

The relationship between organizational effectiveness and authority boundary.

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ABSTRACT

Hierarchical linear modeling was used to analyze relationships between individual and organization measures of effectiveness and type of authority boundary. Permeability of authority boundary was related to effectiveness. Results for clarity and firmness were mixed. The results provide support for Hirschhorn's (1991) psychodynamic model relating organizational effectiveness to authority boundary.

OVERVIEW

Psychodynamic organizational consulting work often involves organizational interventions centering around issues of authority (Klein, Gabelnick, & Herr, 1998). Organizational structure, decision-making channels, hierarchical communication, work teams, and cross-departmental collaboration all involve authority in some way (Hirschhorn & Barnett, 1993). Consequently, within organizations, psychoanalytically informed consultants frequently address authority issues that often involve deep unconscious processes relating to resistance to or ambivalence about authority and its boundaries (Krantz, 1993; Hirschhorn, 1998).

Organizational consultants outside of the psychodynamic field, however, may not view authority as a central construct in organizational work, especially since the root causes of authority problems are often unconscious (Gould, 1993). In addition, the psychoanalytic field tends to be viewed by nonclinicians as qualitative, nonempirical, and irrelevant for organizational work. Traditional organizational development consultants and industrial and organizational psychologists tend to focus on conscious, rational, overt aspects of organizations (French & Bell, 1998; Howard & Associates, 1994; Porras & Robertson, 1992).

But unconscious, irrational, covert processes are just as much a part of organizational life as conscious rational models of organizational development (Hirschhorn, 1997). Attempts to create high performing teams, participative cultures, or joint ventures may fall short if these interventions take place without exploring and understanding an organization's underlying psychodynamics (Cilliers & Koortzen, 2000).

On the other hand, for much psychoanalytic work clear models do not necessarily exist to assist the consultant or organization with making predictable cause-and-effect interventions. Constructs in the psychodynamic field are not as clearly operationalized as they are in more mainstream organizational

development and in industrial and organizational psychology. Although much excellent research exists in the psychoanalytic field (Weiss & Sampson, 1986), most of the theory development occurs through case studies and involves constructs and processes that are qualitative and often ambiguous (Westen, 2000).

This research attempts to bridge the gap between psychodynamic organizational consulting and more mainstream organizational development consulting and industrial and organizational psychology. It also attempts to introduce empirical analytical research, an approach common in industrial and organizational psychology, to the more qualitative case study approach typically found in the development of psychodynamic theories of organizations.

REVIEW OF THE LITERATURE

The importance of authority in a psychodynamic model of organizational consulting is paramount. Ideologies about authority have changed over time. The role of authority in organizations has evolved from advocating an oppressive command and control structure (Taylor, 1911) on the one hand to a lack of any authority boundaries on the other (Block, 1996; Manz & Sims, 2001). Hierarchy has given way to self-directed teams (Fisher, 1999; Hicks & Bone, 1990; Wellins, Byham, & Wilson 1993). Negative views of authority are pervasive (Manz & Sims, 1995; Srivastva & Cooperrider, 1986). Democracy is heralded as the new way to organize through self management and majority vote (Block, 1996; Dew, 1997; Potterfield, 1999; Sholtes, 1988).

However, these newer approaches to authority, where everyone is “equal” in the workplace, may be no more effective than the old authoritarian command and control forms of authority. From a psychodynamic view, it is possible that organizations have confused authoritarian with authoritative, thus refusing to enact any authority boundaries to the organizations’ detriment. Organizational authority, referring to the authority in one’s work role (Gould, 1993), has become associated with

autocracy and dictatorships. Images of feudal lords and oppressive working conditions are stirred up with the mention of hierarchy and authority (Habermas, 1979; Hamori, 1974; Marx & Engels, 1947; Weber, 1958). In contemporary organizations all authority tends to be viewed as authoritarian authority, and all hierarchy tends to be viewed as bureaucratic, oppressive, and ineffective (Hirschhorn, 1998; Jaques, 1990).

HIRSCHHORN'S VIEW

Hirschhorn (1998) argues for a middle ground between authoritarianism and a complete absence of authority boundaries. He refers to this middle ground as a post-modern hierarchy:

We do not need to rid ourselves of hierarchy; rather, we need to “post-modernize” it. Although writers often contrast hierarchy with participative culture, well-functioning hierarchies are based deeply on the principle of delegation that, at bottom, stimulates and requires senior executives to share their leadership with their subordinates. When senior executives delegate leadership, they are lending their authority, never relinquishing it. (Hirschhorn, 1998, pp. 67-68)

A psychodynamic model of organizational consulting suggests that authority boundaries are still necessary in order for organizations to be effective (Berg, 1998; Gould, 1993; Hirschhorn, 1998; Jaques, 1998, 1990; Klein, Gabelnick, & Herr, 1998). The checks and balances that arise across an authority boundary may be key for making an organization effective.

Hirschhorn's model of organizational consulting emphasizes the importance of implementing facilitating structures such as optimal authority boundaries for an organization to accomplish its work. The hypothesis implicit within Hirschhorn's (1991) model is that organizational effectiveness is related to type of authority boundary and that an optimal type of authority boundary might be discovered. The

assumption is that even organizations that are team based, high involvement, and post-modern, still require competent authority boundaries in order to be effective (Hirschhorn, 1998). The research presented here tests this assumption by attempting to identify which types of authority boundaries, if any, are related to organizational effectiveness.

Dimensions of authority boundary and organizational effectiveness

The model developed by Hirschhorn (1991) is based on psychoanalytic (Freud, 1923), systems (Miller & Rice, 1967), and object relations theories (Bion, 1961; Klein, 1959). Hirschhorn & Gilmore (1992) discuss authority boundary in terms of key questions, necessary tensions, and characteristic feelings. These concepts were operationalized as three specific dimensions for this research: clarity, permeability, and firmness.

The clarity dimension of the authority boundary addresses the degree to which organizational members know who is in charge of what (Hirschhorn & Gilmore, 1992).

The permeability dimension of the authority boundary addresses the degree to which organizational members can reach across or through the boundary (Friedlander, 1987).

The firmness dimension of the authority boundary addresses the degree to which the authority boundaries are supported and followed within the organization (Hirschhorn, 1998, p. 57-58, p. 67-68; Klein & Rieth).

Organizational effectiveness is an ambiguous and highly subjective variable that depends on who is defining *effectiveness* (Cameron & Whetten, 1983). Multiple constituents will define the same organization's effectiveness differently (Connolly, Conlon, & Deutsch, 1992). *Effectiveness* has been defined in the psychodynamic literature as the extent to which an organization optimizes task accomplishment (Miller & Rice, 1967).

For this research, *organizational effectiveness* was conceptualized as the degree to which an organization accomplishes its primary task where the primary task is defined as providing quality patient care while controlling costs. Organizational effectiveness was operationalized by measuring perceptions of effectiveness, average number of patient visits per month, and turnover rate (Mobley, Horner, & Hollingsworth, 1978).

Perceptions of authority boundary and effectiveness were measured at the individual level, through questionnaires distributed to physical therapy clinics in a fairly circumscribed geographic area within the Southeast. The individual perceptions were aggregated and used as descriptors of each clinic. In order to control for the effects of within-clinic relationships, both individual level and clinic level data were analyzed using a multilevel analytic strategy (Bryk & Raudenbush, 1992). Based on the conceptualization of authority boundary presented in the psychodynamic literature, we expected positive relationships between the both the average number of patient visits per month and the aggregated measure of effectiveness and the aggregated measures of clarity, firmness, and permeability. We expected negative relationships between the measure of turnover and the aggregated measures of authority boundary.

METHOD

Sample

Participants were employees of Outpatient Physical Therapy Clinics in Tennessee, Georgia and Alabama. A total of 1134 surveys were mailed to 166 organizations. After the mailing and two to three follow up phone calls, 587 surveys were returned from 89 organizations. After deletion of questionnaires with missing values, 577 usable questionnaires from 87 clinics were available for analysis.

Measures

A 32-item questionnaire was developed containing three scales measuring clarity, permeability, and firmness of authority boundary. A separate scale was developed for organizational effectiveness. Scale items followed a Likert scoring format ranging from 1 to 6, with 1 indicating strongly disagree and 6 indicating strongly agree. Descriptive information was collected from each clinic in order to control for differences in organizational type that might affect the results. These contextual organizational variables included profit status, clinic type, number of sites, location, size, and age.

Factor Analysis.

The pooled within-organizations correlation matrix was factor analyzed to determine the number of factors existing in the questionnaire. Oblique rotation identified the three authority boundary dimensions as expected. However the organizational effectiveness scale split into two dimensions – labeled cost effectiveness and quality effectiveness. The loadings on the five factors identified in the factor analysis are presented in Tables 1 and 2. Reliability of the Firmness scale was .72. All other reliabilities were larger than .8.

Analysis

The analyses used hierarchical Linear Modeling (HLM) Software Version 5.04. Perceptions of authority boundaries and perceptions of organizational effectiveness were included at the individual level and means of these measures were also included at the organizational level of analysis. To facilitate assessment of the incremental or contextual effect of the aggregated authority boundary variables, the HLM analysis used grand mean centering of all perceptual variables (Bliese, 2002).. Results for robust standard errors were interpreted. Since the number of patient visits per month and turnover rates were measured only at the clinic level, analyses of these variables used standard regression techniques with clinic as the unit of analysis.

RESULTS

Means, standard deviations of the authority boundary scales are presented in Table 3. The results of the HLM analysis of quality effectiveness are presented in Table 4. A positive relationship was found between mean quality effectiveness and mean permeability as expected. No relationship was found between quality effectiveness and mean clarity or mean firmness. Private practice clinics had greater quality effectiveness than those that were hospital based.. Quality effectiveness was greater for nonprofit clinics than for those recorded as for profit.

Table 5 presents results of the HLM analysis of cost effectiveness. A positive relationship was found between cost effectiveness and mean permeability, as expected. However an unexpected negative relationship was found between Cost effectiveness and mean firmness.. No relationship was found between quality effectiveness and mean clarity. Perceived organizational effectiveness in terms of controlling costs was not related to the any of the other contextual variables.

In summary, the results of the HLM analysis indicated that both quality and cost perceptions of organizational effectiveness are positively related to permeability of authority boundaries . They suggested that perceived quality effectiveness is greater for private practice and nonprofit clinics. Finally, an unexpected negative relationship of cost effectiveness to mean firmness was found.

Results of multiple linear regression of number of patient visits per month onto the mean authority boundary and other contextual variables are presented in Table 6. A positive relationship was found between average number of patient visits per month and mean permeability, as expected. Contrary to expectation, a negative relationship between average number of patient visits and mean clarity was found. No relationship was found between average number of patient visits and mean firmness. Private practice clinics and those with multiple sites were found to have greater numbers of patient visits per month.

The analysis of turnover was complicated by the fact that a large number of clinics reported no turnover in the past 12 months. For this reason, a dichotomous turnover variable was created with value 0 if the clinic reported turnover in the past 12 months and the value 1 if any turnover was reported. Logistic regression results of the analysis of this variable are presented in Table 7. Contrary to our expectation clinics with greater mean clarity were found to have greater likelihood of turnover,. A negative relationship was found between likelihood of turnover and mean firmness No relationship was found between turnover and mean permeability. For profit clinics were found to have greater likelihood of turnover as were larger clinics.

DISCUSSION

Overall, the results indicate that organizational effectiveness is significantly related to type of authority boundary across outpatient physical therapy clinics in the southeastern United States in the expected direction for the permeability dimension.

Organizations that were perceived as being more effective in terms of quality of patient care were perceived as having more permeable authority boundaries. Organizations that were perceived as being more effective in terms of managing overall costs were also perceived as having more permeable authority boundaries. Organizations with a higher average number of patient visits per month were perceived as having more permeable authority boundaries. No relationship was found between turnover and permeability. These findings indicate tentative support for permeability.

Organizations with lower turnover rates were perceived as having firmer authority boundaries, as expected. However, organizations perceived as being more effective in terms of controlling costs had less firm authority boundaries, an unexpected relationship. Average number of patient visits per month was not found to be related to firmness. But likelihood of turnover was negatively related to mean

firmness. These findings can only be taken as mixed evidence for the utility of firmness of authority boundaries as a positive influence on organization effectiveness.

The results of the analyses of clarity of authority boundaries were generally not in accordance with expectations. Organizations with a higher number of average patient visits per month were perceived as having less clear authority boundaries. Organizations with higher turnover were also perceived as having less clear authority boundaries. No relationship was found between perceptions of effectiveness and clarity of authority boundaries. These findings indicate a lack of support for clarity in the expected direction. Organizations in this study that tended to be more effective did not have authority structures that were clear and well understood by members.

The findings from this study indicate that organizations tend to be more effective whenever they have more permeable authority boundaries. Boundaries that allow employees to provide input to their immediate supervisors, allow employees' ideas to be acted upon, allow employees to challenge their immediate supervisors, take employee suggestions seriously, and have managers who are open to criticism tend to be perceived as being more effective in terms of providing a higher quality of patient care and better fiscal management of the organization. It seems that being able to interact across the authority boundary results in organizations which are more effective in accomplishing their primary task.

Based on this study, it can be suggested that when employees follow the chain of command and take their concerns to their immediate supervisors organizations can expect lower turnover. However, the mixed results of the analysis of the relationship of cost effectiveness perceptions to firmness make these conclusions tentative at best.

Intuitively, it seems that the clarity dimension is a precursor, or a necessary but not sufficient condition, for organizations to even begin to study and explore authority boundaries. Although a direct

positive relationship was expected but not found between effectiveness and clarity, it is still not possible to talk about permeability or firmness of an authority boundary unless one knows what the authority boundary is and who is on either side of it. Perhaps clarity is implied in order for permeability or firmness of authority boundaries to be significant.

It is possible that resistance to defining the authority boundary and clarifying it influenced the results of the questionnaire. In order to answer the clarity questions, one has to clearly acknowledge where one is located in the organizational hierarchy. It is possible that even defining one's role in terms of authority or lack thereof creates difficulty and ambivalence.

IMPLICATIONS

This research design empirically tested one aspect of Hirschhorn's (1991) model of psychodynamic consulting that assumes that organizational effectiveness is related to certain facilitating structures, namely type of authority boundary. The study operationalized and empirically measured an important psychodynamic construct, authority boundary, and attempted to link it with an organizational outcome, organizational effectiveness. This methodology was an important step in beginning to empirically validate a psychodynamic model of consulting.

Psychodynamic theory has much to offer leadership, management, teamwork, communication, selection, compensation, and training as part of an overall organizational development effort in the healthcare field. Understanding the psychodynamics or unconscious processes affecting teams, leadership development, or compensation strategies could help traditional interventions increase an organization's effectiveness. Based on a classic psychoanalytic framework, greater awareness regarding psychodynamic constructs such as envy, competition, aggression, and ambivalence involving authority boundaries might help selection processes to go more smoothly or assist teams with accomplishing goals

more quickly as healthcare organizations face the challenges of providing quality patient care at a reasonable cost.

Together, mainstream organizational development, industrial and organizational psychology, and psychodynamic organizational consulting can provide a comprehensive view and approach to working with organizations.

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Table 1 : Factor Analysis of Authority Boundary Items.

Items	Factor		
	1	2	3
C1:Know who's in charge	.866	-.023	-.020
C2:Authority Structure clear	.924	-.014	-.042
C3:Clear chain of command	.829	.012	.002
C4:Know who is supervisor	.345	.092	.356
C5:Know no. authority levels	.561	.097	.123
P1:Input to imm. supervisor	.008	.495	.215
P2:Emp. ideas acted upon	.019	.822	.037
P3:Employees can challenge	.066	.605	-.102
P4:Suggestions taken ser'ly	.006	.903	-.014
P5:Managers open to crit'm	.045	.657	-.017
P6:Subord's take mgr's ser.	-.020	.307	.449
F1:Follow chain of command	.086	-.012	.722
F2:Go around super ®	.018	-.082	.600
F3:Ignore chain ®	.012	-.038	.562
F4:Concerns to imm. super	.028	.163	.525

C: Clarity P: Permeability F: Firmness

Table 2 : Factor Analysis of Effectiveness Items.

Items	Factor	
	1	2
Q1:Effectively treats patients	.856	-.055
Q2:Meets patient needs	.886	-.019
Q3:Provides quality patient care	.786	-.080
C1:Operates efficiently	-.040	.684
C2:Bills ethically	.245	.432
C3:Manages demands of mng'd care	.079	.595
C4:Balances business & clinical	-.069	.836
C5:Quality while controlling costs	.002	.793

Q: Quality Effectiveness C: Cost Effectiveness

Table 3. : Means and Standard Deviations of Measures.

Measure	Mean	Std Dev
Clarity	4.81	.95
Permeability	4.59	.87
Firmness	4.60	.84
Quality effectiveness	5.53	.57
Cost effectiveness	5.19	.63

Table 4: Results of HLM Analysis of Quality Effectiveness.

<u>Level 2 Factor</u>	<u>Coefficient</u>	<u><i>p</i></u>
Mean Clarity	-0.086	0.230
Mean Permeability	0.157	0.015
Mean Firmness	-0.001	0.986
Profit (1) or nonprofit (2)	0.142	0.029
Hospital based (1) or private practice (2)	0.188	0.002
Number of sites one (1) or multiple (2)	-0.056	0.197
Metropolitan (1) or rural (2)	0.032	0.531
Size of clinic	0.031	0.596
Age of clinic	-0.037	0.540
<u>Level 1 Factor</u>	<u>Coefficient</u>	<u><i>p</i></u>
Clarity	0.122	0.000
Permeability	0.110	0.015
Firmness	0.107	0.002

Table 5: Results of HLM Analysis of Cost Effectiveness.

<u>Level 2 Factor</u>	<u>Coefficient</u>	<u><i>p</i></u>
Mean Clarity	0.049	0.540
Mean Permeability	0.179	0.027
Mean Firmness	-0.176	0.034
Profit (1) or nonprofit (2)	-0.004	0.956
Hospital based (1) or private practice (2)	0.060	0.355
Number of sites one (1) or multiple (2)	0.026	0.601
Metropolitan (1) or rural (2)	-0.031	0.561
Size of clinic	0.111	0.101
Age of clinic	-0.058	0.312
<u>Level 1 Factor</u>	<u>Coefficient</u>	<u><i>p</i></u>
Clarity	0.187	0.000
Permeability	0.106	0.025
Firmness	0.219	0.000

Table 6 : Results of Multiple Regression Analysis of Average Number of Patient Visits.

Factor	Coefficient	<i>p</i>
Mean Clarity	-0.109	0.026
Mean Permeability	0.114	0.015
Mean Firmness	-0.069	0.156
Profit (1) or nonprofit (2)	0.008	0.867
Hospital based (1) or private practice (2)	-0.177	0.000
Number of sites one (1) or multiple (2)	0.155	0.000
Metropolitan (1) or rural (2)	-0.019	0.631
Size of clinic	0.734	0.000
Age of clinic	-0.008	0.889

Table 7 : Results of Logistic Regression Analysis of Dichotomous Turnover Variable.

Factor	Coefficient	<i>p</i>
Mean Clarity	0.895	0.009
Mean Permeability	0.016	0.958
Mean Firmness	-1.397	0.000
Profit (1) or nonprofit (2)	-1.022	0.001
Hospital based (1) or private practice (2)	0.512	0.087
Number of sites one (1) or multiple (2)	-0.334	0.219
Metropolitan (1) or rural (2)	-0.133	0.608
Size of clinic	3.545	0.000
Age of clinic	0.989	0.003