

Transformational Leadership and Leaders' Mode of Care Reasoning

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Abstract Previous research on the moral foundations of transformational leadership has focused primarily on stage of justice reasoning; this study focuses on developmental mode of care reasoning. Multilevel regression analyses were conducted on data coded from interviews with a sample of Canadian public sector managers ($N = 58$) and survey responses from their subordinates ($N = 119$). Results indicated that managers' developmental mode of care reasoning significantly and positively predicted subordinates' reports of transformational (but not transactional) leadership, with significant differences in follower reports of transformational leadership between those using more versus less advanced modes of care reasoning. Conceptual implications for understanding transformational leadership and the ethics of leadership, directions for future research, and suggestions for leadership interventions are discussed.

Keywords Care ethics · Ethics · Leadership · Moral reasoning · Transformational leadership

Scholarly interest in the intersection of leadership and ethics is not new (Lichtenstein et al. 1995). However, the ubiquity of corporate scandals during the last decade has led to a growing body of empirical research, not only into the nature, antecedents, and consequences of ethical leadership (e.g., Brown et al. 2005; Mayer et al. 2009), but also into the moral foundations (i.e., problem-solving approaches) associated with specific leadership styles (e.g., Simola et al. 2010; Turner et al. 2002).

One key area of interest has been the moral foundations of transformational leadership (Bass and Steidlmeier 1999). Initial research found a positive association between stage of justice reasoning (Kohlberg 1969, 1976) and follower reports of transformational leadership behavior (Turner et al. 2002). More recent research (Simola et al. 2010) identified a complementary role for propensity toward care perspectives (Gilligan 1977, 1982) in understanding the moral basis of transformational leadership. Despite calls for increased attention to the potential role of care-based perspectives in the moral foundations of leadership (Ciulla 2009), research in this area remains limited. Moreover, although general propensities toward using either conventional justice approaches or care-based complements have been previously assessed (Simola et al. 2010), no consideration has been given to developmental mode of care reasoning, and the purpose of this study is to extend the growing body of research on the moral dimensions of transformational leadership. In particular, we suggest that specific characteristics associated with more advanced modes of care reasoning (Gilligan 1982) can help reveal the moral basis of transformational leadership.

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Theory and Hypothesis Development

During the last two decades, transformational leadership (Bass and Riggio 2006) has gained increasing prominence as an influential leadership approach associated with a broad range of desirable outcomes (Barling et al. 2010; Judge and Piccolo 2004). Transformational leadership is a form of leadership in which relationships are organized around a collective purpose in ways that transform, motivate, and enhance the actions and ethical aspirations of followers (Burns 1978). It comprises four dimensions. These include “idealized influence” in which leaders model certain values and qualities that followers incorporate and emulate; “inspirational motivation,” through which a collective vision rouses followers toward the attainment of group goals; “intellectual stimulation,” which refers to the processes through which leaders kindle novel and creative approaches to problem-solving; and “individualized consideration,” in which individual followers receive the personal support and encouragement they need.

In contrast, transactional leadership involves reciprocity between autonomous agents such that each might benefit through an exchange process (Burns 1978). The two behaviors comprising transactional leadership include “contingent reward” and “management by exception” (Bass 1985). The former occurs when disbursement of rewards is dependent on completion of certain actions or activities; the latter reflects interventions used to correct errors or shortcomings.

In previous research on the moral foundations of transformational leadership, Turner et al. (2002) argued that increasingly sophisticated cognitive abilities associated with Kohlberg’s (1969, 1976) most advanced stage of justice reasoning would enable individuals to evaluate more alternatives when responding to ethical dilemmas, and focus on group (rather than individual) needs. Hence, Turner et al. (2002) predicted that more sophisticated forms of justice reasoning would be positively associated with follower reports of transformational leadership. However, because transactional leadership relies on leader–follower exchange, it would not require the more complex forms of moral reasoning associated with group versus individual self interest. Thus, transactional leadership was predicted to be unrelated to stage of Kohlbergian justice moral reasoning. Results supported both hypotheses, but the extent to which these findings can advance our understanding has been limited by their focus on justice reasoning.

Transformational Leadership and Care Reasoning

Simola et al. (2010) explained why leader propensity toward using care reasoning should be positively related to

follower reports of transformational leadership. They differentiated between justice reasoning that emphasizes autonomy, impartiality, and objectivity in the fair adjudication of conflicting rights, and care reasoning that emphasizes relational interdependence and attentiveness to the subjective and particular experiences of individuals when creatively fulfilling seemingly conflicting responsibilities (Gilligan 1982). Simola et al. noted that these characteristics of care-based reasoning are likely to be associated with the four components of transformational leadership. Idealized influence is predicated on the notion of community interconnection as opposed to individual separation and autonomy (Bass and Steidlmeier 1999), and thus is consistent with care ethics. Inspirational motivation emphasizes the primacy of shared goal attainment versus individual rights to pursuit, which is also consistent with care ethics. Intellectual stimulation, in which followers are encouraged to use innovative forms of problem-solving to resolve emergent concerns, is congruent with the care-based use of creative, non-zero sum problem-solving in which efforts are made to simultaneously fulfill seemingly conflicting responsibilities. Finally, individualized consideration reflects responsiveness to the unique and subjective needs of followers, which is characteristic of a care-based approach. Simola et al. found that transformational leadership was positively related to propensity toward using an ethic of care (but not of justice). Conversely, transactional leadership, with its emphasis on fairness in exchanges between autonomous individuals, was positively related to a propensity toward using an ethic of justice, but not care. Hence, propensity toward using care reasoning might be required for transformational leadership.

Nonetheless, Simola et al. (2010) did not consider whether developmental *mode* of care reasoning as opposed to *propensity* toward using care perspectives adds to our understanding of the moral foundations of transformational leadership. Assessment of this issue would respond to calls for greater consideration of care-based perspectives in effective leadership, which despite their potential for substantial value in moral awareness and deliberation, are often excluded (Ciulla 2009).

Research has demonstrated that the common underlying characteristic uniting different approaches to care reasoning is consideration of the relationship between oneself and others, or the morality of selfishness versus responsibility (Gilligan 1982). Indeed, three perspectives, each with a different focus or “mode of approaching” the relationship between oneself and others, form the foundation of care-based moral problem-solving (Gilligan 1982). The three perspectives range from least to most advanced: a focus on self, a focus on others, and a focus on both self and others with two transitional phases existing between these qualitatively different modes.

The first and least advanced mode of care reasoning, focus on caring for oneself (Gilligan 1982), reflects a “survival” orientation in which individuals maximize their own best interests, and includes avoidance of hurt in the protection of self and self-happiness. Decisions have a practical focus in that there is no differentiation between “shoulds” and “wants” (Gilligan 1982). A transitional phase exists in which individuals become critical of their selfishness and, as a result, recognition of responsibility to others emerges. The second mode of care reasoning focuses on caring for others; goodness is equated with self-sacrifice and placing one’s own needs and desires behind those of others. However, as disequilibrium is noted in one’s own life, a second transition occurs in which individuals begin to recognize the inadequacy of equating caring for others with self-sacrifice. Individuals are now motivated to demonstrate both “goodness” through their responsible actions toward others, and “honesty” through responsible actions to oneself. This leads to the emergence of a third mode of care reasoning in which the focus is on both oneself and others in the notion of care. Within this perspective, authentic efforts are made to identify creative solutions through which the needs of oneself and others are integrated into the resolution of moral dilemmas (Gilligan 1982). Although each mode of care reasoning focuses on the relationship between oneself and others in a morality of selfishness versus responsibility, the balance one negotiates distinguishes between the three modes such that individuals demonstrating a more advanced mode of care reasoning would also be predicted to exhibit higher levels of transformational leadership behaviors.

In particular, recall that the first mode of care reasoning involving a “focus on self” reflects the degree to which certain choices fulfill one’s own desires (Gilligan 1982). This is inconsistent with all four components of transformational leadership (Bass and Riggio 2006). Thus, leaders demonstrating the first mode of care reasoning should be perceived by their followers as demonstrating low levels of transformational leadership.

The second mode of care reasoning, focusing on others at the expense of one’s own needs in a self-sacrificing way (Gilligan 1982) is consistent with some but not all of the behaviors comprising transformational leadership. Demonstrating the second mode of care reasoning by showing responsiveness to the particular and subjective needs of others is consistent with individualized consideration, and intellectual stimulation through the use of creative, interest-based, non-zero sum approaches to problem-solving to resolve conflict between others. However, within this mode, one’s own needs and concerns would be excluded. Followers might therefore observe individualized consideration and some characteristics of intellectually stimulating behaviors. Inspirational motivation and idealized

influence, however, involving the formation of a collective vision directed toward the attainment of authentically shared goals, would not be possible. Instead, there would be a false sense of community reflected in caring for others at the expense of oneself. Thus, leaders demonstrating the second mode of care reasoning (focus on others) would likely be viewed by followers as having moderate levels of transformational leadership.

The third and most advanced mode of care reasoning is focused on caring for both oneself and others (Gilligan 1982), and is characterized by authentic engagement with oneself and others in ways that are necessary for integrative and sustained patterns of behavior that are truly transformational in nature. This third mode reflects several behaviors that are consistent with components of transformational leadership. For example, care characteristics involving an authentic sense of interconnection among individuals and efforts to activate and maintain networks of relationships would be congruent with inspirational motivation and idealized influence aimed at inspiring an authentic sense of shared vision and attainment of collective goals. Similarly, responsiveness to the particular and subjective needs of others is congruent with individualized consideration. Finally, the use of creative, non-zero sum solutions to simultaneously fulfill seemingly conflicting responsibilities is consistent with kindling innovative solutions to problems reflected in intellectual stimulation. Thus, leaders using the most advanced mode of care reasoning (i.e., focus on both oneself and others) would likely be assessed by followers as having high levels of transformational leadership. Therefore, in keeping with the characteristics of these three modes of care,

Hypothesis 1 Leader mode of care reasoning will be significantly and positively related to followers’ reports of transformational leadership.

In contrast, there is no conceptual reason to expect a clear and systematic association between modes of care reasoning and transactional leadership. Transactional leadership is founded on notions of rational and fair exchange between separate and autonomous individuals (Bass and Steidlmeier 1999). Hence, the first mode of care reasoning (fulfilling one’s own desires in a self-interested way) is antithetical to the fair and rational exchanges that characterize transactional relationships. Similarly, the self-sacrificing focus on meeting the needs of others that characterizes the second mode of care reasoning is also inconsistent with a transactional “contingent reward” exchange process (Bass 1985). Rather, leaders demonstrating the second mode of care reasoning would neglect their own needs and interests in favor of goodness toward others. Finally, the notions of connection, interdependence, responsiveness to subjective experiences, and attentiveness

to feelings that characterize the third mode of care reasoning (focus on self and others) are also inconsistent with the assumptions of separation, autonomy, objectivity, and rationality inherent within a transactional approach.

Hypothesis 2 Leader mode of care reasoning will be unrelated to followers' reports of transactional leadership.

Method

Procedure and Participants

The sample comprised 58 public sector managers and 119 of their supervisees from one Canadian province. The managers worked in a network of publicly funded, not-for-profit organizations in the fields of education and social services. The modal leader age (35.4%) was 50–54 years of age, with 3.4% in the 25–29 year range, 12.1% in the 35–39 year range, 13.8% in the 40–44 year range, 20.7% in the 45–49 year range, 8.6% in the 55–59 year range, 5.2% in the 60–64 year range, and 1.7% over 65 years of age. Sixty percent of the leaders were women; 55% had a Master's level degree, 33% an undergraduate degree, and 12% had completed a 2-year college diploma.

Leaders were asked to provide contact information for up to five followers. Followers comprised 119 subordinates (M age = 42.21 years, SD = 11.29 years, range = 22–70 years; 73% female). The number of followers per leader ranged from one to four, with the median number of followers per leader being two; 12 of the leaders had single follower data. Although studies often have several level-1 participants per level-2 cluster (i.e., several followers per leader), the inclusion of a single level-1 participant (follower) for a level-2 "cluster" (leader) is permissible (Hox 2008; Swank 2008) and unlikely to result in concerns when the number of single level-1 cases is moderate (Guo and Cai 2007). Moreover, in such cases, the risk would be upwardly biased standard errors resulting in reduced power to detect significant effects that are actually present, as opposed to the more concerning problem of downwardly biased standard errors resulting in the potential to falsely identify a significant effect when none exists (Clarke 2008).

Each leader was assigned an individualized, randomly generated ID number prior to participating in a face-to-face, 30 min, semi-structured, audio-taped interview designed to assess mode of care reasoning. Followers reported their observations of transformational and transactional behaviors demonstrated by their respective leaders in an online survey using an access code specific to their respective leader. No inducements for participation were offered.

Measures

Ethic of Care Interview

The Ethic of Care Interview¹ (Skoe 1993) is a four-dilemma, semi-structured interview in which respondents answer open-ended questions about one real-life, self-generated moral dilemma, and three hypothetical scenarios reflecting interpersonal dilemmas or conflicts. Participants describe how they resolved their self-reported, real-life dilemma, as well as how the individuals in the three additional vignettes should resolve the predicaments they face. Responses are audio-taped, transcribed, and scored according to a standardized key that reflects each mode of care reasoning, along with the two transitional phases. Mode of care reasoning score is the average across the four dilemmas, rounded to the nearest phase or transition, such that scores of 1, 1.5, 2, 2.5, or 3 are possible. Previous studies have demonstrated acceptable interrater reliability (.76–.95) and interrater agreement (.63–1.00) in the scoring of these interviews, and acceptable internal consistency assessed through intercorrelations among the scores on the constituent dilemmas (.74–.92; Skoe 1998). The interview has also been shown to be construct valid (Skoe 1993, 1998). In the current study, the interviews were coded by two separate raters, including the first author and a paid research assistant, each of whom undertook approximately 24 h of practice in administering and scoring the ECI. Interrater reliability was .89 and interrater agreement computed as the average r_{wg} coefficient was .91. The internal consistency of scores across all four constituent dilemmas was .67.

MLQ

The MLQ Form 5x—Short Instrument² (Bass and Avolio 2000) requires followers to rate the frequency (0 = *not at all*, 4 = *always*) with which their leaders demonstrate behaviors associated with transformational and transactional leadership. Five subscales (20 items) measured transformational leadership (idealized influence—attributed, idealized influence—behavioral), inspirational

¹ The Ethic of Care Interview was used with permission of Dr. Eva Skoe, University of Oslo, Norway. All rights reserved.

² MLQ items were used by special permission of the Distributor, Mind Garden, Inc., 855 Oak Grove Ave., Suite 215, Menlo Park, CA 94025, USA www.mindgarden.com from the Multifactor Leadership Questionnaire by Bernard M. Bass and Bruce J. Avolio. Copyright 1995 by Bernard M. Bass and Bruce J. Avolio. All rights reserved. Reproduction or use of items is prohibited without the Distributor's written consent.

motivation, intellectual stimulation, and individualized consideration, with eight items measuring transactional leadership (contingent reward, active management-by-exception). Within-group agreement with respect to follower reports of transformational leadership as indicated by the intraclass correlation, ICC(1), was .38, and the reliability of the group mean scores as reflected by the ICC(2) value was .54. Within-group agreement with respect to reports of transactional leadership as indicated by ICC(1) was .21, with the reliability of group mean scores as indicated by the ICC(2) being .09, supporting the use of multilevel analysis.

Although CFA of the MLQ (Bass and Avolio 2000) is often desirable, when follower groups vary in size, Full Information Maximum Likelihood estimators are problematic as they specify separate between-group models for each size. Alternate approximations using the Muthén (1989, 1994) Maximum Likelihood estimation algorithm are also problematic when groups are smaller than 100; these are associated with biased standard errors (Hox and Mass 2001). Thus, a CFA was not possible. Instead, composition of scales was based on Bass and Avolio's (2000) robust factor model derived from the responses of 3,786 participants in 14 separate samples. By convention, we focused on two higher order scales, one for each of transformational and transactional leadership. Because first-order dimensions comprising each of these scales consistently show very high intercorrelations, it is difficult to isolate unique associations with other variables. Therefore, researchers typically combine the constituent dimensions into these higher order scales (Judge and Piccolo 2004; Judge et al. 2008). This approach is both consistent with and facilitates direct comparison with previous studies (e.g., Simola et al. 2010; Sivanathan and Fekken 2002; Turner et al. 2002).

Statistical Controls

Previous research has shown positive associations between transformational and transactional leadership (Bass and Avolio 2000; Bono and Judge 2004). Thus, transactional leadership was used as a control variable when transformational leadership was the outcome variable, and vice versa. Because gender is associated with transformational leadership (Bass et al. 1996; Eagly et al. 2003), and age (Gilligan et al. 1991; Rest 1994) and education are associated with level of moral reasoning (Rest 1994; Treviño 1986), age, gender, and education were also included as control variables.

Results

Table 1 presents the means, standard deviations, and intercorrelations among variables. However, this study was

multilevel in design; each leader had a set of followers, with each group of followers being unique to a given leader. Thus, hierarchical linear modeling (Raudenbush and Bryk 2002) was used to circumvent potential problems with biased tests of significance that can occur with regular regression analysis when such dependencies exist (Muthén and Satorra 1989).

Two multilevel regression analyses were computed using HLM6 (Raudenbush et al. 2000). First, follower reports of transformational leadership (level-1) were regressed onto follower reports of transactional leadership (level-1), leader gender, age, education (level-2), and leader level of care reasoning (level-2). Second, follower reports of transactional leadership (level-1) were regressed onto follower reports of transformational leadership (level-1), leader gender, age, education (level-2), and leader level of care reasoning (level-2). For each of the two regressions, three sequential models were used: a one-way random effects analysis of variance (ANOVA) model to test for significant between-group differences in leadership style; a random-coefficient regression (i.e., one-way random effects ANCOVA) to test the assumption of significant variation in intercepts across groups; and an "intercepts-as-outcome" model, through which the actual hypotheses for the study were evaluated. Grand-mean centering was used in all analyses (Hofmann and Gavin 1998; Kreft et al. 1995). Results of the multilevel regression analyses appear in Table 2.³

Transformational Leadership and Mode of Care Reasoning

The χ^2 test associated with the one-way random effects ANOVA model indicated that the between leader variance was significantly different from zero, [$\chi^2(57) = 129.70$, $p < .001$], suggesting the appropriateness of fitting the random-coefficient model. The random coefficient model demonstrated that the mean across groups for the slopes relating follower reports of transformational leadership to follower reports of transactional leadership was statistically significant [slope = .41; $t(117) = 5.23$, $p < .001$]. The R^2 value for the level-1 model was 8.70%. This value reflects the proportion of variance accounted for by transactional leadership to the total within-group variance in transformational leadership (Hofmann et al. 2000). The χ^2 test for the level-1 intercepts indicated that the between-group variance was significantly different from zero

³ Based on a priori conceptual analysis, those in the focus on self or first transitional phase were classified as group one; those with a focus on others were classified as group two, and those in the second transitional phase or having a focus on both self and other were classified as group three.

Table 1 Means, standard deviations, reliabilities, and intercorrelations among variables

Variable	<i>M</i>	SD	1	2	3
1. Care	2.22	.48	(.67)		
2. TRF	3.05	.60	.34**	(.92)	
3. TRA	2.32	.65	.09	.48**	(.69)

Note: $N = 119$. TRF transformational leadership. TRA transactional leadership. Internal consistency reliabilities appear in parentheses along the diagonal. The correlations among care, TRF, and TRA were computed using $N = 119$. Therefore, care and justice scores for each group were assigned down to individual followers within those groups. Thus, the effective N for care is 58

** $p \leq .01$

Table 2 Results of the estimated models

	Parameter estimates ^a						
	γ_{00}	γ_{01-04}	γ_{10}	γ_{11}	σ^2	π_{00}	π_{11}
<i>Models for TRF as L1 dependent variable</i>							
One-way ANOVA							
L1: Transformational leadership _{ij} = $\beta_{0j} + r_{ij}$	4.03	–	–	–	.23	.14	–
L2: $\beta_{0j} = \gamma_{00} + U_{0j}$							
Random coefficient							
L1: TRF Ldrshp _{ij} = $\beta_{0j} + \beta_{1j}$ (TRA Ldrshp _{ij}) + r_{ij}							
L2: $\beta_{0j} = \gamma_{00} + U_{0j}$, $\beta_{1j} = \gamma_{10}$	4.04	–	.41	–	.21	.07	–
Intercepts-as-outcome							
L1: TRF Ldrshp _{ij} = $\beta_{0j} + \beta_{1j}$ (TRA Ldrshp _{ij}) + r_{ij}		$\gamma_{01} = .16$					
L2: $\beta_{0j} = \gamma_{00} + \gamma_{01}$ (Gender _j) + γ_{02} (Age _j) + γ_{03} (Education _j) + γ_{04} (Care _j) + U_{0j} , $\beta_{1j} = \gamma_{10}$	4.03	$\gamma_{02} = .02$ $\gamma_{03} = -.10$ $\gamma_{04} = -.34$.39	–	.22	.03	–
<i>Models for TRA as L1 dependent variable</i>							
One-way ANOVA							
L1: Transactional leadership _{ij} = $\beta_{0j} + r_{ij}$	3.31	–	–	–	.34	.09	–
L2: $\beta_{0j} = \gamma_{00} + U_{0j}$							
Random coefficient							
L1: TRA Ldrshp _{ij} = $\beta_{0j} + \beta_{1j}$ (TRF Ldrshp _{ij}) + r_{ij}							
L2: $\beta_{0j} = \gamma_{00} + U_{0j}$, $\beta_{1j} = \gamma_{10}$	3.32	–	.51	–	.29	.04	–
Intercepts-as-outcomes							
L1: TRF Ldrshp _{ij} = $\beta_{0j} + \beta_{1j}$ (TRA Ldrshp _{ij}) + r_{ij}		$\gamma_{01} = .03$ $\gamma_{02} = -.01$					
L2: $\beta_{0j} = \gamma_{00} + \gamma_{01}$ (Gender _j) + γ_{02} (Age _j) + γ_{03} (Education _j) + γ_{04} (Care _j) + U_{0j} , $\beta_{1j} = \gamma_{10}$	3.32	$\gamma_{03} = .02$ $\gamma_{04} = -.12$.54	–	.30	.04	–

Organization of this table based on Hofmann et al. (2000)

TRF Ldrshp Transformational leadership, TRA Ldrshp Transactional leadership

^a γ_{00} = Intercept of level-2 regression predicting β_{0j} , γ_{01-04} = slopes of level-2 regression predicting β_{0j} , γ_{10} = intercept of level-2 regression predicting β_{1j} , γ_{11} = intercept of level-2 regression predicting β_{1j} , σ^2 = variance in level-1 residual (variance in r_{ij}), π_{00} = variance in level-2 residual for models predicting β_{0j} , π_{11} = variance in level-2 residual for models predicting β_{1j} , U_{0j} = variance in intercepts

$[\chi^2(55) = 99.30, p < .001]$, suggesting the appropriateness of fitting the third model.

With respect to transformational leadership, results of the intercepts-as-outcome model demonstrated that the coefficient for mode of care reasoning [$\gamma_{04} = .34$; $t(53) = 3.04, p < .01$] was significant. In contrast, the coefficients for gender [$\gamma_{01} = .16$; $t(53) = 1.53, p = .13$],

age [$\gamma_{02} = .02$; $t(53) = .87, p = .39$], and education [$\gamma_{03} = -.10$; $t(53) = -.31, p = .19$] were not significant. The R^2 value for this model was 59.08%. This value represents the proportion of variance accounted for relative to the between-groups variance in the intercepts, rather than the total variance in transformational leadership (Hofmann et al. 2000).

Table 3 Scores of the three mode of care reasoning groups on transformational leadership

Dependent variable	Care reasoning group						<i>F</i> (2, 48)
	Focus on self (<i>n</i> = 6)		Focus on other (<i>n</i> = 32)		Focus on self and other (<i>n</i> = 13)		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Transformational leadership	2.58	1.09	3.26	.39	3.38	.35	8.88**
Transactional leadership	2.49	.45	2.70	.65	2.71	.26	.57

Note: A post-hoc Bonferroni comparison demonstrated that the transformational leadership scores of the “focus on self” group were significantly lower than those in the “focus on other” group. ** $p < .001$

Transactional Leadership and Mode of Care Reasoning

The χ^2 test associated with the one-way random effects ANOVA model indicated that the between-group variance was significantly different from zero [$\chi^2(57) = 89.43$, $p < .01$], justifying the fitting of the second model. Within the random-coefficient model, reports of transactional leadership significantly and positively related to follower reports of transformational leadership [slope = .51; $t(117) = 5.99$, $p < .001$]. The R^2 value representing the proportion of variance accounted for by the predictor of transformational leadership relative to the within-group variance in transactional leadership was 12.29%. However, the χ^2 test indicated that the between-group variance was not significantly different from zero [$\chi^2(57) = 71.30$, $p = .10$], suggesting that after controlling for transformational leadership, there was insufficient between-group variation through which to identify associations between leader mode of care reasoning and follower reports of transactional leadership in the third model. Indeed, in predicting transactional leadership, the intercepts-as-outcome model indicated that the coefficients for mode of care reasoning [$\gamma_{04} = -.12$; $t(53) = -1.03$, $p = .31$], gender [$\gamma_{01} = .034$; $t(53) = .32$, $p = .8$], age [$\gamma_{02} = -.014$; $t(53) = -.43$, $p = .67$], and education [$\gamma_{03} = .015$; $t(53) = .18$, $p = .86$] were not significant.

Post-Hoc Analysis

We conducted post-hoc analyses to assess whether differences existed in transformational leadership scores for each of the three modes of care reasoning. Due to variability among follower reports within each leader cluster as indicated by the ICC coefficients, measures of inter-rater agreement (r_{wg} ; James et al. 1984, 1993) among followers were computed. Seven follower clusters had scores below the acceptable median standard of .70 and were eliminated prior to the post-hoc Bonferroni multiple comparisons. Significant differences emerged in transformational leadership scores according to mode of care (see Table 3): Leaders using the most advanced mode of care reasoning (“self and other” focus) had significantly higher follower

ratings for transformational leadership than those with the least advanced mode of care reasoning (focus on self). No significant differences emerged among other comparisons.⁴

Discussion

The purpose of this study was to contribute to a growing body of empirical research on the moral foundations of transformational leadership (Simola et al. 2010; Turner et al. 2002). In doing so, this study responds to Ciulla’s (2009) suggestions on the importance of care-based perspectives as well as more conventional moral reasoning approaches when attempting to understand the moral foundations of effective leadership styles. Moreover, by considering the role of leaders’ mode of care reasoning, this study extended previous research that has focused on more conventional justice approaches (Turner et al. 2002) or investigated only general propensities toward ethics of justice or care (Simola et al. 2010). As predicted, multi-level regression analyses indicated that leaders’ mode of care reasoning was significantly, positively related to follower reports of transformational (but not transactional) leadership. Post-hoc analysis also demonstrated that leaders using a “focus on self” mode of navigating the self-other (selfishness-responsibility) terrain of care reasoning had significantly lower transformational leadership scores than leaders using a “focus on both self and other” mode.

Given that prior research has indicated a positive association between leader stage of justice reasoning (Turner et al. 2002) and between leader propensity toward using care reasoning and follower perceptions of transformational leadership (Simola et al. 2010), the moral foundations of transformational leadership may be complex. The current study suggests that the complement to stage of justice reasoning as a moral foundation of transformational leadership might not simply be leader propensity toward using care reasoning, but rather leader propensity toward using more advanced modes of care reasoning.

⁴ See footnote 3.

As predicted, no significant relationship emerged between leader mode of care reasoning and follower reports of transactional leadership. This non-significant finding in the final intercepts-as-outcomes model may have been related to the minimal between-group variance in transactional leadership after controlling for transformational leadership. Although this result is consistent with the a priori hypothesis, further research is warranted. Replicating this finding would support previous research suggesting that the moral foundation of transactional leadership is unlikely to be located in the realm of care ethics, and more probably founded in either propensity toward or stage of justice reasoning (Simola et al. 2010; Turner et al. 2002).

An important methodological strength of the current study is that the data were based on two different sources (i.e., leaders, subordinates) and two methods (i.e., leader interviews, follower surveys). This minimizes the likelihood of both mono-source and mono-method bias, which is particularly important given that leader traits are differentially related to self and other reports of transformational leadership (Judge et al. 2006).

Nonetheless, some questions remain for future research. First, do the findings generalize to the private sector? It is possible that contextual characteristics such as relatively small organizational sizes and public sector focus allow for more expression and greater recognition of care-based approaches than might occur in larger, private sector organizations. Second, the results of previous research and this study provide a basis for evaluating more integrative models, including assessment of potential interaction effects. For example, might stages of cognitive-developmental reasoning (Turner et al. 2002) and propensity toward care-based reasoning (Simola et al. 2010) interact to predict transformational leadership? This question is consistent with contemporary moral perspectives in which both justice and care approaches are seen as essential to effective moral reasoning (e.g., Clement 1996; Held 1998; Porter 1999).

Alternately, research might explore whether more advanced modes of care reasoning are related to other types of ethical leadership, and if so, in what way? For example, given that courage and healthy forms of resistance against violation, injustice, and carelessness are central to care reasoning (Gilligan et al. 1991), research could consider whether care-based reasoning facilitates the moral courage needed by leaders to translate ethical intentions into ethical actions in the face of organizational pressures to do otherwise (May et al. 2003). Similarly, research might consider whether healthy forms of resistance inherent in mature forms of care reasoning contribute to the “moral resiliency” required in sustained ethical leadership (May et al. 2003).

One final question for future research concerns possible leadership interventions. If more sophisticated forms of justice reasoning and more advanced modes of care reasoning are implicated in transformational leadership, might leadership interventions (e.g., Barling et al. 1996; Dvir et al. 2002) benefit from development activities related to conventional justice as well as care-based complements?

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