Psychodynamic Leadership Approach and Leader-Member Exchange (LMX): A Psychiatric Perspective on Two Leadership Theories and Implications for Training Future Psychiatrist Leaders

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Abstract An increased emphasis in recent years on psychiatrists as healthcare leaders has not only drawn attention to the skills they can bring to this role but has also raised questions about how to best train and prepare them to assume leadership responsibilities. Such training should not be conducted in isolation from, and oblivious to, the wide-ranging expertise in human behaviour and relationships that psychiatrists can bring to the leadership arena. The aim of this theoretical paper is to draw attention to how psychiatrists can use their existing knowledge and skill set to inform their understanding of leadership theory and practice. In particular, the Psychodynamic Leadership Approach and Leader-Member Exchange theory are compared and contrasted to illustrate this point. The former represents a less well-known approach to leadership theory and practice whereas the latter is a widely familiar, conventional theory that is regularly taught in leadership courses. Both are underpinned by their emphasis on leader-follower relationships—and human relationships more broadly—and are intuitively appealing to psychiatrists endeavouring to understand aspects of organisational behaviour in the healthcare settings in which they work and lead. The application of these theories to assist reflection on and understanding of professional and personal leadership behaviours through leadership-oriented Balint-style groups and 360-degree appraisal is proposed. It is hoped that this paper will serve to stimulate thought and discussion about how leadership training for future psychiatrists can be tailored to better harness their existing competencies, thereby developing richer formative learning experiences and, ultimately, achieving superior leadership outcomes.

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1 Introduction

Leadership of mental health services is a multidisciplinary endeavour involving professionals from a range of clinical and non-clinical backgrounds. As clinical experts across the spectrum of mental health and illness, psychiatrists are potentially important players in the leadership arena but, tasked with extensive clinical responsibilities, may find themselves all too easily deferring to non-medical colleagues to administer the health services in which they work. Not utilising psychiatrists' skills to their full potential, including in the leadership domain, may be to the detriment of mental health services and the patients whom they treat.

In recent years, there has been an increased interest in psychiatrists as leaders of mental health services [1–3]. The important role that psychiatrist leaders can play—in partnership with their clinical counterparts—in facilitating clinically sound organisational change and innovation has been identified [4]. In discussing the contribution that doctors in general can make to the leadership and management of healthcare services, the need to provide doctors with specialised training in this area, as distinct to their existing clinical skills, is frequently emphasised [5, 6]. Goodall [7] noted, however, that leaders' 'expert knowledge' (technical competence) has been shown to highly correlate with organisational performance in many settings, and for this reason proposed that placing psychiatrists in leadership positions might lead to better organisational performance in mental healthcare.

This increased emphasis on psychiatrists as healthcare leaders not only draws attention to the skills they can bring to this role but also raises questions about how to best train and prepare them to assume leadership responsibilities. Adopting a generic approach to leadership training for psychiatrists may lead to their unique understanding of diverse areas pertaining to human behaviour, psychological factors, communication, interpersonal relationships and systems theory being overlooked or underutilised in developing formative learning experiences in this field.

2 Objectives

The aim of this theoretical paper is to draw attention to how psychiatrists can use their existing knowledge and skill set to inform their understanding of leadership theory and practice. A psychiatric perspective on two leadership theories will be provided as an example of this approach. In particular, the key principles of the Psychodynamic Leadership Approach and Leader-Member Exchange (LMX) theory will be reviewed as a basis for comparing and contrasting the similarities

and differences and advantages and limitations of these two theories. Consideration will also be given to how these theories can be applied to improving leadership practice. While the paper is focussed on psychiatrists as leaders, the ideas presented are equally relevant to clinicians from non-medical disciplines who are involved in, or aspire to, senior leadership roles in mental health services.

3 Psychodynamic Leadership Approach

3.1 Why Apply Psychodynamic Theory to Leadership?

An understanding of human behaviour in organisations and the skill to motivate others to willingly do things are central to effective leadership. Successful leaders are able to grasp group processes and calm collective anxieties while satisfying followers' needs and inspiring them to attain their hopes and aspirations. While most leadership theory and practice focusses on phenomena that are observable, measurable, rational and conscious, organisations are an extension of everyday life in which unconscious and potentially irrational factors drive human behaviour [8, 9]. The psychodynamic leadership approach, as espoused by proponents such as Zaleznik [10] and Maccoby [11], applies the principles of depth psychology and psychoanalytic theory to leadership and management research and practice [12, 13]. It offers a perspective on understanding and managing the complexities of organisational life by examining the underlying subtexts of human behaviour [9].

3.2 Basic and Applied Psychodynamic Concepts

An individual's first encounter with leadership—as both follower and leader—is through interaction with one's *family of origin* (parents) in early life and the socialisation experiences this provides [13]. Past interactions with significant others are repeatedly played out in a scripted manner in an *inner theatre* of the mind and may result in responses to the perceived (rather than real) intentions of people at work [9]. Parental values are carried into adulthood but may be altered through *maturation* and *individualisation* [13].

Exact behavioural outcomes are not easily foreseen. Either domineering or inclusive leadership styles may mirror or contrast with strict or permissive parenting experiences. In turn, employees may respond in a *dependent*, antagonistic or *independent* manner towards leaders depending on their own early life experiences. Dependency may see employees unconsciously seeking refuge in a 'parent-like' leader to guard against a sense of vulnerability [9]. An independent response entails challenging the limits of the leader-follower relationship and questioning and disregarding non-meaningful directions [13].

Suppression of socially unacceptable thoughts, feelings and behaviours (e.g. urge towards physical aggression) deeply within one's conscience and replacement with more socially acceptable alternatives (e.g. verbal debate) is encouraged through socialisation but may only partially succeed. Thus while a leader may perceive any authoritarian tendencies as successfully suppressed, followers may continue to recognise these in displayed behaviours (as a *shadow of the ego*) [13].

Despite training leaders in responding appropriately to followers, *regression* may occur under pressure towards familiar but maladaptive behavioural patterns originating in childhood. Taught leadership techniques can only overlap with, and not supplant, these deep-seated patterns [13]. Employees may also resort to regressive *social defence mechanisms* and problematic behaviours to cope with work stressors that are not effectively contained by the leader. Employees may divide colleagues and supervisors into allies or adversaries (*splitting*) and display hostility through absenteeism, work avoidance and resignation (*fight or flight* responses). Protection against perceived weakness may be sought by *pairing* up with others, further exacerbating conflict. In turn, senseless rules and regulations may be relied upon by leaders to help employees distance themselves from their anxieties [9].

Leaders may concentrate on boosting their approval among employees (*idealisation*) rather than advancing organisational objectives, in a mutually flattering mirroring process. *Identification with the aggressor* may emerge among employees as a defence against hostile leadership tactics and honesty and truth may be compromised in a *folie à deux* (joint delusional) process to avoid disputes with a leader who is out of touch with reality [9, 14, 15].

3.3 A Psychodynamic Perspective on Leadership Development and Styles

Leadership manifests when a group of people project their values onto an idealised individual via projective identification [16–18]. As long as the group's identification needs are met, the leader is overvalued and negative aspects overlooked. However, this unwavering support may be replaced with condemnation where the group's expectations are no longer satisfied [13, 19].

From a psychodynamic perspective, many organisations directly or indirectly treat followers as child-like, immature individuals whereas leaders are designated the adult role [20]. Complementary transactions (e.g. between a leader-parent and employee-child) are associated with stability, and mismatching transactions (e.g. between a leader-parent and employee-adult) with instability, in leader-follower relationships [13, 21, 22].

Narcissism, encompassing the spectrum of rational self-respect to unfettered selfishness, provides leaders with the confidence needed to rouse others' allegiance [9, 23]. Maccoby [24] asserted that narcissistic (proud, self-protective, aggressive, pursuing good impressions) and narcissistic-coercive (meticulous and self-assured)

leadership styles are most consistent with the concept of capable leadership. Through Freud's processes of identification and idealisation, such leaders symbolise their followers' principles while rising above them [13].

There are limitations to the benefits of narcissism, however. *Constructive, or healthy, narcissists* have had positive childhood experiences and are able to inspire others towards high achievements in a reflective, empathic manner. Conversely, *reactive, or excessive, narcissists* are preoccupied with their own status, accomplishments and ability to dominate others as a means of redressing childhood trauma. Removed from reality, they can inflict chaos upon an organisation [9].

3.4 Implications for Leadership Training

Peer group coaching under the guidance of a skilled facilitator can be used advantageously in psychodynamic leadership training to create reflective leaders, by allowing collective consideration of relational and leadership styles, work habits, problem-solving and decision-making in the wider organisational environment. Appropriate defence mechanisms, emotional expression and reality orientation can be addressed in this context [8, 9, 25].

4 Leader-Member Exchange (LMX) Theory

4.1 Premises of Leader-Member Exchange (LMX) Theory

The central concept of the Leader-Member Exchange (LMX) theory is that an exchange relationship gradually forms between a leader and follower founded on the degree of like-mindedness and the follower's skill and reliability. It is a role-making process whereby the follower's role is jointly established [26–28]. The theory presupposes that leaders lead and followers follow because they derive gains from each other in a mutually beneficial exchange relationship [29], the quality of which is the focus of investigation [13, 30].

4.2 Quality of Leader-Member Relationships

LMX theory describes vertical dyadic linkages between a superior and his or her subordinates as 'low-quality' or 'high-quality' leader-member relations. The former occur within the constraints of formal contractual agreements between the leader and members of the 'out-group'. The latter are extended relationships based on mutual trust, rapport and negotiation between the leader and members of the 'in-group' [13]. The theory posits that leaders generally establish high-quality

interactions with a few dependable followers who act as aides and confidants [28]. Whether subordinates become members of the 'in-group' or 'out-group' depends on how the delineation of leader-member responsibilities evolves as well as their personal appraisal of the risks and benefits of a closer leader-member relationship and the wider organisational responsibilities beyond the formal contract that this will entail [13, 26].

Future leader-member relationships are influenced by prior experiences as well as the temperament, beliefs and personal and professional skills of both parties in the dyad [13]. There is evidence that the quality of the leader-member exchange is established very soon after the relationship starts, with first impressions of whether the leader and follower can meet each other's expectations counting [31]. The likelihood of 'in-group' membership is enhanced by a positive atmosphere between leader and follower and political savviness on the follower's part [32]. As the relationship develops, leaders offer followers collaborative duties extending beyond formally-defined contractual obligations by way of a trial. If a follower's reaction to this is interpreted positively by the leader, further opportunities for closer collaboration will be presented; otherwise, the relationship will revert to formally defined norms [13, 33].

The quality of the leader-member exchange is continuously evolving and has been postulated to be influenced by: (1) perceived contribution to the exchange; (2) loyalty; (3) affect (perceived interpersonal attraction) [33]; and (4) professional respect [13, 34].

4.3 Developing Leader-Member Relationships

Graen and Uhl-Bien [35] delineated three phases in the development of high-quality, 'in-group' relationships as part of leadership making [13, 32].

1. Phase 1 ('role-taking' or 'stranger phase'): Mutual awareness of how respect is perceived and expected by leader and follower.
2. Phase 2 ('role-making' or 'acquaintance phase'): Deepening of trust as a basis for the relationship progressing and leader and follower shaping one another's views and actions.
3. Phase 3 ('role routinisation' or 'partner phase'): A high-quality pattern of leader-member exchange is now standard.

4.4 Effectiveness of Leader-Member Relationships

Compared to out-group members, who receive little attention or support, in-group members perform better and are more dedicated to organisational goals [36]. They are more content at work and less likely to resign. In-group members in

a healthcare context displayed superior citizenship behaviours—such as working harder to perform their roles—that increase the likelihood of a leader conferring additional resources, e.g. a budget increase or pay rise [37]. Furthermore, in-group members in various industrial settings are more likely to display helpful workplace-related behaviours extending beyond the call of duty and role definition [38, 39].

In the banking sector, managers perceived as being superior in status were able to forge higher-quality relationships with employees [40]. Furthermore, better LMX relationships across a range of industries increased the transformational effectiveness of leaders, with positive implications for teamwork [41]. High quality LMX relationships were shown to facilitate emergent leadership in a telecommunications team with a shared vision, which in turn may enhance team performance [42]. Better LMX relationships among group leaders in the manufacturing sector resulted in improved communication about, and attention to, safety and fewer work-related accidents [39, 43].

5 Similarities and Differences

A common underpinning of both the psychodynamic leadership approach and LMX theory is their focus on leader-follower relationships. LMX theory is more akin to a range of other leadership theories in focussing on observable aspects of leadership that can potentially be subjected to qualitative and quantitative investigation. The psychodynamic approach can complement and add greater depth to the understanding of leader-follower relationships afforded by the LMX model. Its underlying precepts may be harder to recognise or demonstrate, however, limiting the ability to undertake empirical leadership studies. Furthermore, whether in practice, training or research applications, psychodynamic theory may (ironically) be met with greater resistance from potential participants who may be unprepared to confront the deeper understanding of their behaviour encouraged by this approach. Embarking on an in-depth psychodynamic understanding of oneself outside a longer-term individual psychotherapeutic relationship may entail risks for some participants that need to be considered in rolling out time-limited, psychodynamically-oriented leadership workshops. With this perspective in mind, it is worth considering more fully the advantaged and limitations of each approach.

6 Advantages and Limitations

Strengths of the psychodynamic approach include its attention to the intricacy of relationships, conscious and unconscious motives, how leaders originate and are maintained, and relevance to a range of organisations [13]. Furthermore, the psychodynamic approach aims to generate reflective practitioners by concentrating on leaders' and followers' insight into the factors motivating their relationship.

Coaching, case studies and 360-degree feedback can be employed to provide a meaningful understanding of individual and organisational behaviour [9].

Strengths of LMX theory are that it comprehensively describes leadership processes (particularly the difference between 'in-group' and 'out-group' relationships), draws attention to the importance of communication in leadership [44], and is validated by research findings in the public sector [13, 45].

Weaknesses of the psychodynamic approach include overlooking the situational context in which leadership occurs and application of subjective Freudian theory—which is hard to scientifically verify—to 'normal' leader-follower behaviour [9, 13]. As the route to psychodynamic change varies between individuals, a uniform training model may be difficult to achieve. Furthermore, important structural factors may be missed by an individually-focussed training program [9].

LMX theory also has limitations. A leader must simultaneously value all followers while fostering a closer relationship with a subset of aides in the interests of advancing organisational goals [28]. Accordingly, a better understanding of how differing dyadic relationships impact on each other and collective organisational efficacy is needed [46], along with more research regarding how LMX relationships develop and role-making occurs over time. The impact of situational factors (e.g. demographic, job and organisational variables) on LMX relationships also merits further investigation [28, 47].

7 Discussion

Although the Psychodynamic Leadership Approach may appear abstract and distant from the reality in which organisations operate, there is some literature describing its practical application in the business sector. For example, Kets de Vries et al. [48] described a psychodynamically-informed leadership development program for business executives incorporating predominantly group-based leadership coaching practices. Similarly, Bell and Huffington [49] outlined a systems psychodynamic approach to leadership coaching designed to promote self-awareness and attunement to organisational factors that can impede or facilitate the leadership role. Ward et al. [50] examined the psychotherapeutic modalities that psychodynamic group coaching draws upon, such as intensive short-term dynamic psychotherapy and group therapy, and concluded that each was separately effective. However, further research into the effectiveness of psychodynamic leadership coaching as an entity in its own right appears warranted.

Adapting psychodynamic leadership coaching for use among psychiatrist leaders and other senior mental health leaders and managers is an obvious possibility. However, psychodynamic leadership coaching, as implemented in the business world, is not entirely alien to psychoanalytically-informed approaches to supervision and professional development already in use within medicine and psychiatry in particular. 'Balint groups' are a well-established approach to fostering reflective

practice among medical practitioners and other health professionals involved in direct patient care [51]. Balint groups allow doctors to meet regularly to discuss the cases of patients they perceive as a source of interpersonal difficulties in their day-to-day work. Balint group leaders are either psychoanalysts or professionals working in closely-related fields. Their role is to foster a tolerant and safe environment in which cases can be presented by participants and subsequently commented on and discussed without fear of criticism or interrogation by other group members [52, 53]. Groups are made up of 6 to 12 members and convene over several years at weekly to monthly intervals. Over time, this approach assists group members to gain a broader outlook on the initial challenges they encountered and promotes improved doctor-patient interactions [54]. The benefits of Balint groups in introducing psychiatry trainees to psychological processes [55] and serving as an introduction to more comprehensive psychotherapeutic practice [56] have been reported.

It is evident that the Balint group methodology could be adapted from a patient-oriented to a leadership-oriented focus to assist psychiatrists and other mental health professionals with leadership responsibilities to reflect on and better understand the factors underlying professional (e.g. establishing organisational goals) and personal (e.g. building good workplace relations) leadership behaviours they display at work [57]. Insights gained may be invaluable in overcoming complex interpersonal challenges encountered in the leadership role. In Australia, the Royal Australian and New Zealand College of Psychiatrists' (RANZCP) Continuing Professional Development (CPD) Program provides a structure under which mandatory peer review groups are constituted to support practicing psychiatrists in exercising their duties [58]. Peer review activities will also be a mandatory part of the new Continuing Education Program (CEP) of the Royal Australasian College of Medical Administrators (RACMA) that is due to be implemented fully in 2017 [59]. Although RANZCP peer review groups are not required to adopt an explicitly Balint-style methodology or focus exclusively on leadership issues, psychiatrists with an interest or involvement in leadership can draw upon both these perspectives in presenting topics and participating in related group discussions.

The approaching introduction of revalidation for doctors by the Medical Board of Australia is likely to entail increased rigour in the CPD requirements expected by specialist medical colleges of their individual members [60, 61]. In view of the evolving regulatory climate in which medicine is practiced, there may be dual benefits for psychiatrists in leadership roles to establish Balint-style groups focussed on leadership topics—both to assist them in exercising their leadership responsibilities more effectively but also to satisfy regulatory authorities as to their continued learning and reflective practice in this field. For such groups to function effectively, however, it is essential that material discussed remains confidential within the groups themselves (as opposed to group attendance records, which may be of relevance to regulators). Ensuring confidentiality in leadership-oriented Balint-style groups is even more important than in their patient-oriented prototypes, as effectively de-identifying discussions about workplace colleagues may be problematic in small organisations. Indeed, this may be a major barrier to

effective group functioning if not handled appropriately. Groups should preferably be established with psychiatrist leaders outside one's own workplace to address this issue.

In the spirit of interprofessional learning and practice [55, 62], such groups need not be restricted to psychiatrists. Indeed, there may be advantages in constituting groups comprised of psychiatrists and other senior medical administrators from other areas of medicine, or psychiatrists and senior mental health service leaders and managers from non-medical disciplines. The former approach allows psychiatrists to compare and contrast their own leadership experiences with those of colleagues in other medical fields whereas the latter may assist in better understanding the experiences and perspectives of non-medical team members in services akin to those which they lead. In both cases, psychiatrists may offer unique insights to other group members in relation to the leadership challenges that are discussed.

Balint groups constituted for doctors and healthcare workers outside the psychiatric sector rely on the psychodynamic expertise of the group leader [52, 53] but do not entail specialised knowledge of psychodynamic theory or related terminology by group participants [51]. However, in constituting such groups for psychiatrists and other mental health service leaders, it may be assumed that this group of professionals is likely to bring along a greater understanding of the complexity of human interactions than the average healthcare professional. This may facilitate deeper engagement with the psychodynamic aspects of the leadership dilemmas that are brought to the group for consideration.

Furthermore, while Balint groups may have their origins in psychodynamic thinking, the similarities between the Psychodynamic Leadership Approach and LMX theory suggest that the latter may also provide a useful framework for understanding leader-follower relationships within a Balint-style group. The potential benefits of effective leader-member relationships for the multidisciplinary mental health teams that psychiatrists lead—and the patients that team members collectively care for—are manifold. For example, there is evidence from the manufacturing sector that high-quality leader-member exchanges may improve communication about safety, with an increased commitment to safety and fewer workplace accidents as a result [39, 43]. The scope to translate this research into improved risk management and patient safety in a multidisciplinary mental health setting is readily apparent.

Similarly, the finding that positive leader-member exchanges resulted in superior citizenship behaviours in a hospital setting [37, 39] has implications for psychiatrist leaders in the multidisciplinary mental health sector. An improved understanding of the disparity with which members of the 'in-group' or 'out-group' may be inadvertently approached by leaders can enable psychiatrists to reduce unjustified preferential treatment between multidisciplinary team members and promote better leader-member relationships with all clinicians whom they lead. In turn, this may strengthen team members' commitment to organisational goals and to the teamwork needed to achieve these, as has been demonstrated in the retail sector [36, 39].

There is also evidence that emergent leadership is more likely to occur in teams characterised by positive LMX relationships and a shared vision for the future

[39, 42]. It is important for psychiatrist leaders to be aware of and actively foster this process in leading clinical teams and services more broadly, in the interests of identifying and supporting potential future leaders in both the clinical and administrative domains. The need to sponsor effective mental health leaders is especially pertinent and urgent in the face of a looming shortage globally in the availability of psychiatrists and other specialist mental healthcare workers [63].

A further example of how the Psychodynamic Leadership Approach and LMX theory can be incorporated into existing approaches for leadership development is provided by 360-degree appraisal or multi-source feedback, a process for assessing doctors' performance and professional behaviours by systematically obtaining feedback from colleagues and patients [64–66]. The introduction of revalidation may see 360-degree appraisal become a more widespread CPD activity for Australian doctors, as is currently the case in the United Kingdom [67]. Indeed, RACMA has already introduced this technique as an optional CEP activity and, from 2017, it will be one of the ways in which the mandatory requirement for annual peer review activities can be met [59]. For psychiatrist leaders, the Psychodynamic Leadership Approach and LMX theory dovetail well with the methodology of 360-degree appraisal. Both theories can assist psychiatrist leaders to maximise the learning derived from this process by offering useful frameworks for reflecting on and making sense of feedback received.

8 Conclusion

The important role that psychiatrists can play in the effective leadership and management of psychiatric services is being increasingly recognised. Psychiatrists' existing clinical expertise does not represent a sufficient skill set on its own to prepare them for leadership positions and cannot supplant the need for specialised training in this field. Such training, however, should not be conducted in isolation from, and oblivious to, the wide-ranging expertise in human behaviour and relationships that psychiatrists can bring to the leadership arena.

In this paper, the Psychodynamic Leadership Approach and Leader-Member Exchange theory have been compared and contrasted to illustrate this point. The former represents a less well-known approach to leadership theory and practice whereas the latter is a widely familiar, conventional theory that is regularly taught in leadership courses. Both are underpinned by their emphasis on leader-follower relationships—and human relationships more broadly—and are intuitively appealing to psychiatrists endeavouring to understand aspects of organisational behaviour in the healthcare settings in which they work and lead. These theories can be applied in leadership-oriented Balint-style groups to reflect on and work through challenging leadership dilemmas. They can also be used by psychiatrists to make sense of feedback received about their leadership behaviours through 360-degree appraisal. It is hoped that this paper will serve to stimulate thought and discussion about how leadership training for future psychiatrists can be tailored

to better harness a range of existing psychiatric competencies that are unique among medical practitioners and potentially applicable to leadership roles. Such an approach may be helpful in developing richer formative learning experiences and, ultimately, achieving superior leadership outcomes in mental healthcare.

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