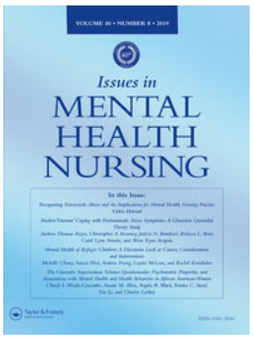

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Leadership, Thought Diversity, and the Influence of Groupthink

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Effective decision-making underpins mental health nurses' capacity for providing person-centred, evidenced-based care. Whilst team environments have the potential to support effective decision-making, poor decision-making can occur when busy individuals, eager to please others, enable group consensus to pervade at the expense of thoughtful debate, reflection and negotiation. The promulgation of such 'groupthink' may negatively impact care. In this column, the concept of groupthink is explored and its impacts considered. Strategies for tackling groupthink are proposed in order to support effective leadership, thought diversity and the achievement of organisational and team goals.

Groupthink is a way of thinking that people adopt when they participate in a connected 'in-group' whose modus operandi is consensus as opposed to consideration of alternative views or actions (Janis, 1997, p. 237). Groupthink is also referred to as 'concurrence-seeking tendency' (Shirey, 2012, p. 67), whereby decision makers seek concurrence instead of making calculated, and considered decisions (Yetiv, 2003). It has been suggested that groupthink arises in cohesive groups, and in circumstances where individual group members automatically revert to applying pressure to maintain harmony within the group when the need for decision-making arises (Janis, 1997). Whilst group members may perceive these actions to reflect group solidarity and like-mindedness, they can be counterproductive (Janis, 1997, p. 237). If the close-knit group adopts a concurrence-seeking tendency when making decisions as opposed to considering other options (Janis, 1997), decisions may not always be the best decisions (Macleod, 2011). As Janis notes, the 'superglue of solidarity that bonds people together often causes their mental process to get stuck' (Janis in Shirey, 2012, p. 67).

It is important to appreciate, however, that poor decisions are not always due to groupthink, nor does groupthink always results in poor decisions. Groupthink reflects the *processes* rather than the *outcomes* of decision-making, where pressure for group cohesion overrides 'individualised thought and expression' (Macleod, 2011, p. 46). Bearing this in mind, decisions made by groups can result in better problem solving than an individual working alone, given the diversity of ideas, expertise and experiences group members can contribute. The more input given to consider a problem the greater the likelihood of being able to consider a variety of viable solutions as part of the decision-making process (Macleod, 2011). Identifying and assessing alternative solutions to an issue or problem are necessary stages in decision-making. Where there is groupthink these stages may be barely considered if at all (Macleod, 2011). In this circumstance the group leader is often directive and individual viewpoints and open debate discouraged. Peer pressure within the group then leads to conformity and effective decision-making is compromised as the group blocks new information and ideas (Macleod, 2011).

Whilst the groupthink concept has attracted some controversy (Esser, 1998), it continues to be widely accepted and studied in decision-making across sectors, including clinical healthcare (Heinemann, Farell, & Schmitt, 1994). Shirey (2012) explains that where groupthink becomes the modus operandi the group is likely to compile limited data to inform discussion and decision-making, is negligent in questioning assumptions, and neglects to adopt a 'bigger picture' approach in seeking expert opinion or determining solutions, thus considering only select options (Shirey, 2012). When groupthink occurs, the result may be ill-informed decision-making and inappropriate or suboptimal outcomes. This may compromise strategic planning or organisational change and, when this occurs in healthcare and nursing, can result in costly inefficiencies and poorer stakeholder outcomes (Shirey, 2012). In nursing and healthcare for example, decisions about patient safety that are raised by staff, but then put aside when pressure is exerted on staff to reconsider their position, may lead to further compromising of patient safety.

For many, the idea that groupthink may exist in their domain is confronting. Many of us would consider that we would not allow groupthink to occur, given our personal and professional values, aims and abilities. However, the following

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indicators of groupthink identified by Janis (1997) may be observed in nursing groups (adapted from Macleod, 2011):

- Illusions of invulnerability – where heightened levels of optimism preclude the group from identifying warnings signs of danger, believing that the group by virtue of its cohesion can deal with any situation that may arise.
- Collective rationalisation – overlooking warning signs that differ from the group's assumptions.
- Unquestioned belief in morality – trusting in the group's superior moral stance.
- Stereotyping adversaries – adopting negative views to outsider's perspectives.
- Pressure for conformity – feeling compelled to accept the point of view of the majority.
- Self-censorship of ideas – group members maintaining group security/integrity by preventing information that they deem harmful to the group from being divulged.

The following four factors may act as antecedents to groupthink: high cohesion, structural faults, situational contexts, and time constraints (Janis, 1997; Shirey, 2012). Low or high levels of cohesion within groups occur in response to the persuasive influence of the leader (Henningsen, Henningsen, Eden, & Cruz, 2006). Structural faults arise in response to the insular nature of the group and group homogeneity (Macleod, 2011). Situational contexts influencing groupthink may include diminished group effectiveness and elevated levels of stress arising from external pressures (Henningsen et al., 2006). Time constraints have been added as a fourth antecedent, given the impact time may have in enabling thoughtful and well evaluated decisions to be made (Shirey, 2012). Of these four factors, cohesion is thought to be the most influential and potentially dangerous antecedent to groupthink (Henningsen et al., 2006). Groupthink does not only occur in highly cohesive groups but may also be evident within groups with a false perception of cohesion (Heinemann et al., 1994).

Groupthink may be prevented by adopting a proactive approach to counter antecedents. Strategies provided here that may be applied have been adapted from Shirey (2012). In relation to reducing the negative impact of high cohesion, it may be valuable to ensure group diversity by considering attributes required when determining group membership. It may also be useful to convene multiple independent groups to address the one issue or problem, or to break into subgroups to identify advantages and disadvantages of a problem. It may also be advantageous to engage individual group members to critically evaluate decisions.

To address structural faults, it may be helpful to seek expert input to canvass alternate views, or to engage external convenors to manage groups and processes. It may also be useful to establish norms whereby the leader refrains from presenting their perspective at the outset of decision-making, while also rewarding 'truth speakers' within the group. Rotating group member roles and responsibilities may also have a positive effect, as may practicing simulations examining variable responses to issues and strategies that could be adopted (Shirey, 2012, p. 70).

In relation to situational contexts, it is important to choose group members who are capable and confident in presenting diverse views. Conducting in-service education regarding roles, responsibilities and consequences associated with decision-making at all levels may also be useful, as may mandating that team members be signatories to decision-making, thereby acknowledging individual responsibilities in processes and outcomes (Shirey, 2012). Finally, in relation to the additional antecedent of time constraints, it may be beneficial to assign appropriate timeframes to enable productive team processes. It may also be useful to allow additional time to reflect on difficult decisions and alternatives that were previously excluded, or to offer a 'second chance' to select a different resolution (Shirey, 2012, p. 70).

To reduce groupthink, both the convenor and group members have a role to play in encouraging open discussion (Fernandez, 2007). The convenor or chair needs to convey their expectations of the group at the outset as well as seeking group input as to how the leader and the group will function. This may include explicit encouragement for ideas to be freely aired, debated and considered on their merit (Fernandez, 2007). A strategy for operationalising such an approach is suggested to contain four key questions: 1. What is known? 2. What facts explain the circumstance/issue? 3. What can be learnt from previous situations? And 4. What expert input should be sought? When considering the issue or problem in this way, the group needs to consider what is emerging from the information they have, and whether similar or recurring issues are arising (Fernandez, 2007).

The need for effective leaders and staff diversity is well established (Shirey, 2012). Indeed, diversity is central to organisational success as it can provide rich and useful diversity of thought (Fernandez, 2007). A diverse group of staff (e.g. background, professional and life experiences) holds individual perspectives on ideas that when shared can generate momentum for collaboration, creativity and entrepreneurship. Thought diversity also provides opportunities for debate, deliberation and reflection before proceeding with actions. These processes aid in avoiding groupthink (Fernandez, 2007), which is inconsistent with transformative practices.

By better identifying and discussing a diversity of perspectives a team can enable 'the bigger picture' to emerge, thus developing a better understanding of what is occurring and the ramifications or implications across the organisation or service (Fernandez, 2007). As perspectives are identified, group members may simultaneously consider alternative views and solutions. Asking a group member to adopt the 'devil's advocate' role when considering solutions is one means of checking whether or not the questions asked have been answered and done so thoroughly, including considering whether or not sufficient and adequate information has been provided to determine solutions (p. 671). This person can provide a 'reality check' for the group as to whether or not goals and decisions are appropriate and feasible (Fernandez, 2007, p. 671).

Importantly, an effective decision-making group needs to openly listen to a person offering a different perspective, rather than censuring them (Fernandez, 2007). Adopting these strategies requires staff to learn how to participate in

difficult conversations and to enable and appreciate the role of constructive criticism. Leaders can guide group members during these conversations and promote new perspectives and discussions. If these do not emerge then the culture of the group may be stagnant and new members needed. Once decisions are reached reflection and evaluation of their utility is paramount prior to them being accepted and operationalised (Fernandez, 2007).

In summary, groupthink arises when the group culture is dominated by the influence of some members to the extent that others' views or ideas are impeded from being considered. This may mean that dominant members override others when they are trying to speak; are dismissive of others; ignore others point of view or automatically adopt a negative stance towards another's opinion (Fernandez, 2007). The challenge for nursing leadership is to sustain group cohesion through education about roles, responsibilities and the art of engaging in difficult conversations. Encouraging constructive input and evaluation of alternative views, achieving appropriate levels of agreement and avoiding one-dimensional thinking as a default position (Macleod, 2011) are fundamental to effective and productive decision-making.

Disclosure statement

No potential conflict of interest was reported by the authors.

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