of leaders may contribute to reduced work stress, improved engagement and job satisfaction, and the positive mental state of their teams. In turn, developed leaders and engaged employees positively influence patient experience and organizational outcomes.

This study identified feedback mechanisms as strong sources for participants' knowledge of their competence, but not well-developed processes in their organizations. For example, P3 shared "I know that you are supposed to be held accountable to your metrics, but I would say maybe [only] if you are not doing well. I guess if you are not hearing anything then you are in good shape." P9 had reached out to others for constructive feedback, but received only "surface-level positive comments" in return. P9 was aware of a need to improve and wanted the constructive help, but those P9 consulted were unwilling or unable to provide feedback. Unsolicited feedback was a source of competence knowledge for 11 of the participants, but only P11 shared that unsolicited feedback was a source of constructive criticism. A lack of insight from external sources hampers awareness of strengths and weaknesses.

Self-awareness develops through an internal process of reflecting on self-assessment and other-assessment of performance and outcomes of work effort (Manthey & Fitch, 2012; Morin, 2011). This requires understanding of performance expectations, the ability to assess performance accurately, and honest feedback from others (Morin,

2011). Therefore, this study generated two recommended actions for practice to improve leader effectiveness: improvement of performance-evaluation processes and development of a feedback culture.

Collectively, a number of sources contributed to four recommendations for improvement of the performance-evaluation process (Baker, Perreault, Reid, & Blanchard, 2013; Cole, 2015; French, Colbert, Pien, Dannefer, & Taylor, 2015; Garret & Camper, 2015; Jung et al., 2016; Kraut, Yarris, & Sargeant, 2015; Kromrei, 2015). First, communication about performance should occur with greater frequency; quarterly meetings at minimum, short weekly or monthly meetings for best practice. Second, to provide knowledge of performance for these meetings, raters should observe performance with the same regularity. Third, the performance-evaluation process should expand beyond that of performance assessment to include a plan for development. Finally, self-assessment should be included as an element of the process to explore differing perspectives.

Changing the performance-evaluation tool or process does not drive improvement itself. The quality of feedback given during a performance evaluation will contribute to development and improvement. Developing a feedback culture, where trust is strong, enhances the outcomes of the performance evaluation and elevates the effectiveness of the feedback (Cole, 2015; Baker et al., 2013; Roussin & Zimmerman, 2014; Ziskin, 2013). The development of a feedback culture provides additional benefit beyond the performance-evaluation process.

Challenges exist in the quality of person–person feedback, as individuals are unlikely to give honest, constructive feedback in person (Govaerts et al., 2013; Vazire &

Carlson, 2011). Additionally, feedback tends to be general, but specific feedback is more apt to improve performance (Krajc, 2008; Krajc & Ortmann, 2008). The literature supports four recommendations to enhance the quality of feedback and for the creation of a feedback culture (Cole, 2015; French et al., 2015; Kraut et al., 2015; Kromrei, 2015; Ziskin, 2015). First, leaders should encourage individuals throughout the organization to give and receive feedback frequently. To change the culture of an organization, senior leaders should model this process. Second, review and select feedback models, such as the Ask-Tell-Ask model (French et al.), to implement a process for effective provision of feedback. Third, provide training on the selected feedback model and on the methods for holding effective difficult conversations. Finally, recognize the influence of emotions on acceptance of feedback and include this as part of the training program.

Methodologically, two aspects of the data-collection process are worthy of including in this section as they contributed to experiential understanding. The first was the use of imaginative variation during the initial interview. Question 7 asked, “if you were to equate how you feel in your role to a musical style, what would you choose and why?” For eight participant interviews, this question enhanced the depth of shared experience. Responses prompted clarity to the experience or the addition of new information. The second method was the inclusion of the workspace observation. Data elements from observation included displayed awards, thank-you notes, and other objects. The observation also prompted additional insights regarding how participants structured their environment to organize their work or their relationships with staff. The use of imaginative variation questioning and observation contributed substantially to the awareness of participants’ experiences.

Conclusion

Healthcare leaders have great influence on the experiences of their employees and, in turn, the experiences of patients. Development of these leaders enhances the potential for this influence to be positive. This study supported the cumulative evidence from the literature that leader development is a shared responsibility between the individual leader and the organization for whom they work. This study also contributed to the research by raising awareness of the necessity of honest and constructive feedback, and that the current provision of feedback fails to match this need. For the cycle of development to function and leader competency to improve there is a shared responsibility between individual leader and the organization they serve. A culture of feedback that provides honest and constructive feedback on a regular basis is the responsibility of the organization. Reflection on this feedback is the responsibility of the individual. Employees and patients deserve leaders and healthcare systems who recognize and own this shared responsibility.

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Appendix A: Comparison of Competency-Model Competencies Aligned to Six Domains for This Study

Table A1

Competency Model Domains and Competencies from Aitken and von Treuer (2014) Aligned to the Six Domains of Leadership Competency

Domain	Competencies	Alignment to six domains
Leadership and governance in service integration	Organization management	Leadership
	Clarity of shared vision	Leadership
	Fostering organizational readiness	Leadership
	Leadership	Leadership
Relationship management and communication skills	Collaborating with partners	Leadership
	Communication	Leadership
	Multidisciplinary teamwork	Leadership
Management of people, organizational systems and processes	Management of people	Leadership
	Management of organizational systems and processes	Management
	Planning, evaluation, and service improvement	Management
Practice knowledge	Program and practice knowledge	Technical
	Advocacy and community development	Leadership
Personal characteristics and capabilities	Personal integrity, achievement focus, and self-management	Leadership

Note. Description of each competency was available from the resource and assisted in identifying alignment to the six domains. Adapted from "Organisational and Leadership Competencies for Successful Service Integration," by K. Aitken & K. von Treuer, 2014, *Leadership in Health Services, 27*(2), p. 162. This competency model was healthcare focused, specifically for the integration of patient care services for gained efficiencies.

Table A2

Competency Model Domains and Competencies from Bapat et al. (2011) Aligned to the Six Domains of Leadership Competency

Domains	Subdomains	Competencies	Alignment to six domains
Self-management	Work habits	Time management	Technical
		Goal orientation	Technical
		Organization skills	Technical
		Work ethic	Intrapersonal
		Follow through	Intrapersonal
	Work attitudes	Initiative	Intrapersonal
		Effort	Intrapersonal
		Persistence	Intrapersonal
		Energy	Intrapersonal
		Optimism	Intrapersonal
	Stress management	Self-control	Intrapersonal
		Stress tolerance	Intrapersonal
		Personal resiliency	Intrapersonal
		Work-life balance	Intrapersonal
		Adaptability	Intrapersonal
	Self-insight	Optimism[a]	Intrapersonal
		Self-confidence	Intrapersonal
		Self-awareness	Intrapersonal
		Self-Reliance[b]	Intrapersonal
		Humility	Intrapersonal
		Suspending Prejudices	Intrapersonal
	Learning	Learning strategies	Technical
		Intellectual curiosity	Intrapersonal
		Continuous learning	Technical
		Seeking feedback	Intrapersonal

Table continues

Domains	Subdomains	Competencies	Alignment to six domains
Leading others	Communication	Communicating with coworkers	Interpersonal
		Active listening	Interpersonal
		Facilitating discussion	Leadership
		Public speaking	Technical
		Developing external contacts	Interpersonal
		Communicating outside the organization	Leadership
	Interpersonal awareness	Psychological knowledge	Technical
		Social orientation	Interpersonal
		Social perceptiveness	Interpersonal
		Service orientation	Interpersonal
		Nurturing relationships	Interpersonal
	Motivating others	Taking charge	Leadership
		Orienting others	Management
		Setting goals for others	Management
		Reinforcing success	Leadership
		Developing and building teams	Leadership
	Developing others	Knowledge of principles of learning	Technical
		Interpreting the meaning of information for others	Leadership
		Assessing others	Management
		Coaching, developing and instructing	Leadership
	Influencing	Cooperating	Interpersonal
		Persuading	Leadership
		Resolving conflicts/negotiating	Leadership
		Empowering	Leadership
		Inspiring	Leadership
		Politically savvy	Leadership

Table continues

Domains	Subdomains	Competencies	Alignment to six domains
Task management	Executing tasks	Task-relevant knowledge	Technical
		Delegating	Leadership
		Attention to detail	Intrapersonal
		Coordinating work activities	Management
		Providing feedback	Leadership
		Multitasking	Intrapersonal
	Solving problems	Analytic thinking	Cognitive
		Analyzing data	Cognitive
		Mental focus	Intrapersonal
		Decision making	Management
		Designing work systems	Management
	Managing information and material resources	Managing materials and facilities	Management
		Managing information resources	Management
		Performing administrative activities	Management
		Maintaining quality	Management
	Managing human resources	Succession planning/recruiting	Management
		Personnel decision quality	Management
		Managing personnel policies	Management
		Maintaining safety	Management
	Enhancing performance	Enhancing task knowledge	Management
		Eliminating barriers to performance	Management
		Benchmarking	Management
		Strategic task management	Management

Table continues

Domains	Subdomains	Competencies	Alignment to six domains
Innovation	Creativity	Generating ideas	Cognitive
		Critical thinking	Cognitive
		Synthesis/reorganization	Cognitive
		Creative problem solving	Cognitive
	Enterprising	Problem identification	Cognitive
		Seeking improvement	Management
		Gathering information	Cognitive
		Independent thinking	Leadership
		Technologically savvy	Technical
	Integrating perspectives	Openness to ideas	Leadership
		Research orientation	Interpersonal
		Collaborating	Interpersonal
		Engaging in nonwork interests	Intrapersonal
	Forecasting	Perceiving systems	Leadership
		Evaluating Long-Term Consequences	Leadership
		Visioning	Leadership
		Managing the future	Leadership
	Managing change	Sensitivity to situations	Leadership
		Challenging the status quo	Leadership
		Intelligent risk-taking	Leadership
		Reinforcing change	Leadership

Table continues

Domains	Subdomains	Competencies	Alignment to six domains
Social responsibility	Civic responsibility	Communicating with the community	Leadership
		Helping the community	Leadership
		Civic action	Interpersonal
		Adopting beneficial values for society	Intrapersonal
		Providing a good example	Leadership
		Social action	Leadership
	Social knowledge	Knowledge of:	
		Sociology and anthropology	Technical
		History and geography	Technical
		Foreign language	Technical
		Philosophy and theology	Technical
		Organizational justice principles	Technical
		Legal regulations	Technical
	Ethical processes	Open-door policy	Leadership
		Instituting and following fair procedures	Leadership
		Explaining decisions in respectful manner	Leadership
		Ensuring ethical behavior of subordinates	Management
	Leading others	Servant leadership	Leadership
		Valuing diversity	Leadership
		Distributing rewards fairly	Management
		Responsibility for others	Leadership
		Avoiding exploitative mentality	Leadership
	Acting with integrity	Financial ethics	Intrapersonal
		Work-place ethics	Intrapersonal
		Honesty and integrity	Intrapersonal
		Being accountable	Intrapersonal
		Courage of convictions	Intrapersonal

Note. Description of each competency was available from the resource and assisted in identifying alignment to the six domains; [a]Competency is listed in the model on page 6, but missing from the definition for subdomain competencies on page 13; [b]Not listed in the model on page 6, but defined among the subdomain competencies on page 13. Adapted from "A Leadership Competency Model: Describing the Capacity to Lead" by A. Bapat, M. Bennett, G. Burns, C. Bush, K. Gobeski, S. Langford, … S. Wagner, 2011, retrieved from http://www.chsbs.cmich.edu/leader_model This competency model was general to leadership across industries.

Table A3

Competency Model Domains and Competencies from Beinecke and Spencer (2007) and Beinecke (2009) Aligned to the Six Domains of Leadership Competency

Domains	Competencies[a]	Alignment to six domains
Personal skills and knowledge	Emotional intelligence	Intrapersonal
	Leader's values and beliefs	Intrapersonal
	Ethics, morality, and respect for human rights	Intrapersonal
	Adaptability, creativity, flexibility, and situational awareness	Intrapersonal
	Reflective thinking and practicing and challenging thinking	Cognitive
	Intelligence, knowledge, and competence	Cognitive
Interpersonal (people) skills	Communicating (written, verbal, listening, and presenting)	Leadership
	Teamwork and small-group skills, collaboration, and meeting management	Leadership
	Coaching, mentoring, development, and personal growth	Leadership
	Negotiating, resolving conflict, facilitating, agreement building, and mediation	Leadership
	Working with people of other cultures and promoting diversity	Leadership
Transactional (execution, management) skills	Quality management	Management
	Human-resource management, staffing, and recruiting	Management
	Finance, budgeting, and funding, and health economics	Management
	Organizational theory and design	Management
	Information systems and technology management	Management
Transformational skills	Visioning and setting shared a strategic vision and mission	Leadership
	Managing of complex organizational change	Leadership
	Setting goals, setting direction, alignment, and driving for results	Leadership
	Mobilizing support, influencing, inspiring, and motivating others	Leadership
	Working across complex interorganizational systems	Leadership
Policy and program knowledge: Understanding	Government and political knowledge	Technical
	Funding and legislation	Technical
	Recovery and other health issues	Technical
	Knowledge of diverse stakeholders	Technical

Note. Clear description of each competency was not available from the resource; therefore, best judgment was used in identifying and aligning to the six domains. [a]Abbreviated original text in one or more of the listed competencies. Adapted from "International Leadership Competencies and Issues," by R. H. Beinecke and J. Spencer, 2007, *The International Journal of Leadership in Public Services, 3*(3), p. 10; "Leadership Training Programs and Competencies for Mental Health, Health, Public Administration, and Business in Seven Countries," by R. H. Beinecke, 2009, *International Initiative for Mental Health Leadership*, retrieved from http://www.iimhl.com/files/docs/20090213.pdf. This competency model was healthcare focused; specifically, mental health.

Table A4

Competency Model Domains and Competencies from Boyatzis (1982) Aligned to the Six Domains of Leadership Competency

Domain	Competencies	Alignment to six domains
Goal and action management	Concern with impact	[a]
	Diagnostic use of concepts	Cognitive
	Efficiency orientation	Intrapersonal
	Proactivity	Leadership
Leadership	Conceptualization	Cognitive
	Self-confidence	Intrapersonal
	Use of oral presentations	Technical
	Logical thought	Cognitive
Human resource management	Managing group process	Leadership
	Use of socialized power	Leadership
	Accurate self-assessment	Intrapersonal
	Positive regard	Interpersonal
Directing subordinates	Developing others	Leadership
	Spontaneity	Intrapersonal
	Use of unilateral power	Management
Focus on others	Perceptual objectivity	Intrapersonal
	Self-control	Intrapersonal
	Stamina and adaptability	Intrapersonal
	Concern with close relationships	Interpersonal
Specialized knowledge	Specialized knowledge	Technical

Note. Description of each competency was available from the resource and assisted in identifying alignment to the six domains. [a]Competency did not align to any of the six domains. Adapted from *The Competent Manager: A Model for Effective Performance*, by R. E. Boyatzis, 1982, New York, NY: Wiley-Interscience, p. 94, 118, 138, 156, 180, and 183. This competency model was general to leadership across industries.

Table A5

Competency Model Domains and Competencies from Calhoun et al. (2008) Aligned to the Six Domains Of Leadership Competency

Domains	Competencies	Alignment to six domains
Transformation	Achievement orientation	Intrapersonal
	Analytical thinking	Cognitive
	Community orientation	Leadership
	Financial skills	Technical
	Information seeking	Intrapersonal
	Innovative thinking	Cognitive
	Strategic orientation	Leadership
Execution	Accountability	Leadership
	Change leadership	Leadership
	Collaboration	Interpersonal
	Communication skills	Leadership
	Impact and influence	Leadership
	Information-technology management	Cognitive
	Initiative	Intrapersonal
	Organizational awareness	Leadership
	Performance measurement	Management
	Process management/ organizational design	Management
	Project management*	Management
People	Human resource management*	Management
	Interpersonal understanding	Interpersonal
	Professionalism	Intrapersonal
	Relationship building	Interpersonal
	Self-confidence	Intrapersonal
	Self-development	Intrapersonal
	Talent development	Leadership
	Team leadership	Leadership

Note. Description of each competency was available from the resource and assisted in identifying alignment to the six domains. Adapted from "Development of an Interprofessional Competency Model for Healthcare Leadership," by J. G. Calhoun, L. Dollett, M. E., Sinioris, J. A. Wainio, P. W. Butler, J. R. Griffith, & G. L. Warden, 2008, *Journal of Healthcare Management, 53*(6), p. 378. This competency model was healthcare focused.

Table A6

Competency Model Domains and Competencies from Citaku et al. (2012) Aligned to the Six Domains of Leadership Competency

Domain	Competencies	Alignment to six domains
Self-management	Goal orientation	Intrapersonal
	Initiative	Intrapersonal
	Effort	Intrapersonal
	Persistence	Intrapersonal
	Self-control stress tolerance	Intrapersonal
	Continuous learning	Intrapersonal
	Self-reliance	Intrapersonal
	Setting goals for others (LO)	Management
Justice orientation	Maintaining safety (TM)	Management
	Knowledge of organizational justice principles (SR)	Technical
	Knowledge of legal regulations (SR)	Technical
	Assessing others (LO)[a]	Management
	Coaching, developing and instructing (LO)[a]	Leadership
Task management	Succession planning/recruiting	Management
	Personnel decision quality	Management
	Enhancing task knowledge	Management
	Eliminating barriers to performance	Management
	Strategic task management	Management
	Responsibility for others (SR)	Leadership
Innovation	Critical thinking	Cognitive
	Creative problem solving[a]	Cognitive
	Identifying problems	Cognitive
	Collaborating[a]	Interpersonal
	Perceiving systems	Leadership
	Identifying downstream consequences	Leadership
	Visioning	Leadership
	Managing the future	Leadership
	Sensitivity to situations	Interpersonal

Table continues

Domain	Competencies	Alignment to six domains
	Challenging the status quo[a]	Leadership
	Intelligent risk-taking	Leadership
	Reinforcing change	Leadership
	Developing and building teams (LO)	Leadership
	Psychological knowledge (LO)	Technical
	Social perceptiveness (LO)	Interpersonal
	Knowledge of principles of learning (LO)	Technical
	Assessing others (LO)[a]	Management
	Coaching, developing and instructing (LO)[a]	Leadership
	Politically savvy (LO)	Leadership
Social responsibility	Providing a good example	Leadership
	Open-door policy	Leadership
	Explaining decisions in respectful manner	Leadership
	Servant leadership	Leadership
	Distributing rewards fairly	Management
	Honesty and integrity	Intrapersonal
	Being accountable	Intrapersonal
	Adaptability	Intrapersonal
	Seeking feedback	Intrapersonal
	Communicating with coworkers (LO)	Interpersonal
	Active listening (LO)	Interpersonal
	Facilitating discussion (LO)	Leadership
	Cooperating (LO)	Interpersonal
	Empowering (LO)	Leadership
	Creative problem solving (IN)[a]	Cognitive
	Openness to ideas (IN)	Leadership
	Collaborating (IN)[a]	Interpersonal
	Challenging the status quo (IN)[a]	Leadership

Note. Wagner et al. (2004) was cited as the foundation for this competency model. The notations of LO, TM, SR, and IN denote the original domain to which these competencies were aligned in the Wagner et al. competency model: LO = Leading Others, TM = Task Management, SR = Social Responsibility, IN = Innovation. Clear description of each competency was not available from the resource; therefore, best judgment was used in identifying and aligning to the six domains. [a]Identified to multiple domains. Adapted from "Leadership Competencies for Medical Education and Healthcare Professions: Population-Based Study," by F. Citaku, C. Violato, T. Beran, T. Donnon, K. Hecker, & D. Cawthorpe, 2012, *BMJ Open, 2*, pp. 6–7. This competency model was healthcare focused.

Table A7

Competency Model Domains and Competencies from Garman and Scribner (2011) Aligned to the Six Domains of Leadership Competency

Domain	Competencies	Alignment to six domains
Fosters positive change	Advocates for and adapts to change	Leadership
	Partners for change	Leadership
	Cultivates a quality-supportive climate	Leadership
	Drives for results	Leadership
Organizational awareness	Strategic planning	Leadership
	Strategic thinking and alignment	Leadership
	Financial acumen	Technical
	Systems thinking[a]	Leadership
Communicating[a]	Verbal communication skills	Interpersonal
	Written communication skills	Technical
	Listening and receiving feedback[a]	Interpersonal
	Educating	Management
Self-management[a]	Professional ethics	Intrapersonal
	Manages personal limits[a]	Intrapersonal
	Resilience and self-restraint[a]	Intrapersonal
Performance improvement	Managing data	Management
	Analytic thinking/ knowledge-based decision making	Cognitive
	Develops a knowledge-rich environment	Leadership
Professionalism/ professional values	Consumer advocacy	Interpersonal
	Future focus	Leadership
	Lifelong learning	Intrapersonal

Note. [a]Used the health-administrators leadership model created by Garman, Tyler, & Darnall (2004), among others, as the foundation for this model. Similarities to Garman et al. are minimal. Clear description of each competency was not available from the resource; therefore, best judgment was used in identifying and aligning to the six domains. Adapted from "Leading for Quality in Healthcare: Development and Validation of a Competency Model," by A. Garman & L. Scribner, 2011, *Journal of Healthcare Management, 56*(6), p. 378. The Professionalism/Professional Values domain was identified as necessary across all levels of leadership. Communicating, Self-management, and Performance Improvement most aligned to midlevel leadership. Fosters Positive Change and Organizational Awareness are competency domains most necessary for senior-level leaders. This competency model was healthcare focused, specifically leading for quality improvement.

Table A8

Competency Model Domains and Competencies from Garman, Tyler, and Darnall (2004) Aligned to the Six Domains of Leadership Competency

	Competencies	Alignment to six domains
Charting the course	Strategic vision[b,c]	Leadership
	Innovativeness[b,c]	Leadership
	Systems thinking[b,c]	Leadership
	Flexibility/ adaptability[a,b,c]	Intrapersonal
Developing work relationships	Individual understanding[a,b]	Interpersonal
	Mentoring[a,b]	Leadership
	Physician/clinician relations[a,b,c]	Leadership
Broad influence	Consensus building[b]	Leadership
	Persuasiveness[a,b,c]	Leadership
	Political skills[b,c]	Leadership
	Collaboration/team building[a,b,c]	Leadership
Structuring the work environment	Work design and coordination[a,b,c]	Leadership
	Feedback giving/ performance management[b,c]	Leadership
	Use of meetings[b]	Management
	Decision making[a,b,c]	Management
Inspiring commitment	Building trust[a,b,c]	Leadership
	Listening/receiving feedback[a,b,c]	Interpersonal
	Tenacity[b,c]	Leadership
	Self-presentation[a,b,c]	Intrapersonal
Communication	Energizing[a,b,c]	Leadership
	Crafting messages[a,b,c]	Technical
	Writing[a,b]	Technical
	Speaking[a,b,,c]	Technical
Self-management	Managing limits[a,b]	Intrapersonal
	Balance[b,c]	Intrapersonal
	Resilience/self-restraint[a,b,,c]	Intrapersonal

Note. Description of each competency was available from the resource and assisted in the identifying alignment to the six domains. Each competency was assessed for alignment to leader level: [a] Aligned to entry-level, [b] to midlevel, and [c] to senior-level leaders. Midlevel leaders require all 26 competencies. Adapted from "Development and Validation of a 360-Degree-Feedback Instrument for Healthcare Administrators," by A. N. Garman, L. Tyler, & J. S. Darnall, 2004, *Journal of Healthcare Management, 49*(5), p. 312. This competency model was healthcare focused.

Table A9

Competency Model Domains and Competencies from Hogan Assessment Systems (2009) Aligned to the Six Domains of Leadership Competency

Domains	Competencies	Alignment to six domains
Intrapersonal	Achievement orientation	Intrapersonal
	Ambiguity tolerance	Intrapersonal
	Caring	Intrapersonal
	Competitive	Intrapersonal
	Dependability	Intrapersonal
	Detail orientation	Intrapersonal
	Flexibility	Intrapersonal
	Following procedures	Intrapersonal
	Initiative	Intrapersonal
	Perseverance	Intrapersonal
	Planning/organizing	Management[b]
	Professionalism	Intrapersonal
	Responsibility	Intrapersonal
	Risk management	Management[b]
	Self-confidence	Intrapersonal
	Self-development	Intrapersonal
	Stress tolerance	Intrapersonal
	Time management	Intrapersonal
	Trustworthiness	Intrapersonal
	Vigilance	Intrapersonal
	Work attitude	Intrapersonal
	Work ethic	Intrapersonal

Table continues

Domains	Competencies	Alignment to six domains
Interpersonal	Active listening	Interpersonal
	Building relationships	Interpersonal
	Citizenship	Interpersonal
	Influence	Leadership[a]
	Negotiation	Leadership[a]
	Oral communication	Interpersonal
	Organizational commitment	Interpersonal
	Service orientation	Interpersonal
	Social engagement	Interpersonal
	Teamwork	Interpersonal
	Valuing diversity	Interpersonal
Technical (Work skills)	Financial acumen	Technical
	Goal setting	Technical
	Industry knowledge	Technical
	Information analysis	Technical
	Innovation	Cognitive[b]
	Political awareness	Leadership[a]
	Presentation skills	Technical
	Problem identification	Cognitive[b]
	Problem solving	Cognitive[b]
	Quality orientation	Management[b]
	Safety	Technical
	Sales ability	Technical
	Written communication	Technical

Table continues

Domains	Competencies	Alignment to six domains
Technical (Work skills)	Financial acumen	Technical
	Goal setting	Technical
	Industry knowledge	Technical
	Information analysis	Technical
	Innovation	Cognitive[b]
	Political awareness	Leadership[a]
	Presentation skills	Technical
	Problem identification	Cognitive[b]
	Problem solving	Cognitive[b]
	Quality orientation	Management[b]
	Safety	Technical
	Sales ability	Technical
	Written communication	Technical
Leadership	Building teams	Leadership
	Business acumen	Leadership
	Decision making	Management[b]
	Delegation	Leadership
	Employee development	Leadership
	Managing change	Leadership
	Managing conflict	Leadership
	Managing performance	Leadership
	Motivating others	Leadership
	Resource management	Management[b]
	Strategic planning	Leadership
	Talent management	Leadership

Note. Description of each competency was available from the resource and assisted in the identify alignment to the six domains. [a]Realignment to a different category based on the definitions used in this study. [b]Realignment to a different category based on the addition of two categories beyond the four identified by Hogan (Hogan Assessment Systems, 2009; Hogan & Warrenfeltz, 2003). Adapted from "The Development of the Hogan Competency Model," by Hogan Assessment Systems, 2009, pp. 17–19. This competency model was general to leadership across industries.

Table A10

Competency Model Domains and Competencies from Korn Ferry (2014) Aligned to the Six Domains of Leadership Competency

Domain	Subdomains	Competencies	Alignment to six domains
Thought	Understanding the business	Business insight	Technical
		Customer focus	Interpersonal
		Financial acumen	Technical
		Technologically savvy	Technical
	Making complex decisions	Manages complexity	Interpersonal
		Decision quality	Cognitive
		Balances stakeholders	Interpersonal
	Creating the new and different	Global perspective	Leadership
		Cultivates innovation	Leadership
		Strategic mindset	Leadership
Results	Taking initiative	Action oriented	Leadership
		Resourcefulness	Cognitive
	Managing execution	Directs work	Management
		Plans and aligns	Management
		Optimizes work processes	Management
	Focusing on performance	Ensures accountability	Leadership
		Drives results	Leadership
People	Building collaborative relationships	Collaborates	Interpersonal
		Manages conflict	Leadership
		Interpersonally savvy	Interpersonal
		Builds networks	Interpersonal
	Optimizing diverse talent	Attracts top talent	Leadership
		Develops talent	Leadership
		Values differences	Leadership
		Builds effective teams	Leadership

Table continues

Domain	Subdomains	Competencies	Alignment to six domains
	Influencing people	Communicates effectively	Interpersonal
		Drives engagement	Leadership
		Organizationally savvy	Leadership
		Persuades	Leadership
		Drives vision and purpose	Leadership
Self	Being authentic	Courage	Intrapersonal
		Instills trust	Leadership
	Being open	Demonstrates self-awareness	Intrapersonal
		Self-development	Intrapersonal
	Being flexible and adaptable	Manages ambiguity	Intrapersonal
		Nimble learning	Cognitive
		Being resilient	Intrapersonal
		Situational adaptability	Intrapersonal

Note. Description of each competency was available from the resource and assisted in identifying alignment to the six domains; adapted from The Korn Ferry Leadership Architect™, by Korn Ferry, 2014, Los Angeles, CA: Author, p. 28. This competency model was general to leadership across industries.

Table A11

Competency Model Domains and Competencies from Suh et al. (2012) Aligned to the Six Domains of Leadership Competency

Domains	Competencies	Alignment to six domains
Hospitality	Knowledge in front office operations	Technical
	Knowledge in human resources	Technical
	Knowledge in housekeeping operations	Technical
	Knowledge in accounting	Technical
	Knowledge in finance	Technical
Interpersonal	Interaction with subordinates	Interpersonal
	Peer interaction	Interpersonal
	Guest interaction	Interpersonal
	Interaction with superiors	Interpersonal
Supervisory	Staff training	Management
	Scheduling	Management
	Interview skills	Management
	Knowledge in event planning	Technical
	Knowledge in cultural differences	Management
Food and Beverage Management	Basic food preparation	Technical
	Basic beverage management	Management
	Foodservice skills	Technical
Leadership	Tolerance for change	Intrapersonal
	Openness to new ideas	Intrapersonal
	Strategic thinking	Leadership
	Personal integrity	Intrapersonal
Communication	Oral English communication	Technical
	English writing skills	Technical
	Presentation skills	Technical
	Oral communication	Interpersonal

Table continues

Domains	Competencies	Alignment to six domains
Uncategorized[a]	Housekeeping operations	Technical
	Front office system	Technical
	Computer mastery	Technical
	Second-language fluency	Technical
	Guest research ability	Cognitive
	Knowledge of marketing	Technical
	Knowledge in food and beverage	Technical
	Knowledge in food sanitation	Technical
	Knowledge in law	Technical
	Knowledge in catering	Technical
	Recruiting ability	Management
	Written communication	Technical
	Listening skills	Interpersonal
	Leadership	Leadership
	Decision making	Cognitive
	Negotiation skills	Leadership
	Creativity	Intrapersonal
	Boundary-spanner role	[a]

Note. [a]Competency did not align to any of the six domains. Clear description of each competency was not available from the resource; therefore, best judgment was used to identify and align to the six domains. Adapted from "Important Competency Requirements for Managers in the Hospitality Industry" by E. Suh, J. J. West, & J. Shin, 2012, *Journal of Hospitality, Leisure, Sport & Tourism Education, 11,* p. 107, 108. This competency model focused on the hospitality industry.

Table A12

Competency Model Domains and Competencies from Testa and Sipe (2012) Aligned to the Six Domains of Leadership Competency

Domain	Competencies	Alignment to six domains
Business savvy	Planning	Leadership
	Numberwise	Leadership
	Continuous improvement	Leadership
	Strategic decision making	Leadership
	Systems thinking	Leadership
	Technical service	Management
	Results oriented	Leadership
People savvy	Interpersonal communication	Interpersonal
	Expressive service	Leadership
	Team orientation	Leadership
	Coaching and training	Leadership
	Inspiration	Leadership
	Cultural alignment	Leadership
	Networked	Interpersonal
Self-savvy	Accountability	Leadership
	Professionalism	Intrapersonal
	Self-development	Intrapersonal
	Time management	Management
	Spirit of optimism	Intrapersonal
	Change management	Leadership

Note. Description of each competency was available from the resource and assisted in identifying and aligning to the six domains. Adapted from "Service-Leadership Competencies for Hospitality and Tourism Management," by M. R. Testa & L. Sipe, 2012, *International Journal of Hospitality Management, 31*, p. 653. This competency model focused on the hospitality industry, specifically on service leadership.

Table A13

Competency Model Domains and Competencies from Tubbs and Schulz (2005) Aligned to the Six Domains of Leadership Competency

Categories	Domains	Competencies[a]	Alignment to six domains
Core personality			Intrapersonal
Values			Intrapersonal
Behaviors	Understanding the big picture	Demonstrating knowledge of entire organization	Technical
		Using systems theory	Leadership
		Using technology effectively	Technical
		Demonstrating global sensitivity	Leadership
		Using effective compensation	Management
		Demonstrating ethical practices	Intrapersonal
	Attitudes are everything	Demonstrating a vision	Leadership
		Showing inclusiveness and respect for diversity	Interpersonal
		Overcoming adversity	Intrapersonal
		Demonstrating confidence in self and others	Leadership
	Leadership, the driving force	Inspiring others	Leadership
		Going against outdated or ineffective practices	Leadership
		Building trust	Leadership
		Varying leadership to the demands of the situation	Leadership
		Delegating	Leadership
		Evaluating others	Management
		Mentoring others	Leadership
		Demonstrating sensitivity and empathy	Interpersonal
		Seeing nuances of alternatives	Leadership
		Serving as an appropriate role model	Leadership
	Communication, the leader's voice	Demonstrating appropriate emotional intelligence	Intrapersonal
		Using active listening	Interpersonal
		Demonstrating nondefensiveness	Intrapersonal
		Using language skillfully	Interpersonal
		Using body language skillfully	Interpersonal
		Interviewing effectively	Management
		Negotiating effectively	Leadership
		Making skilled presentations	Technical

Table continues

Categories	Domains	Competencies[a]	Alignment to six domains
	Innovation and creativity	Developing an innovative organizational climate	Leadership
		Improving creative decision making	Cognitive
		Using weird ideas that work	Leadership
		Avoiding indecision based on old paradigms	Leadership
		Learning reframing	Cognitive
		Encouraging creative abilities	Leadership
	Leading change	Creating transformational change	Leadership
		Developing a continuous learning culture	Leadership
		Building mechanisms to create and sustain change	Leadership
		Managing the change process	Management
		Developing change agents	Leadership
		Encouraging individual change	Leadership
		Encouraging structural change	Leadership
	Teamwork and followership	Learning to focus	Intrapersonal
		Solving problems effectively with no-fault solutions	Leadership
		Developing a team-oriented culture	Leadership
		Developing incentive and reward systems	Management
		Managing your boss	Interpersonal
		Effectively navigating organizational politics	Leadership
		Supporting others on the team	Interpersonal
		Effectively using empowerment	Leadership
		Developing self-directed work teams	Leadership

Note. Clear description of each competency was not available from the resource; therefore, best judgment was used in identifying and aligning to the six domains. [a]Abbreviated original text in one or more of the listed competencies. Adapted from "Leadership Competencies: Can They Be Learned?" by S. L. Tubbs & E. Schulz, 2005, *The Business Review, Cambridge, 3*(2), pp. 7–8. This competency model was general to leadership across industries.

Table A14

Competency Model Domains and Competencies from U.S. Department of Labor, Employment and Training Administration (2012) Aligned to the Six Domains of Leadership Competency

Category	Tier	Competencies	Alignment to six domains
Occupation	9: Management	Staffing	Management
		Informing	Leadership
		Delegating	Leadership
		Networking	Leadership
		Monitoring work	Leadership
		Entrepreneurship	Leadership
		Supporting others	Leadership
		Motivating and inspiring	Leadership
		Developing and mentoring	Leadership
		Planning and acting strategically	Leadership
		Preparing and evaluating budgets	Management
		Clarifying roles and objectives	Leadership
		Managing conflict and building teams	Leadership
		Developing an organizational vision	Leadership
		Monitoring and controlling resources	Management
	8: Occupation-specific requirements		Technical
	7: Occupation-specific Technical		Technical
	6: Occupation-specific knowledge		Technical
Industry	5: Industry-sector		Technical
	4: Industry-wide		Technical

Table continues

Category	Tier	Competencies	Alignment to six domains
Foundational	3: Workplace	Working well in teams	Interpersonal
		Focusing on customers	Interpersonal
		Planning and organizing	Intrapersonal
		Thinking creatively	Cognitive
		Solving problems and making decisions	Cognitive
		Working with tools and technology	Technical
		Scheduling and coordinating	Technical
		Checking, examining and recording	Technical
		Understanding business fundamentals	Technical
		Adhering to sustainable practices	Technical
		Emphasizing health and safety	Technical
	2: Academic	Reading	Cognitive
		Writing	Cognitive
		Mathematics	Cognitive
		Basic computer skills	Technical
		Communication	Technical
		Science and technology	Cognitive
		Critical and analytical thinking	Cognitive
	1: Personal Effectiveness	Interpersonal skills	Interpersonal
		Integrity	Intrapersonal
		Professionalism	Intrapersonal
		Initiative	Intrapersonal
		Dependability and reliability	Intrapersonal
		Adaptability and flexibility	Intrapersonal
		Lifelong learning	Intrapersonal

Note. Description of each competency was available from the resource and assisted in identifying alignment to the six domains; adapted from "Technical Assistance Guide for Developing and Using Competency Models: One Solution for the Workforce Development System" by U.S. Department of Labor, Employment and Training Administration, 2012, updated by JBS International; "Building Blocks for Competency Models" by Competency Model Clearinghouse, 2015, retrieved from http://www .careeronestop.org/CompetencyModel/pyramid_definition.aspx; "Building Block Model" by Competency Model Clearinghouse, 2015, retrieved from http://www.careeronestop.org/CompetencyModel/competency -models/building-blocks-model.aspx. This competency model was general to leadership across industries.

Table A15

Competency Model Domains and Competencies from U.S. Office of Personnel Management (n.d.) Aligned to the Six Domains of Leadership Competency

Domain	Competencies	Alignment to six domains
Leading change	Creativity and innovation	Leadership
	External awareness	Leadership
	Flexibility	Leadership
	Resilience	Leadership
	Strategic thinking	Leadership
	Vision	Leadership
Leading people	Conflict management	Leadership
	Leveraging diversity	Leadership
	Developing others	Leadership
	Team building	Leadership
Results driven	Accountability	Leadership
	Customer service	Leadership
	Decisiveness	Leadership
	Entrepreneurship	Leadership
	Problem Solving	Leadership
	Technical Credibility	Leadership
Business acumen	Financial management	Leadership
	Human capital management	Leadership
	Technology management	Leadership
Building coalitions	Partnering	Leadership
	Politically savvy	Leadership
	Influencing/negotiating	Leadership
Fundamental competencies	Interpersonal skills	Interpersonal
	Oral communication	Leadership
	Integrity/ honesty	Leadership
	Written communication	Technical
	Continual learning	Intrapersonal
	Public service motivation	Leadership

Note: Description of each competency was available from the resource and assisted in identifying alignment to the six domains; adapted from Downloaded from *Proficiency levels for Leadership Competencies,* by U.S. Office of Personnel Management, n.d., retrieved from https://www.opm.gov/policy-data-oversight/assessment-and-selection/competencies/proficiency-levels-for-leadership-competencies.pdf This competency model was general to leadership across industries.

Appendix B: Comparison of Competency-Model Domains Aligned to Six Domains for This Study

Table B1

Competency Model Domains from Aitken and von Treuer (2014), Bapat et al. (2011), and Beinecke (2009) and Beinecke and Spencer (2007) Aligned to the Six Domains of Leadership Competency

Domains	Aitken and von Treuer (2014)	Bapat et al. (2011)	Beinecke (2009); Beinecke & Spencer (2007)
Cognitive			
Technical			Policy and program knowledge: understanding
Management			Transactional (execution, management) skills
Interpersonal			
Intrapersonal			
Leadership	Leadership and governance in service integration	Innovation	Interpersonal (people) skills
	Management of people, organizational system and processes	Leading others	Personal skills and knowledge[a]
	Personal characteristics and capabilities	Self-management[a]	Transformational Skills
	Practice knowledge	Social responsibility	
	Relationship management and communication skills	Task management	

Note. [a]Individual competencies align with soft and hard domains; thus, the domain itself aligns to leadership; adapted from "Organisational and Leadership Competencies for Successful Service Integration," by K. Aitken & K. von Treuer, 2014, *Leadership in Health Services, 27,* 150–180, doi: 10.1108/LHS-08-2012-0028; *A Leadership Competency Model: Describing the Capacity to Lead*, by A. Bapat, M. Bennett, G. Burns, C. Bush, K. Gobeski, S. Langford, … S. Wagner, 2011, retrieved from http://www.manchesterchristian.com/WebPageFiles/MCC_Competency_Definition_V1_3.pdf; "International Leadership Competencies and Issues," by R. H. Beinecke & J. Spencer, J, 2007, *The International Journal of Leadership in Public Services, 3*(3), 4–14. doi:10.1108/17479886200700017.

Table B2

Competency Model Domains from Boyatzis (1982), Calhoun et al. (2008), Citaku et al. (2012), and Garman and Scribner (2011) Aligned to the Six Domains of Leadership Competency

Domains	Boyatzis (1982)	Calhoun et al. (2008)	Citaku et al. (2012)	Garman and Scribner (2011)
Cognitive				
Technical	Specialized knowledge			
Management			Self-management[b]	
Interpersonal	Focus on others			
Intrapersonal	Focus on others		Self-management[b]	Self-management
Leadership	Directing subordinates	Execution	Innovation	Fosters positive change
	Goal and action management	People	Justice orientation	Organizational awareness
	Human resource management	Transformation	Social responsibility	Performance improvement
	Leadership[a]		Task management	Professionalism/ professional values
				Communicating[a]

Note. [a] Individual competencies align with soft and hard domains; thus, the domain itself aligns to leadership; [b] Analysis of the self-management domain identified hard and soft competencies; however, I did not agree with the categorization of "setting goals for others" as an intrapersonal competency. Rather, this would have aligned more appropriately to the task management domain; adapted from *The Competent Manager: A Model for Effective Performance,* by R. E. Boyatzis, 1982, New York, NY: Wiley-Interscience; "Development of an Interprofessional Competency Model for Healthcare Leadership/Practitioner Application," by J. G. Calhoun, L. Dollett, M. E. Sinioris, J. A. Wainio, P. W. Butler, J. R. Griffith, & G. L. Warden, 2008, *Journal of Healthcare Management, 53,* 375–391, retrieved from http://www.nchl.org/documents/navlink/2008_calhoun_jhcm_interprofessionalcompetencies_uid8112009301022.pdf; "Leadership Competencies for Medical Education and Healthcare Professions: Population-Based Study," by F. Citaku, C. Violato, T. Beran, T. Donnon, K. Hecker, & D. Cawthorpe, 2012, *BMJ Open*, *2,* e000812, doi:10.1136/bmjopen-2012-000812

Table B3

Competency Model Domains from Garman et al. (2004), Hogan Assessment Systems (2009), and Korn Ferry (2014) Aligned to the Six Domains of Leadership Competency

Domains	Garman, Tyler, and Darnall (2004)	Hogan Assessment Systems (2009)	Korn Ferry (2014)
Cognitive			
Technical			
Management		Intrapersonal[a]	
Interpersonal			
Intrapersonal	Self-management	Intrapersonal[a]	
Leadership	Broad influence	Interpersonal	Thought
	Charting the course	Leadership	Results
	Communication	Technical	People
	Developing work relationships		Self
	Inspiring commitment		
	Structuring the work environment		

Note. [a] Analysis of the intrapersonal domain identified both hard and soft competencies; however, I did not agree with the categorization of "planning/organizing" or "risk management" as an intrapersonal competency. Rather, these would have aligned more appropriately to the technical (work skills) domain; adapted from "Development and validation of a 360-degree-feedback instrument for healthcare administrators," by A. N. Garman, L. Tyler, & J. S. Darnall, 2004, *Journal of Healthcare Management, 49*(5), 307–322, retrieved from http://www.ache.org; *The Development of the Hogan Competency Model*, by Hogan Assessment Systems, December, 2009, retrieved from http://www.hoganassessments.co.uk/sites /default/files/research/8.pdf; *Korn Ferry Leadership Architect™ Research Guide and Technical Manual*, by Korn Ferry, 2014, Los Angeles, CA: Author.

Table B4

Competency Model Domains from Academy of Medical Royal Colleges and Institute for Innovation and Improvement (2010), Suh, West, and Shin (2012), Testa and Sipe (2012) Aligned to the Six Domains of Leadership Competency

Domains	Academy of Medical Royal Colleges & Institute for Innovation and Improvement (2010)	Suh, West, and Shin (2012)	Testa and Sipe (2012)
Cognitive			
Technical		Hospitality	
Management		Supervisory	
		Food and Beverage Management	
Interpersonal		Interpersonal	
Intrapersonal	Demonstrating personal qualities		
Leadership	Improving services	Communication[a]	Business savvy
	Managing services	Leadership	People savvy
	Setting direction		Self-savvy
	Working with others		

Note. [a] Individual competencies align with soft and hard domains; thus, the domain itself aligns to leadership; adapted from *Medical Leadership Competency Framework,* by Academy of Medical Royal Colleges and Institute for Innovation and Improvement, 2010, Coventry, England: Author, retrieved from http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf; "Important Competency Requirements for Managers in the Hospitality Industry," by E. Suh, J. W. West, & J. Shin, J., 2012, *Journal of Hospitality, Leisure, Sport & Tourism Education, 11,* 101–112. doi:10.1016/j.jhlste.2012.02.005; "Service-Leadership Competencies for Hospitality and Tourism Management," by M. R. Testa & L. Sipe, 2012, *International Journal of Hospitality Management, 31,* 648–658. doi:10.1016/j.ijhm.2011.08.009.

Table B5

Competency Model Domains from Tubbs and Schulz (2005), U.S. Department of Labor, Employment and Training Administration (2012), and U.S. Office of Personnel Management (n.d.) Aligned to the Six Domains of Leadership Competency

Domains	Tubbs and Schulz (2005)	U.S. Department of Labor, Employment and Training Administration (2012)	U.S. Office of Personnel Management (n.d.)
Cognitive		Academic	
Technical		Academic	
		Industry-sector	
		Industry-wide	
		Occupation-specific	
Management			
Interpersonal	Attitudes are everything	Personal effectiveness	
Intrapersonal	Communication, the leader's voice	Personal effectiveness	
Leadership	Innovation and creativity	Management	Building coalitions
	Leadership, the driving force	Workplace[a]	Business acumen
	Leading change		Fundamental competencies
	Teamwork and followership		Leading change
	Understanding the big picture		Leading people
			Results driven

Note. [a] Individual competencies align with soft and hard domains; thus, the domain itself aligns to leadership. adapted from "Leadership Competencies: Can They be Learned?" by S. L. Tubbs & E. Schulz, 2005, *The Business Review, Cambridge*, *3*(2), 7–12, retrieved from http://www.jaabc.com; *Technical Assistance Guide for Developing and Using Competency Models—One Solution for the Workforce Development System*, by U.S. Department of Labor, Employment and Training Administration, 2012, retrieved from http://www.careeronestop.org/competencymodel/info_documents/tag.pdf; *Proficiency Levels for Leadership Competencies*, by U.S. Office of Personnel Management, n.d., retrieved from Retrieved from https://www.opm.gov/policy-data-oversight/assessment-and-selection/competencies /proficiency-levels-for-leadership-competencies.pdf.

Appendix C: Leadership Traits Identified by Coffin (1944)

Table C1

Leadership Traits Identified by Coffin (1944) Aligned to the Six Domains of Leadership Competency

Domain	Trait	Alignment to six domains
Intelligence	High intelligence	Cognitive
	Insight	Cognitive
	Intellectual vision	Cognitive
	Brilliant	Cognitive
	Clever	Cognitive
	Well-informed	Cognitive
Moral sensitivity	Fairness	Leadership
	Justice	Leadership
	Sound judgment	Leadership
	Open-mindedness	Leadership
	Devotion to truth	Intrapersonal
	Moral vision	Leadership
	Altruism	Intrapersonal
	Idealism	Intrapersonal
Imagination	Originality	Intrapersonal
	Imagination	Cognitive
	Forethought	Cognitive
	Inquisitiveness	Cognitive
	Mental flexibility	Cognitive
	Wide interests	Cognitive
Restraint	Restraint	Intrapersonal
	Inscrutability	Intrapersonal
	Self-control	Intrapersonal
Dynamic physical characteristics	Physical power	*
	Size	*
	Strength	*
	Tonus	*
	Erect carriage	*

Table continues

Domain	Trait	Alignment to six domains
Drive and determination	Zeal	Intrapersonal
	Drive	Intrapersonal
	Enthusiasm	Intrapersonal
	Dynamic personality	Intrapersonal
	Face-to-face mode of address	Intrapersonal
	Aggressive	Intrapersonal
	Ambitious	Intrapersonal
	Ascendant	Intrapersonal
	Desire for eminence	Intrapersonal
	Brave	Intrapersonal
	Persistent	Intrapersonal
	Tenacious	Intrapersonal
	Perseverance	Intrapersonal
	Singleness of purpose	Intrapersonal
Responsibility	Mature	Intrapersonal
	Dignified	Intrapersonal
	Frank	Intrapersonal
	Appearance of character	Intrapersonal
	Stable	Intrapersonal
	Reliable	Intrapersonal
	Neat	*
	Integrity	Intrapersonal
	Devoted to duty	Intrapersonal
	Industrious	Intrapersonal
	Love of work	Intrapersonal
	Concentration	Cognitive
Self-reliance	Sense of purpose and direction	Leadership
	Self-reliance	Intrapersonal
	Self-confidence	Intrapersonal
	Self-trust	Intrapersonal
	Decisiveness	Intrapersonal
	Initiative	Intrapersonal
	Finality of judgment	Intrapersonal

Table continues

Domain	Trait	Alignment to six domains
Imperturbability	Poise	Intrapersonal
	Serenity	Intrapersonal
	Self-composed	Intrapersonal
	Even-tempered	Intrapersonal
	Cheerful	Intrapersonal
	Optimistic	Intrapersonal
	Patient	Intrapersonal
	Tolerant	Intrapersonal
Social responsiveness	Susceptibility to social stimulation	Interpersonal
	Social participation	Interpersonal
	Friendliness	Interpersonal
	Affection	Interpersonal
	Sociable	Interpersonal
	Extroverted	Interpersonal
	Expansive	Interpersonal
Easy maintenance of good relations with others	Tact	Intrapersonal
	Diplomacy	Intrapersonal
	Kindness	Intrapersonal
	Sympathetic	Intrapersonal
	Cooperative	Intrapersonal
	Humanness	Interpersonal
	Knowledge of human nature	Cognitive
Responsibility	Mature	Intrapersonal
	Dignified	Intrapersonal
	Frank	Intrapersonal
	Appearance of character	Intrapersonal
	Stable	Intrapersonal
	Reliable	Intrapersonal
	Neat	*
	Integrity	Intrapersonal
	Devoted to duty	Intrapersonal
	Industrious	Intrapersonal
	Love of work	Intrapersonal
	Concentration	Cognitive

Table continues

Domain	Trait	Alignment to six domains
Self-reliance	Sense of purpose and direction	Leadership
	Self-reliance	Intrapersonal
	Self-confidence	Intrapersonal
	Self-trust	Intrapersonal
	Decisiveness	Intrapersonal
	Initiative	Intrapersonal
	Finality of judgment	Intrapersonal
Imperturbability	Poise	Intrapersonal
	Serenity	Intrapersonal
	Self-composed	Intrapersonal
	Even-tempered	Intrapersonal
	Cheerful	Intrapersonal
	Optimistic	Intrapersonal
	Patient	Intrapersonal
	Tolerant	Intrapersonal
Social responsiveness	Susceptibility to social stimulation	Interpersonal
	Social participation	Interpersonal
	Friendliness	Interpersonal
	Affection	Interpersonal
	Sociable	Interpersonal
	Extroverted	Interpersonal
	Expansive	Interpersonal
Easy maintenance of good relations with others	Tact	Intrapersonal
	Diplomacy	Intrapersonal
	Kindness	Intrapersonal
	Sympathetic	Intrapersonal
	Cooperative	Intrapersonal
	Humanness	Interpersonal
	Knowledge of human nature	Cognitive

Note. *Trait did not align to any of the six domains. Clear description of each competency was not available from the resource; therefore, best judgment was used to identify and align to the six domains. Adapted from "A Three-Component Theory of Leadership" by T. E. Coffin, 1944, *The Journal of Abnormal and Social Psychology*, *39*, p. 67.

Appendix D: Interview Guide

Participant's Code Number: _____
Date and Time: _____
Place: _____

Opening

- Thank the participant for agreeing to participate and donate their time.
- Explain the purpose of the study, how the participant was selected, and review a copy of the consent form with the participant. Receive a signed consent form.
- Restate the interview time commitment of 60-90 minutes.
- Ask if the participant has any questions.
- Explain the rationale for recording the interview and receive their consent to turn on the audio recorder.

If not already obtained, receive a copy of the participant's résumé.

Interview

1. Tell me about your career path, how did you get where you are today?

2. Tell me about the skills, knowledge, and abilities you possessed when you first began your career.
   a. How have these changed?

   b. What contributed to this change?

3. Tell me about the skills, knowledge, or abilities required for your current role.
   a. How do your skills, knowledge, and abilities align to those you listed?

   b. How do you know this?

4. What words would you use to describe yourself in your professional life? Tell me why you describe your professional-self in these words.

5. If you were to equate how you feel in your role to a musical style (classical, heavy metal, alternative, etc.), what would you choose and why?

6. How would you define:
   a. Leadership?

   b. Competence?

   c. Self-awareness?

7. I would next like to observe your office (or personal workspace) and ask questions about what I see or do not see.

a. Books: Can you tell me about the books I see on your shelves, what have you gained from these? What else do you read (journals or other) that relates to your role?

   If there are no books, ask: Do you read books, journals, or other materials that relate to your role?

b. Certificates/Awards: Please tell me about this certificate/award – what did you do to earn this recognition?

   If there are no certificates/awards ask: Have you received certificates or awards for the work you have done? What did you do to earn this recognition?

c. Displayed Quotes: Tell me about the quote(s) I see displayed, what do these mean to you?

d. How do you feel about the space; for example, how you have personalized or organized the space?

Peer Referral Question

Are there individuals in similar roles such as yourself who you would define as a competent leader and could refer for inclusion in this study?

a. Describe why you perceive them to be competent.

b. Do you have contact information, phone or email, for these leader(s)?

Closing

- Ask for their approval for subsequent conversations or interviews regarding the collected data and information pertinent to the study.
- Remind the participant that their data is available for their review at any time and that the data will be kept confidential.
- Ask if the participant has any questions.
- Thank the participant for their time.

Appendix E: Demographic Information Form

The purpose of the data collected on this form is to gather demographic data from study participants. Please answer the following questions about yourself and provide the form to the researcher either by e-mail or during the in-person interview scheduled on (date). This information will remain confidential, as will all information collected from you. Your name will not be associated with the reported results from the research.

1. Participant's Code Number:_____

2. Employer:_____

3. Gender: ☐ Male ☐ Female

4. Age: ☐ < 25 ☐ 25–35 ☐ 36–45 ☐ 46–55 ☐ > 55

5. Education level:
   ☐ High School
   ☐ Associate's Degree Type/Field of Study:
   ☐ Bachelor's Degree Type/Field of Study:
   ☐ Master's Degree Type/Field of Study:
   ☐ Doctorate Type/Field of Study:
   ☐ No response

6. Licensure: _____

7. Title of current role: _____

8. Years in healthcare: _____

9. Years with current organization: _____

10. Years in current role: _____

11. Years of leadership experience: _____

Appendix F: Postinterview Comment Sheet

Participant's Code Number:_____
Date and Time:_____
Length of interview:_____

Interview Content:

1. What were the most valuable insights gained from this interview?

2. What items came up that might be worth exploring further?

3. How would you describe the participant's perception of their leadership competence?

4. What was the participant's supporting rationale for being self-aware of their competence? Was it substantial or lacking? What was your overall perception of the rationale?

Interview Quality:

5. How would you describe the participant's comfort level with the interview and questions? What was the overall tone of the interview?

6. How would you rate the overall quality of the interview? What would you do differently to improve the quality?

7. Were you effective in extracting the details you wished from the participant? Why or why not? How will you improve your methods before the next interview?

8. How appropriate were the questions? Are modifications needed?

Appendix G: Postreflective Statement Questions

1. What is my background as a midlevel nonclinical, healthcare leader?

2. Why did I select self-awareness of leadership competence as my research focus?

3. What assumptions of participants, based on gender, sexual orientation, race/ethnicity, age, or socioeconomic status, do I hold and how might they influence the interpretation of the data?

4. What do I believe I will learn from the participants? What are the assumed experiential themes I expect to see from my research?

5. What could I learn from the participants that would surprise or shock me?

6. What expectations from each data source do I have?
   a. Interview
   b. Observation
   c. Résumé
   d. Job Description
   e. Performance Review Process and Form

Appendix H: Sample Letter of Organizations' Cooperation

Community Research Partner Name
Contact Information

Date

Dear Denise Wiseman,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Midlevel Nonclinical Healthcare Leaders' Awareness of Leadership Competence within Insert Name of Community Partner. As part of this study, I authorize you to perform the following research activities:

- Perform introductory interview with a senior leader who has oversight responsibility or knowledge of performance for midlevel nonclinical leaders at Insert Name of Community Partner. Interview will be audio recorded.
- Receive copies of job descriptions for included nonclinical leader participants from the senior leader or their designee.
- Receive copy of performance evaluation process documentation and forms (containing no personal feedback for identified participants) from the senior leader or their designee.
- Receive initial participant referrals from the senior leader.
- Contact referred leader participants via telephone or email.
- Receive copy of participant's résumé and completed demographic-information form.
- Interview leader participants' in their personal workspace (office) or other private location within Insert Name of Community Partner. Two in-person interviews per participant; each interview will be audio recorded.
- Observe leader participants' personal workspace (office). Observations will be video recorded and only the participant and researcher will be present.
- Review and discuss content from collected documents with leader participants. These documents include job description, performance review forms, demographic-information form, and résumé.
- Provision of study findings to individual participants or Insert Name of Community Partner if requested.

I understand the following:

- Our organization's responsibilities include:
    - Identification of initial, up to five, midlevel nonclinical leaders for inclusion in the study. Additional leaders may be referred by participants during their first in-person interview.
    - Provision of job descriptions for each participant leader.
    - Provision of performance evaluation process documentation and forms.

  - Provision of a private location for interviews if a participant's personal workspace cannot ensure confidentiality.

- The participation of each referred leader will be voluntary and at their own discretion.

- The data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

- Supervision of the research activities will be performed by remote faculty members, there is no requirement for onsite supervision by Insert Name of Community Partner personnel.

- I may reserve the right to withdraw Insert Name of Community Partner and the leader participants from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the policies of Insert Name of Community Partner.

Sincerely,

Authorization Official
Contact Information

Appendix I: Introductory E-mail

Dear _____,

My name is Denise E. Wiseman and I am a doctoral candidate in the School of Management at Walden University. At this time, I am working to complete my dissertation by studying the topic of leadership-competence self-awareness. This study is under the supervision of Dr. Stephanie Hoon.

As I stated in our telephone conversation on (date), your name was provided to me by a peer/senior leader who identified you as an individual who demonstrates leadership competence and meets the criteria for inclusion in this study. You verbally stated an interest to participate in the study and we have scheduled an interview for (date and time). In advance of this meeting, I am providing you with a copy of the informed consent and a demographic-information form. Please review these documents in advance of our meeting and supply the demographic-information form and a copy of your résumé either by e-mail or during the interview. I will review the informed consent with you in person when we meet and collect your signature on the form then.

Please feel free to contact me if you have any questions in advance of our meeting or if you need to reschedule. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is XXX-XXX-XXXX. Thank you for your time and acceptance to participate in this study.

Sincerely,

Denise E. Wiseman, MBA
Principal Investigator

Appendix J: Senior-Leader Sponsor Meeting and Interview

Sponsor's Code Number:_____
Date and Time:_____
Place:_____

Opening

- Thank the sponsor for agreeing to participate and donate their time.
- Explain the purpose of the study, how the organization was selected, and review a copy of the senior-leader sponsor consent form. Receive a signed consent form.
- Restate the interview time commitment of 30 minutes.
- Ask if the sponsor has any questions.
- Explain the rationale for the recording the interview and receive their consent to turn on the audio recorder.

If not already obtained

- Define the documents to be collected and arrange for receipt.

Interview

1. Please identify up to five midlevel nonclinical leaders you feel demonstrate leadership competence.

2. For each of the leaders you have identified, describe why you believe they demonstrate leadership competence.

Closing

- Thank the sponsor for their time.
- Remind the sponsor that the data for their organization are available for their review at any time and that the data will be kept confidential.
- Notify the sponsor that they will be informed via email when the data collection has concluded.

Appendix K: Competencies from Interviews, Résumés, and Performance Expectation Documents

Table K1

Competencies

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Accountability—holding others accountable	Leadership	I	-	I	I	I	-	I	I	I	-	I	-
Accountability—holding self accountable (also expressed as responsiveness, sense of urgency, and ownership)	Intrapersonal	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE
Achievement or solution focused/goal oriented	Intrapersonal	I, R	I	I	I	I, PE	I, PE	I, PE	I, PE	I, R	I, PE	I, R	I, PE
Adaptability and flexibility	Intrapersonal	I	-	I	I	I	-	I, R	I	I	I	I, R	I
Added: Ask for help	Intrapersonal	I	-	I	-	PE	PE	I, PE	PE	-	PE	I	I, PE
Added: Compassion	Intrapersonal					PE	PE	PE	PE		PE		PE
Adhering to sustainable practices	Technical	-	I, R	-	-	-	-	-	-	-	-	-	-
Altruism	Intrapersonal	I	-	I	-	I	-	I	-	-	-	-	I
Ambiguity tolerance	Intrapersonal	-	I	I	I	-	-	I	I	I	-	-	I
Ambitious	Intrapersonal	I	I	-	I	-	-	-	I	-	-	I	-
Analytic thinking	Cognitive	-	R	R, PE	I, R, PE	R, PE	I, PE	PE	I, R, PE	I, R, PE	PE	R, PE	I, R, PE
Approachable/open-door policy	Leadership	I	-	I	I	I	I[a]	I	I	I	-	I	I
Attention to detail	Intrapersonal	I	-	-	I	PE	PE	I, PE	PE	-	I, PE	-	I, PE
Benchmarking	Management	I, R	-	PE	PE	I, PE	PE	I, PE	PE	PE	I, PE	PE	PE

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Building trust	Leadership	I	-	I	I	I	-	I	I	I	I	I	I
Business acumen/insight	Leadership	-	-	I, R	-	I	I	I, R	I, R	R	-	I, R	-
Caring	Intrapersonal	I	-	I	I	I	-	I	I	I	-	-	I
Challenging the status quo	Leadership	-	I	I	I	I, PE	I, PE	PE	PE	I	I, PE	I	PE
Change leadership	Leadership	PE	I, PE	R, PE	I, PE	I, PE	PE	I, PE	I, PE	I, R, PE	I, PE	I, PE	PE
Change management	Leadership	-	I	-	I	I, PE	I, PE	I, PE	I, PE	I	PE	I	I, PE
Checking, examining and recording	Technical	-	-	-	I	-	-	-	-	I	-	I	-
Clarity of shared vision	Leadership	I	-	-	I	I	-	-	I	I	-	I	-
Coaching, developing and mentoring	Leadership	I, R	I	I	I, R	I, PE	PE	I, PE	I, R, PE	I, R	I, PE	I, R	I, R, PE
Collaborating/partnering	Leadership	I, PE	I, R, PE	R, PE	I, R, PE	I, PE	I[a], PE	I, PE	I, PE	I, PE	R, PE	I, R, PE	I, PE
Communication: Interpersonal communication	Interpersonal	I, PE	I, PE	I, PE	I, PE	I, PE	PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, R, PE
Communication: Interpreting the meaning of information for others / explaining decisions in respectful manner	Leadership	I, R, PE	PE	R, PE	I, PE	I, PE	PE	I, PE	I, R, PE	I, PE	PE	I, PE	R, PE
Communication: Listening skills / active listening	Interpersonal	I, PE	I, PE	I	I	I, PE	I, PE	I, PE	I, PE	I	I, PE	I	I, R, PE
Communication: Presentation skills—public speaking	Technical	-	-	-	-	-	-	-	I	I	-	I	-
Communication: Presentation skills—small groups/work environment	Technical	-	I	-	-	PE	PE	PE	I, PE	I	I, PE	I	I, PE
Communication: Written communication	Technical	-	-	PE	PE	PE	PE	PE	I, R, PE	I, R, PE	PE	PE	PE

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Competitive	Intrapersonal	-	-	I	I	I	I	-	-	-	I	I	-
Concentration/focus	Cognitive	-	-	-	-	PE	I, PE	PE	I, PE	-	PE	-	PE
Conceptualization	Cognitive	-	I	-	I	-	-	-	-	R	-	-	-
Concern with impact	Intrapersonal	I	-	-	I	I	-	I	-	-	-	-	I
Consensus building	Leadership	-	-	I, PE	PE	PE	PE	PE	PE	PE	PE	PE	PE
Cooperating	Interpersonal	I	-	-	-	I	-	I	-	I	I	-	-
Coordinating work activities/directs work	Management	I	I	R	I, R	-	-	I, R	I, R	I	I, R	I	I, R
Courage	Intrapersonal	I	I	I	I	-	-	I	-	-	-	I	-
Courage of convictions	Intrapersonal	-	I	-	I	-	-	I	I	-	I	I	I
Creating transformational change	Leadership	-	I	-	-	-	-	-	I	I	-	I	-
Critical thinking/logical thought	Cognitive	-	-	PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, R, PE	R, PE	I, PE
Cultural alignment	Leadership	-	-	-	-	I	-	I	I	-	-	-	-
Customer focus (customer oriented)	Leadership	I, R, PE	I, R, PE	I, R, PE	I, R, PE	I, PE	PE	I, R, PE	I, PE	I, R, PE	I, R, PE	I, PE	PE
Customer service	Interpersonal	I, PE	I, R, PE	I, R	I	PE	PE	I, PE	I, R, PE	I	I, PE	R	I, PE
Decision making—knowledge based decision making	Cognitive	I	I	I, PE	I, PE	PE	I, PE	I, PE	I, PE	I, PE	I, PE	PE	PE
Decisions—Perceives the impact and implications of decisions	Leadership	I	I	I	I	-	-	I	I	I	-	I	-
Decisiveness	Intrapersonal	-	-	I	I	PE	PE	I, PE	I, PE	I	I, PE	I	I, PE
Delegating	Leadership	-	I	-	-	I	I	I	-	-	-	I	-
Demonstrating knowledge of entire organization	Technical	-	-	-	-	I	-	I	I	I	I	-	I

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Dependability	Intrapersonal	I, PE	I, PE	I	I	I	I	I	I	I	I	I	I
Developing a continuous learning culture	Leadership	I	-	-	-	I	-	I	-	-	-	-	-
Developing a team-oriented culture	Leadership	I	I	I	I	I	-	I	I	I	-	I	I
Developing incentive and reward systems	Management	I	-	-	I	-	-	-	-	-	-	-	-
Developing self-directed work teams	Leadership	I	I	-	-	I	-	-	-	-	-	I	-
Difficult conversations*	Leadership	I, PE	I, PE	-	I	-	-	I	-	I	-	I	-
Diplomacy	Intrapersonal	-	-	I	-	I	-	I	I	-	I	-	I
Distributing rewards fairly (recognizes or rewards behavior)	Management	I, PE	PE	I, PE	I, PE	PE	PE	I, PE	I, PE	PE	PE	I, PE	PE
Drive/driven	Intrapersonal	I, R	I	I	I	I	I	I	I	I	I	I	I, R
Drives engagement	Leadership	I, PE	I, PE	I, R	I	I	-	I, R	I	I	I	I	-
Drives vision and purpose	Leadership	I	I	-	-	-	-	-	I	I	I	I	-
Driving for results	Leadership	I	R	I, R, PE	I, PE	I	I	I	I, R	I, R, PE	I, R	I, R, PE	-
Dynamic personality (assertive)	Intrapersonal	-	-	-	I	-	I	I	I, R	-	-	-	-
Effectively using empowerment	Leadership	I	I	-	-	I, PE	PE	I, PE	I, PE	I	PE	I	PE
Efficiency orientation	Intrapersonal	-	-	-	-	-	-	-	R	-	-	-	-
Emotional intelligence	Intrapersonal	I	I	I	I	I	-	I	I	I	I	I	-
Empathy	Interpersonal	I	-	I	I	I	-	I	I	I	I	-	-
Energy	Intrapersonal	-	I	-	I	-	-	I	I	-	-	I	I
Engaging in nonwork interests	Intrapersonal	-	I	-	-	I	-	-	I, R	-	-	I	-

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Even-tempered	Intrapersonal	I	-	I	I	I	-	-	I	-	-	-	-
External awareness	Leadership	-	-	-	-	-	-	-	I	I	I	I	-
Facilitating discussion (liaison)	Leadership	-	I, R	-	I, R	I	-	I, R	R	-	-	-	-
Finance and budgeting	Technical	I, R, PE	R, PE	R	R	I, R, PE	PE	I, R, PE	I, R, PE	I	I, PE	I, R	I, R, PE
Follow through	Intrapersonal	I, PE	I, PE	-	I	I, PE	PE	I, PE	I, PE	-	PE	I	I, PE
Forethought	Cognitive	-	I	-	-	-	-	I	-	-	-	-	-
Frank/direct	Intrapersonal	-	I	I	I	I	I	I	I	-	I	-	-
Future focus	Leadership	-	I	-	-	-	-	I	R	I	-	I	-
Goal setting	Technical	I, PE	PE	R	I	I, PE	PE	I, PE	I, PE	I, R	I, PE	I, R	I, PE
High expectations/standards*	Intrapersonal	I	-	-	I	-	-	I	-	I	I	-	-
High intelligence	Cognitive	I	I	I	I	I	I	I	I	I	I	I	I, R
Honesty and integrity	Intrapersonal	I	R	I, PE	I, PE	I, PE	PE	I, PE	I, PE	PE	I, PE	I, PE	I, R, PE
Human resource management: Clarifying roles and objectives	Management	-	I	PE	I, PE	-	-	I	-	PE	I	PE	-
Human resource management: Staffing, scheduling, coordinating	Management	R, PE	PE	-	R	-	-	I, R	R	I	I	-	-
Human resources: Performance measurement/management	Management	I, R, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, R, PE	R, PE	I, PE	I, PE	I, R, PE	I, PE
Human resources: Recruiting, interviewing, selecting	Management	I, PE	I, PE	-	I	I	-	I	I	-	I	I	I
Humility	Intrapersonal	I	I	I	I	I	-	I	-	-	-	-	-
Independent thinking	Leadership	PE	I, PE	I	I	PE	PE	PE	PE	-	PE	I	PE
Industrious	Intrapersonal	-	-	-	-	-	-	I	-	-	-	I	-

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Industry, program, or practice knowledge (task-relevant knowledge)	Technical	I, R, PE	I, R, PE	I, R, PE	I, R, PE	I, R	I	I, R	I, R	I, R, PE	I, R	I, R, PE	I, R
Influence	Leadership	-	I	-	I	I, PE	PE	PE	I, PE	I	I, PE	I	PE
Information analysis	Cognitive	-	-	R	I	-	I	-	I	-	-	R	-
Information seeking	Intrapersonal	PE	PE	PE	I, PE	-	-	-	I	PE	-	I, PE	-
Initiative	Intrapersonal	-	I	I	I	PE	PE	I, PE	I, PE	I	PE	I	I, PE
Inquisitiveness	Cognitive	-	I	-	I	-	-	-	-	-	-	-	-
Inspiring	Leadership	I	-	-	-	-	-	I	-	-	-	-	-
Instituting and following fair procedures	Leadership	-	-	I	-	-	-	I	-	-	-	-	I
Intelligent risk-taking	Leadership	I	I	I	-	PE	PE	PE	I, PE	I	PE	I	PE
Interpersonally savvy	Interpersonal	I	I	I	I	I, PE	PE	I, PE	I, PE	I	I, PE	I	I, PE
Kindness	Intrapersonal	-	-	-	-	I	-	I	-	-	-	-	-
Knowledge of diverse stakeholders	Technical	-	R	I, R, PE	PE	I	-	I	I, R	PE	-	PE	-
Knowledge of human nature	Technical	-	-	I	I	I	-	I	I	I	-	-	I
Knowledge of marketing	Technical	PE	PE	I	I, R	-	-	-	-	-	-	-	-
Knowledge of: Legal regulations	Technical	R, PE	R, PE	-	R	R, PE	I, PE	I, R, PE	R, PE	I	I, PE	-	I, PE
Listening and receiving feedback	Interpersonal	I	I	I	I	I	-	I	I	I	I	I	I
Love of work	Intrapersonal	I	I	-	I	I	-	I	I	-	I	I	-
Maintaining (managing) quality	Management	I, R, PE	I, PE	I, R	I	I, PE	PE	I, R, PE	I, R, PE	I, R	I, R, PE	I, R	I, PE
Maintaining (managing) safety	Management	R, PE	I, R, PE	-	I	-	-	I, R	I, R	-	I, R	-	I, R

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Management of organizational systems and processes	Management	-	I	I, R	R	I	-	I, R	I, R	-	I, R	-	I
Management of people, eliminating barriers to performance	Leadership	I	I	I	I	I	-	I	I	I	I	I	-
Manages complexity	Interpersonal	-	-	-	-	-	-	I	I	I	I	-	I
Managing conflict	Leadership	-	I	I	I	PE	PE	I, PE	PE	I	PE	I	I, PE
Managing data	Management	-	-	-	I	I	I	-	-	I	-	-	-
Managing information resources	Management	-	-	-	-	-	-	-	I	-	I	-	I
Managing the future	Leadership	-	I	-	-	-	-	I	I	-	-	I	I
Meeting management	Management	-	I	-	I	-	-	-	-	-	-	-	I
Monitoring and controlling resources	Management	PE	R, PE	I, R	R	PE	PE	I, R, PE	R, PE	I, R	PE	I, R	I, PE
Motivating others	Leadership	I	-	I, R	I	I, PE	PE	I, R, PE	I, PE	-	I, PE	I, R	PE
Multidisciplinary teamwork	Leadership	PE	I, R, PE	R	I	I, R	-	I, R	I	-	-	I, R	-
Negotiation	Leadership	-	I	-	I	-	I	I	R	-	I	-	-
Networking	Interpersonal	I	I	-	I	I	-	I	I	I	I	-	I
Nimble learning/quick to learn	Cognitive	-	-	-	I	-	I	-	I	R	-	-	-
Nondefensive	Intrapersonal	I	-	-	I	I	-	I	I	-	-	I	I
Open-mindedness/open to ideas	Leadership	I	-	I	I	I	-	-	I	I	-	I	I
Optimism	Intrapersonal	I	I	I	I	I	-	-	I	-	I	-	I
Optimizes work processes/process improvement	Management	R, PE	I, R, PE	I, R, PE	I, PE	PE	PE	I, R, PE	I, R, PE	I, R, PE	I, R, PE	I, PE	I, R, PE
Organization skills	Technical	PE	I, PE	-	I	-	-	I	I	I	I	-	-

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Organizational commitment/loyal	Interpersonal	I	-	I	-	I	-	I	-	I	I	-	I
Organizationally savvy	Leadership	-	-	-	-	I, PE	PE	I, PE	I, PE	-	PE	I	PE
Overcoming adversity	Intrapersonal	-	-	I	I	PE	PE	I, PE	PE	-	I, PE	I	PE
Performing administrative activities	Management	-	-	R	I, R	I	I	I	-	I	-	-	-
Perseverance	Intrapersonal	I	-	I	I	-	-	I	I	-	I	I	-
Personal growth/continuous learning/self-development	Intrapersonal	I, PE	I, PE	I, PE	PE	I, PE	PE	I, PE	I, PE	I, R, PE	I, PE	I, PE	I, PE
Planning and acting strategically/strategic thinking	Leadership	-	I	R, PE	I, PE	-	-	-	I, R	I, PE	-	PE	-
Planning and organizing	Intrapersonal	-	I, R	-	I, R	-	-	-	I	R	I, R	I	R
Plans and aligns	Management	-	-	-	-	-	-	-	I	-	I	-	I
Politically savvy	Leadership	-	I	-	I	I	-	I	I	-	-	I	-
Problem identification	Cognitive	PE	I, PE	PE	I, PE	-	I	I	I, R	I, PE	-	I, PE	I
Problem solving	Cognitive	PE	I, PE	PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE	I, PE
Process management/organizational design	Management	-	I	R, PE	PE	-	-	-	R	PE	I	PE	-
Professional ethics	Intrapersonal	I	-	I, PE	PE	I	-	I	I	I, PE	-	PE	-
Professionalism	Intrapersonal	I, PE	I, PE	I	I	I	-	I	I	-	I	I	I
Project management*	Management	R	R	I, R, PE	PE	-	-	-	I, R	R, PE	I	I, PE	I
Providing feedback	Leadership	I	I	PE	PE	I, PE	PE	PE	PE	PE	PE	I, PE	I, PE
Reflective thinking	Interpersonal	I	I	I	I	I	-	I	I	I	I	I	I
Relationship building	Interpersonal	I, R	I	I, R, PE	I, R, PE	I, R, PE	PE	I, PE	I, R, PE	I, R, PE	I, R, PE	I, PE	I, R, PE

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Reliable	Intrapersonal	I	I	-	I	I	-	I	-	-	I	I	-
Resilience	Leadership	I	-	I	I	-	-	I	I	-	-	-	I
Resourcefulness	Cognitive	-	-	I	I	-	I	I	-	-	-	-	-
Respectful*	Intrapersonal			PE	PE	PE	PE	PE	PE	PE	PE	PE	PE
Responsibility	Intrapersonal	I	-	-	I	I	-	I	I	I	I	I	I
Responsibility for others	Leadership	I	-	-	I	I	-	I	I	I	-	-	-
Risk management	Management	-	-	-	-	-	-	I	I	I	-	-	I
Role model	Leadership	I, PE	I, PE	I, PE	I, PE	I	-	I	I	PE	-	I, PE	I
Seeking feedback	Intrapersonal	I	I, R	I, PE	I, PE	PE	PE	PE	I, PE	PE	I, PE	I, PE	PE
Self-abnegation (take one for the team)*	Intrapersonal	I	-	I	-	I	-	I	-	-	-	-	I
Self-awareness	Intrapersonal	I	I	I	I	I	I	I	I	I	I	I	I
Self-composed	Intrapersonal	I	I	I	I	I	-	-	I	-	-	-	-
Self-confidence	Intrapersonal	I	I	I, PE	I, PE	I	I	I	I, R	I, PE	I	I, PE	I
Self-reliance	Intrapersonal	-	-	I	I	-	I	I	I	-	-	-	-
Self-restraint/self-control	Intrapersonal	-	-	-	-	-	-	I	I	-	I	I	I
Sense of purpose and direction	Leadership	-	-	I	I	I	-	I	I	I	I	I	-
Servant leadership	Leadership	I	I, R	I	-	I	-	I	-	-	-	-	I
Service orientation	Interpersonal	PE	PE	I	-	I	-	I	I	I	I	-	I
Setting goals for others	Management	I, PE	I, PE	I, R, PE	PE	I, PE	PE	I, PE	I, PE	I, PE	I, PE	I, R, PE	I, PE
Situational awareness	Intrapersonal	-	-	-	I	I	-	I	I	-	I	I	-
Stable	Intrapersonal	I	I	I	I	I	I	I	I	I	I	I	I

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Strategic task management	Management	-	-	-	-	-	-	R	I	I	-	-	I
Stress tolerance	Intrapersonal	-	-	I	I	-	-	-	I	I	-	I	-
Succession planning	Management	-	-	-	-	I	-	-	I	-	-	-	I
Supporting others on the team	Interpersonal	I	I	I, PE	I, PE	I	-	I	I	I, PE	I	I, PE	I
Suspending prejudices	Intrapersonal	-	-	I	I	I	-	-	-	-	-	-	-
Systems thinking	Leadership	-	I	-	-	-	-	-	I	-	I	I	-
Taking charge	Leadership	-	I	I	I	-	-	I	I	-	I	-	-
Team building	Leadership	I	I, R	I, R	I	I	I[a]	I	I	I, R	I	I, R	-
Teamwork	Interpersonal	I, PE	I, PE	PE	I, R, PE	I	-	I	I	I, R, PE	I, R	I, PE	I
Technologically savvy	Technical	-	-	-	-	-	-	-	I, R	I	I	-	-
Tenacity	Leadership	-	-	I	I	-	-	I	-	-	-	-	-
Thinking creatively/generating ideas/innovative thinking	Cognitive	PE	PE	-	-	PE	PE	PE	PE	-	PE	-	PE
Time management	Intrapersonal	-	R	-	-	-	-	-	-	I	I	I	-
Tolerance for change (adapts to change)	Intrapersonal	I	-	I	I	I, PE	PE	I, PE	I, PE	I	I, PE	I	I, PE
Tolerant	Intrapersonal	I	-	I	-	-	-	I	-	-	-	-	-
Tolerant of mistakes (supports blameless culture—just culture)*	Leadership	I, PE	PE	I	-	PE	PE	PE	PE	-	PE	I	PE
Training, instructing, educating, orienting	Management	I, R, PE	I, R, PE	R	I, R	I, PE	PE	I, R, PE	I, R, PE	I	I, R, PE	-	I, R, PE
Trustworthiness	Intrapersonal	-	I	-	I	I	-	I	-	I	I	-	I
Understanding business fundamentals	Technical	I	I	I	I	I	I	I	I	I	I	I	I

Table continues

Competency	Domain	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Valuing/leveraging diversity, values differences	Leadership	PE	I, R, PE	I, R, PE	I, PE	I, PE	PE	I, PE	PE	I, PE	PE	I, R, PE	PE
Varying leadership to the demands of the situation	Leadership	-	-	I	-	-	I	-	I, R	-	-	-	-
Visioning	Leadership	-	I	-	-	-	-	-	I	-	-	-	-
Willing to speak up*	Intrapersonal					PE	PE	PE	PE		PE		PE
Work attitude	Intrapersonal	I	I	I, PE	I, PE	I	-	I	I, R	I, PE	-	I, PE	-
Work design and coordination	Leadership	-	I	-	-	-	-	-	-	-	-	-	-
Work ethic	Intrapersonal	I	I	I	I	I	I	I	I	I	I	I	I
Working across complex interorganizational systems	Leadership	-	-	-	-	I	-	I	I	-	-	-	-
Working with tools and technology	Technical	-	-	-	-	-	I	I	I	I	-	-	-
Work–life balance	Intrapersonal	-	-	-	-	I, R	-	-	-	-	-	-	-

Note. The inclusion of a competency does not validate that the participant is skilled; alternatively, the exclusion does not imply they are not. This analysis is simply an indication of the competencies identified from the data collection process. [a]P6 made contradictory statements regarding these three competencies (approachable/open-door policy, collaborating, and team building).