The Team Sub Focused Leadership Program (TSFLP)

DAU

MAVERICK& BOUTIQUE

Class Handout

20-21 July 2021

DAU MAVERICK& BOUTIQUE

Welcome, Cohort 4, to TSFLP Workshop Two!

In this workshop, we'll be shifting our perspective from the individual leader to the culture of teams and organizations. What are the qualities of cultures that produce high performance and high satisfaction? How might we as leaders help to create positive culture from wherever we are in an organization? How do we and others need to show up to do this? What happens when we don't?

We'll spend some time integrating the material from Workshop One and the books we've read so far into the new material, so please review as necessary and come equipped with ideas and questions to contribute. We'll also discuss your experience with the Mindfulness Challenge from Workshop One.

This document contains the worksheets and instructions you will need for the workshop. We suggest, if you are able, that you print it in advance, so you can refer to it when need be. We will also be posting this document at the start of the workshop, so you can retrieve it then as well.

Looking forward to spending time with you this week to learn and grow as leaders.

Very respectfully,

The TSFLP Facilitation Team

Day One:

Time	Topic
0800 – 0845	Welcome, check-in, and overview of Workshop Two
0845 – 0930	Review of concepts from Workshop One/Mindfulness Challenge report out
0930 – 1130	Understanding, creating, and changing team culture
1130 – 1300	LUNCH and read Covey article on Trust (30 mins.)
1300– 1530	Building a culture of trust
1530 – 1600	Day One reflection and close

Day Two:

Time	Topic
0800 – 0845	Check-in from Day One: Small group conversation on reflection then report out
0830 – 1100	Systems Planning and Analysis: Creating Risk-Aware Organization and Team Culture
1100 – 1200	Leader as Coach: A Culture of Coaching Part 1
1200 – 1300	LUNCH
1300– 1530	Leader as Coach: A Culture of Coaching Part 2
1530 – 1600	Check-out, next steps, and close

Exercise 3: What Stands in the Way Becomes the Way

Content covered on pages 7-8 of Dare to Lead.

In *Dare to Lead*, we learn about ten behaviors and cultural issues that leaders identified as getting in our way in organizations across the world.

01. We avoid tough conversations, including giving honest, productive feedback.

02. Rather than spending a reasonable amount of time proactively acknowledging and addressing the fears and feelings that show up during change and upheaval, we spend an unreasonable amount of time managing problematic behaviors.

03. Diminishing trust caused by a lack of connection and empathy.

04. Not enough people are taking smart risks or creating and sharing bold ideas to meet changing demands and the insatiable need for innovation.

05. We get stuck and defined by setbacks, disappointments, and failures, so instead of spending resources on clean-up to ensure that consumers, stakeholders, or internal processes are made whole, we are spending too much time and energy reassuring team members who are questioning their contribution and value.

06. Too much shame and blame, not enough accountability and learning.

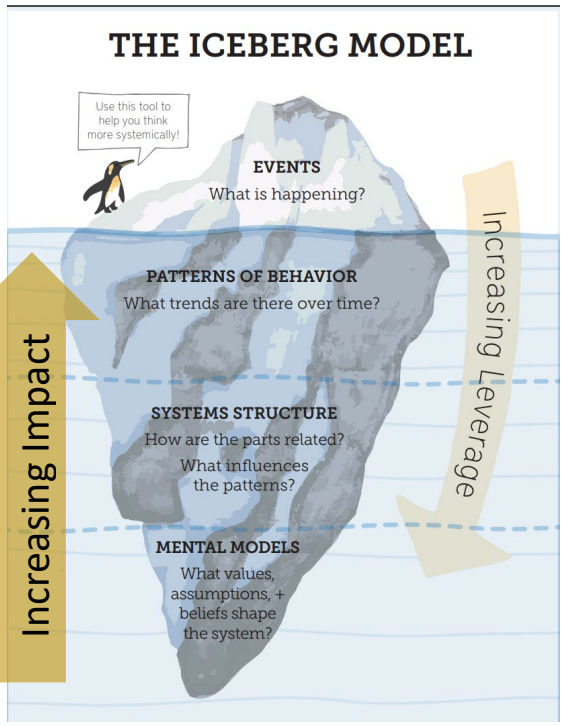
07. People are opting out of vital conversations about diversity and inclusivity because they fear looking wrong, saying something wrong, or being wrong. Choosing our own comfort over hard conversations is the epitome of privilege, and it corrodes trust and moves us away from meaningful and lasting change.

08. When something goes wrong, individuals and teams are rushing into ineffective or unsustainable solutions rather than staying with problem identification and solving. When we fix the wrong thing for the wrong reason, the same problems continue to surface. It's costly and demoralizing.

09. Organizational values are gauzy and assessed in terms of aspirations rather than actual behaviors that can be taught, measured, and evaluated.

10. Perfectionism and fear are keeping people from learning and growing.

The Iceberg Model



Only 10 per cent of an iceberg's total mass is above water. But the 90 percent we can't see creates what we see at the visible tip. The Iceberg Model helps us understand issues from a systems thinking perspective, by focusing on what's beneath the waterline.

The events in a system are always rooted in the beliefs and values of the people working in the system. The visible behavior of a system - what we see at the event level - is driven by influences at deeper levels. If you want to affect meaningful change, you need to begin with how people think.

There are four levels:

1. **Events**: If you had a video camera right now, what would it record?
2. **Patterns of behavior**: If you left the video on for a day, week, months, what trends might you observe?
3. **Systems structures**: Thinking about all the elements you saw on the video, how do the different parts relate to each other? Consider things like laws, rules (tacit and explicit), policies, social order, organizational dynamics, etc.
4. **Mental models**: What underlying values, assumptions and beliefs shape the structures, behaviors, and events in the system you observed on your video?

If we **try** to solve problems by dealing with issues at the **events level,** we are only able to react to what we observe directly, dealing only with symptoms rather than causes. If we go deeper into the **patterns of behavior** level, we are better able to respond at the events level. Going deeper still, you see that the **systems structure** allows the patterns to exist. Going deeper still to the **mental model** level, you are able to see the thinking that went into creating the system in the first place. Changing our thinking is one of the most powerful things we can do to make change.

We can use the Iceberg Tool to both ANALYZE and REDESIGN an existing system. Once we know the ways of thinking and the structures that are influencing what is happening at the top of the iceberg, we can change how we think and what we do to get a different result.

Source: Donnella Meadows Institute/Academy for Systems Change
http://donellameadows.org/
Resource: *Thinking in Systems* by Donnella Meadows

Applying the Iceberg Systems Thinking Model to Real-life Events

Dimension	Example: Late to Work	PMO Example: Not Enough Time
Events	Pam, a young woman on your team arrives an hour late for work after dropping off her young child at daycare.	Missed deadlines; cursory analysis of products; employees stay late at work; teams work "in their lanes"; duplicative products and efforts; lots of meetings; people spend large amounts of time locating information and people; people appear tense and distracted.
Patterns of Behavior	Pam is late on the same day a week later and the week after that.	Low communication across functional lines; meetings absorb most weekly "white space"; working lunches at desk; people don't use vacation time, published processes usually not followed; people complain but nothing changes; trust eroded; people feel disempowered.
System Structure	The organization has strict policies about when staffers need to be in the office — policies that don't consider the needs of workers, such as when daycare facilities open in the morning.	PMO structured along functional lines; no rules for meetings; inefficient communication tools and processes. Processes designed by people who don't use them; unclear lines of accountability, so it takes a long time to find the right people; no teams responsible for facilitating systems change.
Mental Models (Underlying values, assumptions, and beliefs)	We don't trust our employees to get the job done. "Face time" is more important than productivity. (These attitudes affect the company's policies and ultimately how it treats all employees, including those with small children.)	"Busy" is good. We reward people for "doing things right" vice "doing the right things". It takes too long to redesign processes and practices, so we use work-arounds. Meetings are the best/only way to coordinate and get things done.

Practice with an Example from Your Organization

Think of a problematic situation you're dealing with. Work your way down the iceberg in steps one through 4 below.

Dimension	Question	Response
1. Events	What events do you observe (what would a video camera see)?	
2. Patterns of Behavior	What patterns of thinking and behavior are happening (what would the camera see over time)?	
3. Systems Structure	What structures are in place that support the events and behaviors you observe, e.g., rules (tacit and explicit), policies, structures, etc.	
4. Mental Models	What mental models (values, assumptions, beliefs) underpin all of the above? What shift would make a big change?	

The
BRAVING INVENTORY

Boundaries | You respect my boundaries, and when you're not clear about what's okay and not okay, you ask. You're willing to say no.

Reliability | You do what you say you'll do. At work, this means staying aware of your competencies and limitations so you don't over promise and are able to deliver on commitments and balance competing priorities.

Accountability | You own your mistakes, apologize, and make amends.

Vault | You don't share information or experiences that are not yours to share. I need to know that my confidences are kept, and that you're not sharing with me any information about other people that should be confidential.

Integrity | You choose courage over comfort. You choose what is right over what is fun, fast, or easy. And you choose to practice your values rather than simply professing them.

Nonjudgment | I can ask for what I need, and you can ask for what you need. We can talk about how we feel without judgment.

Generosity | You extend the most generous interpretation possible to the intentions, words, and actions of others.

BRAVING Trust – Team Inventory

Take a few minutes to reflect on your journey to BRAVING Trust. How does your team show up on each of these dimensions? How often do you and others exhibit the qualities below? Please circle the number that best reflects where your team is now are now.

Remember, this is not about judging yourself or anyone else. The purpose of this exercise is to understand your current reality and to identify avenues for growth.

Boundaries: We respect each other's boundaries. When we're not clear about what's OK, we ask. We're willing to say no to each other.

(Rarely) 1 2 3 4 5 6 7 8 9 10 (Always

Reliability: We do what we say we'll do. At work this means staying aware of our competencies and limitations, so we don't over promise and are able to deliver on commitments and balance competing priorities.

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Daring Feedback

THE ENGAGED FEEDBACK CHECKLIST

I know that I'm ready to give feedback when ...

____ I'm ready to sit next to you rather than across from you.

____ I'm willing to put the problem in front of us rather than between us (or sliding it toward you).

____ I'm ready to listen, ask questions, and accept that I may not fully understand the issue.

____ I'm ready to acknowledge what you do well instead of picking apart your mistakes.

____ I recognize your strengths and how you can use them to address your challenges.

____ I can hold you accountable without shaming or blaming.

____ I am open to owning my part.

____ I can genuinely thank someone for their efforts rather than criticize them for their failings.

____ I can talk about how resolving these challenges will lead to growth and opportunity.

____ I can model the vulnerability and openness that I expect to see from you.

High Consequence Event Prevention Framework

Behaviors Lexicon

Looking Up

Reflexive Obedience - Taking action in accordance with an approved procedure or process without solid understanding of the procedure and its principles

Questioning Attitude – Anticipation of expected outcomes combined with alertness for indicators inconsistent with those outcomes, reinforced by sound technical knowledge of the principles and backed by a readiness to intercede when actual outcomes do not match expectations

Uncontrolled Nuclear Weapons Move: The officer checking an intended inert missile transfer shortcut the procedure and assumed that all missiles were inert after checking only one. He did not understand the surety principles and objectives that the procedure supported.

Reluctance to Question Authority - Blindly accepting guidance from leadership without making courageous pushback when it is necessary or appropriate

Forceful Back-Up - Providing pushback, underpinned with solid technical and principles-based insight, when it is evident that the leader does not understand the error in a decision or directed action

Greenville Collision: Crewmembers did not challenge incorrect actions by their Commanding Officer when surfacing the submarine. They were overawed by the Commanding Officer's aura of mastery and trusted his judgment over their own.

Sticking to Past Program Decisions - Being unwilling to spend the time and effort to question past assumptions or methodologies to ensure past decisions are correct for current circumstance

Considered Review of Past Decisions - Conducting reviews, reinforced by sound, current technical knowledge, when past decisions are revisited in new development efforts or when new knowledge becomes available that bears on a past decision

Fukushima Reactor Accidents: TEPCO stood by the original plant layout, despite warnings based on improved seismological understanding that the design basis for the installation was flawed.

Concealment of Dissension - Over-filtering of information provided up the organizational leadership chain that intentionally or unintentionally conceals disagreements, dissension or “split decisions” encountered during the development of a recommendation

Transparent Decision Support - Ensuring visibility by decision makers into split risk judgments, providing them an opportunity to “drill down” in order to better understand the details of risk as they reach a decision

Loss of Shuttle Challenger: Morton Thiokol engineers raised strong concerns about launching in a lower temperature than in any prior mission, but their concerns were not presented to the launch decision maker.

Looking Down

Insularity - Failure to solicit or provide information or advice outside the unit, generally under an assumption of self-sufficiency and without consideration of the value of information flow across unit boundaries. Lack of awareness of opportunities for improvement that may exist outside the unit.

Encouragement of Ideas and Criticisms - Encouraging the free flow of ideas, recommendations and criticisms up, across, and as appropriate, outside the organization

Target Drone Impact on Chancellorsville: Weapons test range controllers and briefers did not accurately communicate the risks presented by the exercise or disclose their ongoing problems with drone control, considering such issues to be internal matters of no concern to the ship.

Technical Arrogance - Being unwilling to be subject to the scrutiny of others or to welcome the inputs of others on the basis that they are not knowledgeable enough to offer any input that would be of value

Openness to Scrutiny and Education - Being open to scrutiny from within and outside the organization, as well as being willing to educate others regarding the basis for actions or decisions, on the premise that the more people know about how we operate, the better

Explosion and Sinking of Deepwater Horizon: The prime contractor chose, without explanation, to override or ignore a subcontractor’s or a subordinate’s expert advice regarding safety-related measures for the temporary disconnect at least seven separate times, believing the experts to be too conservative.

Looking Down

Not Invented Here - Being unwilling to fairly consider the ideas of others lower in the organization or outside the organization because of a perception that to do so could harm the reputation of the organization or make the work of the organization more difficult

Invitation for Benchmarking/Innovation - Being open to good ideas that have yielded success elsewhere and having faith in the quality of innovation when it is done by those who are closest to the problem

Highly Enriched Uranium Facility Security Breach at Y-12: The security contractor at Y-12 was evaluated as the best among the NNSA facilities (based on its own reporting) and was very well rewarded. Seeking improvements or identifying local shortfalls based on good practices at other NNSA sites would only hurt its bottom line.

Success Suffices - Believing that acceptable system output can lessen the need to understand anomalous system performance when desired system outputs prove achievable through workarounds or despite the anomaly

Interrogation of the Unexpected - Aggressively evaluating and solving anomalous system performance, establishing new knowledge and correcting issues before they combine to yield failure

Loss of Shuttle Columbia: Although not anticipated during shuttle development, foam strikes occurred on every launch. Risk of a damaging foam strike was downplayed and was not thoroughly investigated, in part because of the record of success in shuttle missions.

Culture of Production - Exhibiting excessive concern for completing a mission, task, or project without due regard for readiness, standards, or consideration of risks

Culture of Risk Evaluation - Accepting risk only with careful, deliberate evaluation and placing priority on risk management ahead of production schedules and budgetary efficiency

Deepwater Horizon: On the day of the explosion, the crew had two jobs: get the drill rig (a ship) ready to move to a new location, and successfully disconnect from the drilled well. Rapidly completing preparations for the move received priority attention due to concern for lost revenues. Although the disconnect carried great risk, it garnered too little of the operators' divided attention.

Tribal Knowledge - Relying on an ad hoc mix of procedure, oral history, and on-the-job training in conducting technical efforts

Integrated Technical Understanding - Promoting procedurally-based operations founded on system knowledge and thoughtful, technically sound understanding of expected system performance, ensuring any new methods are incorporated into approved procedures

Loss of B-2: Ground crews, operating in a challenging environment, developed an ad hoc routine for readying aircraft for missions. A new ground crew, unaware of the informal (but necessary) procedural change, inadvertently miscalibrated key speed and pressure sensors.

Passive Oversight - Assuming that subordinates know what to do and will do it without direct supervision or effective feedback (*laissez-faire*)

Vertical Knowledge and Engagement - Leadership understanding and engagement at all levels, across the full scope of the complete system operation for which they are responsible

Hurricane Katrina: Although federal, state and local officials were well aware of shortfalls in hurricane preparedness following a major exercise, leadership at every level failed to follow up to determine whether known gaps were being addressed. Hurricane preparedness for New Orleans became an administrative process lacking substance. When Katrina struck, responsible state and local officials were unprepared; supporting federal authorities were not ready to fill the gaps.

Looking Across

Surrender to Bureaucratic Process - Allowing established bureaucratic processes to replace technical and professional judgment with compliance practices that may not be suited to the circumstance

Embrace of Supportive, Thoughtful Process - Suppressing bureaucratic approaches that can degrade performance through unthinking compliance, augmenting them with process aligned to the circumstance

Y-12 Security Breach: Approved waivers allowed guards to physically monitor areas covered by inoperable cameras. With over sixty cameras out of commission, these waivers were still routinely approved despite the impracticality of the required level of physical monitoring with the existing guard force.

Looking Across

Informal or Stove-Piped Treatment of Risk - Unwillingness to be systematic about the treatment of risk across an organization, allowing poor risk evaluation, or imbalance in the level of risk taken in different aspects of the organization's system responsibilities

Formal, Systematic Risk Engagement - Engaging risk assessment objectively and consistently across the organization

Drone Impact on Chancellorsville: The test plan called for manual action to turn away the drone at 2,500 yards. If turn away failed, operators had six seconds, if everything and everyone operated perfectly, to recognize failure and act to prevent impact. Perfection was not achievable, nor was the necessary operation practiced. The substantial risk was not recognized or mitigated.

Groupism - Replacing technical merit with consensus or group dynamics (i.e. "voting") as a basis for determining a course of action

Transparency and Technical Rigor - Adhering to transparent decision-making processes with technical rigor and clearly-identified responsibility for decision-making

Fukushima Reactor Accidents: Before the earthquake, industry regulators and power company officials met routinely, but failed to reach any decisions about when and how to comply with recommendations for improving resilience against disaster. The group passively accepted a lack of action, deciding to do nothing while explicitly deferring any action decision to years in the future.

Absence of Accountability - Ineffectively assigning or enforcing clear organizational responsibilities

Unambiguous Execution of Accountability - Unambiguously assigning and acknowledging individual responsibility, authority and accountability for all levels and aspects of system ownership, and delivering reward or correction as appropriate

B-52 Air Show Rehearsal Crash: Wing and Operations Group Commanders failed to enforce accountability on a B-52 pilot known to be a "hotdog." Senior leaders did not hold the pilot accountable, even though he had violated flight regulations on at least six occasions prior to the air show rehearsal and his immediate commander had recommended he be grounded.

Focus on Inputs Vice Outputs - Tendency to monitor and measure "inputs" (e.g., hours worked, training attended, funding expected, bureaucratic boxes checked) rather than outputs (e.g., successful end-to-end testing, adequacy of integrated system performance)

Output-Based Evaluation - Evaluation of performance of the system is based on technically founded expectations for its integrated outputs as opposed to narrow, stove-piped, input observations

Deepwater Horizon: BP leaders commenced the well bottom cement job based on knowledge that the cement mixture had been submitted to Halliburton for testing (an input), though testing had not been completed. The cement job was declared successful based on the amount of cement pumped (an input) and drill mud displaced. Cement testing (completed after the explosion) showed that cure time needed to be increased to get a satisfactory plug.

Not My Problem - Unwillingness to think beyond the limits of individual or group responsibilities to consider how actions by the individual/group will affect the system outcomes over space and time

Broad System Ownership - Understanding of the integrated system activity, both spatially and temporally, and a willingness to speak up about problems in other areas outside or beyond an individual's immediate responsibilities to help ensure overall mission success

Hurricane Katrina: The Army Corps of Engineers built levees that should have been more effective against Hurricane Katrina than they actually proved to be. The Corps appropriately passed responsibility for maintenance of the installed levee system to local "levee boards," but failed to monitor and identify that some levees had fallen into disrepair. Despite their mission to reduce risk from disasters, the Corps failed to ensure levees they built were adequately maintained.

Disregard of Honest Appraisal - Being unwilling to engage in close self-examination or permit close internal examination by others out of a sense of vulnerability

Rigorous and Open Self-Appraisal - Facilitating self-examination as well as independent reviews, as necessary, to assure the earliest objective identification of opportunities for personal or organizational improvement

Nuclear Logistics Failure: As a result of base realignment and closure, logistics management of classified nuclear weapons components was transferred to a new organization and moved to a new location. Self-monitoring of the new organization was not performed, and managers failed to identify and correct process errors that led to classified Minuteman III parts being mislabeled as helicopter batteries and shipped to Taiwan.

Looking Within

Situational Values - Believing that an individual's rationalization of choice in one area of human legal, ethical or moral behavior is independent of that person's choices in other areas with legal, ethical or moral implications.

Universal Standards - Aligning to internally consistent boundaries in legal, moral, and ethical issues in all aspects of work and life

B-52 Air Show Rehearsal Crash: The pilot during the crash was the Wing Standardization Officer, responsible for enforcing flight standards for the full scope of the wing's flying operations, but he did not personally abide by the instructions that he regularly gave other airmen.

Misplaced Loyalties - Being willing to "look the other way" or to excuse poor performance or behavior from a member of a team in order to shield either the member or the team from the just consequences of such behavior

Loyalty to Core Values - Founded on ethically based priorities, unbiased evaluation and aligned action

Y-12 Security Breach: Security force supervisors facilitated sharing of proficiency exams and answers to promote high grades and allowed practice before small arms proficiency testing to improve measured readiness reporting, both of which factored into improved contract incentive payments.

I'm Above the Rules - Believing personal empowerment and value to the organization to be so great that special perks apply

Humility and Leadership by Example - Recognizing that the success of an organization depends on mutual trust and fairness based on equal attention to rules

Greenville Collision: The Commanding Officer disregarded standard operating procedures and his own standing orders; he directed or personally took action that deviated from guidance at multiple stages of the surfacing procedure, leading directly to the collision.

Who Am I to Judge? - Believing that assignment to a discrete role within the organization, limits responsibility and accountability for correct output within that defined sphere

Personal Courage - Persistently standing up for what is right and appropriate in operation of the complete organization, and challenging those who take shortcuts or incorrectly characterize the operation

Loss of Shuttle Challenger: Engineers did not feel a personal sense of responsibility to correct management's claims to the American public that the probability of a catastrophic shuttle failure was 1 in 100,000 when they judged the probability to be more like 1 in 100.

Others do it, Must be OK - Believing that because members of other organizations or groups are allowed to take advantage of the 'system,' without sanction, it is therefore OK for us to take similar advantage at (or a little beyond) their demonstrated violation

Public Trust Acceptance - Recognizing that standards and expectations for the workforce in a public or high risk technology exceed those of most organizations; it is not OK to emulate the incorrect example of others

Y-12 Security Breach: During the investigation, nearly all members of the contractor security force knew that supervisors had distributed the answers to the investigator's security force knowledge exam before it was administered. No one reported or objected to the cheating.

Unreasonable Demands - Imposing goals, requirements, or standards that are effectively unobtainable through legitimate means while applying undo pressure for success, stimulating subordinates to cross ethical boundaries to meet the requirements

Setting Realistic, Resourced Goals - Identifying the appropriate ways to resource goals and arranging the necessary means to achieve them

ICBM Crew Cheating: Leaders in the missile squadrons determined who would have opportunities for the choice jobs and promotions by the scores on the recurring monthly exams. Though the passing grade was 90%, perfection was required to advance, a practice that prompted the cheating.

Risk Aware Behavior	VS	Human Element Weakness

LOOKING UP	
Questioning attitude	*Reflexive obedience*
Forceful back-up	*Reluctance to question authority*
Considered review of past decisions	*Sticking to past program decisions*
Transparent decision support	*Concealment of dissension*

LOOKING DOWN	
Encouragement of ideas and criticisms	*Insularity*
Openness to scrutiny and education	*Technical arrogance*
Invitation for benchmarking/innovation	*Not invented here*
Interrogation of the unexpected	*Success suffices*
Culture of risk evaluation	*Culture of production*
Integrated technical understanding	*Tribal knowledge*
Vertical knowledge and engagement	*Passive oversight*

LOOKING ACROSS	
Embrace of supportive, thoughtful process	*Surrender to bureaucratic process*
Formal, systematic risk engagement	*Informal or stove-piped treatment of risk*
Transparency and technical rigor	*Groupism*
Unambiguous execution of accountability	*Absence of accountability*
Output based evaluation	*Focus on inputs vice outputs*
Broad system ownership	*Not my problem*
Rigorous and open self-appraisal	*Disregard of honest appraisal*

LOOKING WITHIN	
Universal standards	*Situational values*
Loyalty to core values	*Misplaced loyalties*
Humility and leadership by example	*I'm above the rules*
Personal courage	*Who am I to judge?*
Public trust acceptance	*Others do it, must be OK*
Setting realistic, resourced goals	*Unreasonable demands*

Principles of a Risk Aware Organization

Ownership
Leadership at all Levels

Empowerment
Responsibility, Authority, and Accountability

Mindfulness
Risk Aware Behaviors to Leverage Technical Strength

Assessment
Dynamic Risk Balance Between Safety & Production

Continuous Improvement
High Velocity Learning

As a Risk Aware Organization We Value…

Members who speak up, push back, and elevate risk issues if the approach is not right

Engaged supervisors who set the tone and standard for mindful behavior

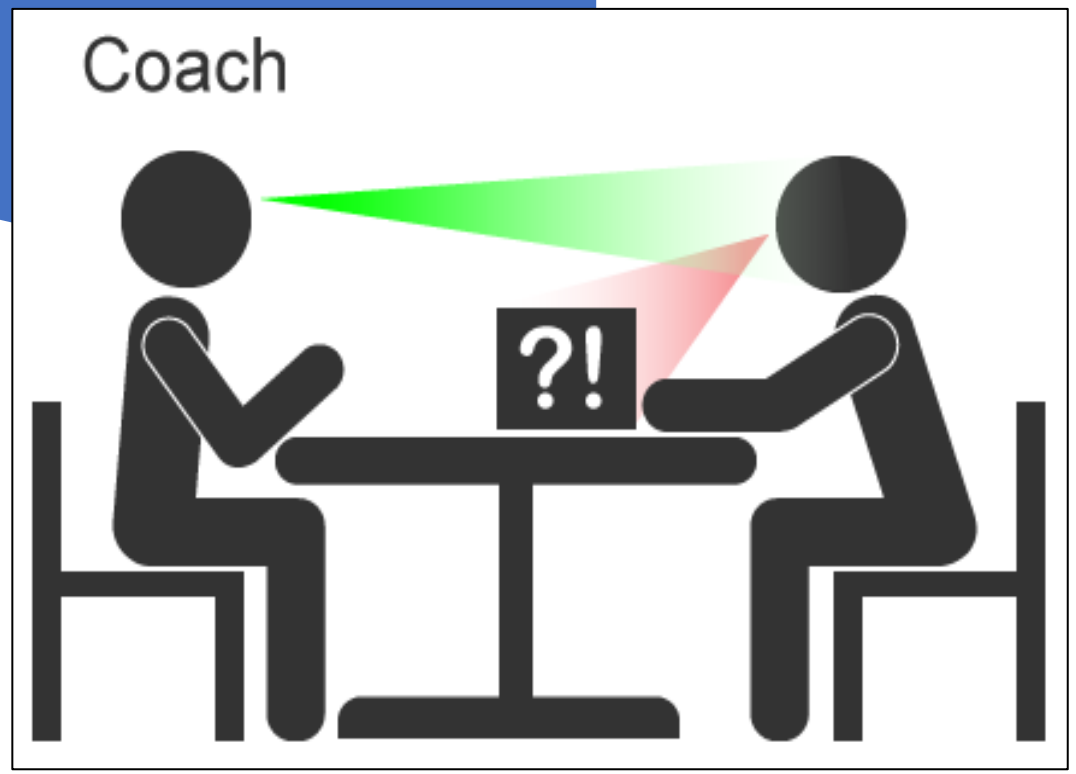
Co-workers ready to identify and resolve unnecessary risk, even outside of their team

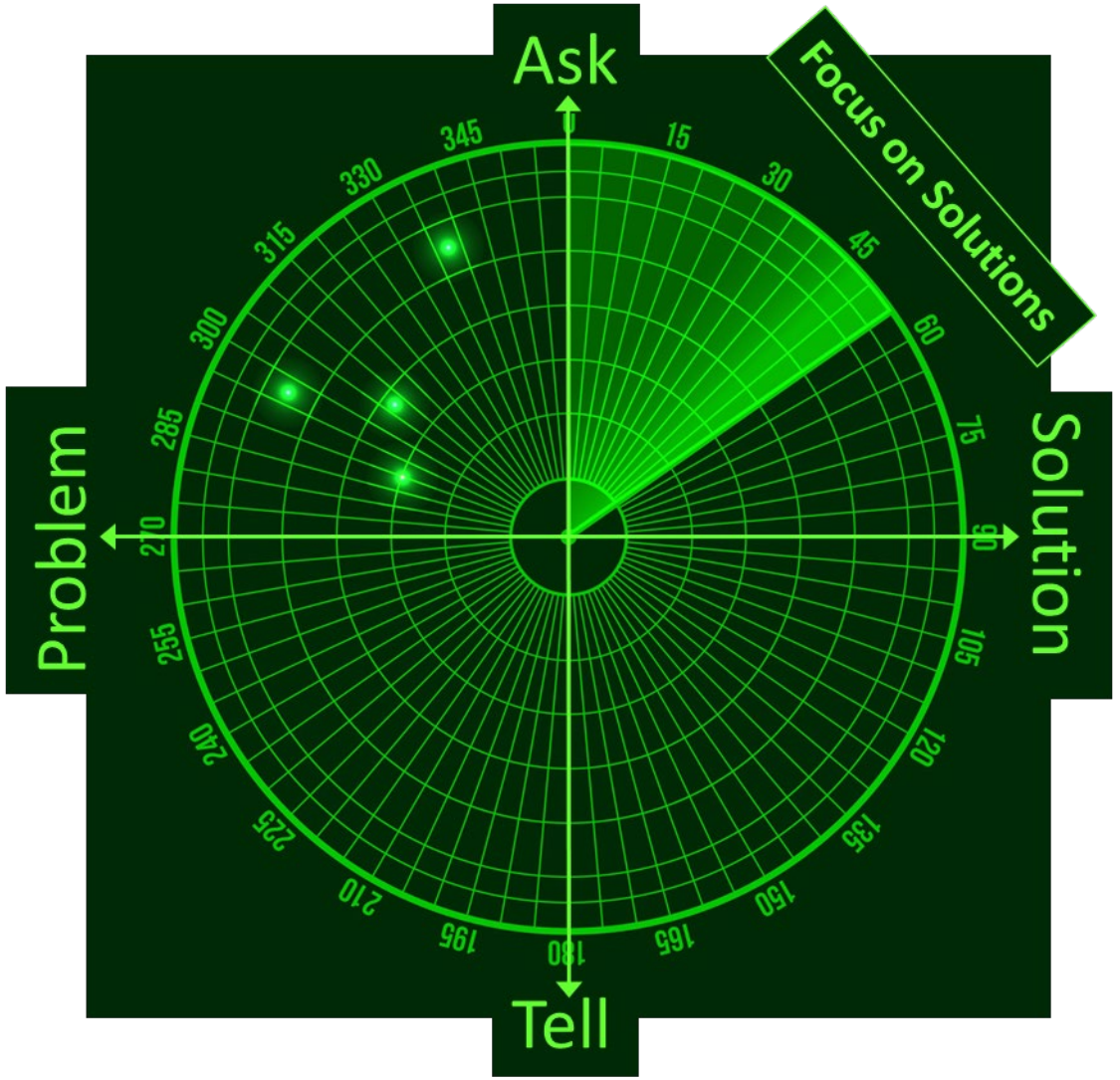
Individuals whose moral compass steers them, with integrity, to the right answer

WORKSHOP #2 - Leader as Coach

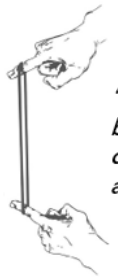
Time	Duration	Topic	
11:00	45 min	Coaching…What it is and what it isn't (30 min) Ask-Tell-Problem-Solution Coaching Practice	
1:00	45 min	Two Models for a Coaching Conversation: 3VQ and TGROW	
		WWF – Coaching Exercise and Debrief	
2:30	30 min	Coaching Competencies – Presence, Active Listening, Powerful Questioning	
	15 min	Neuroscience of Coaching…aka Why this coaching stuff is so challenging at first!	
3:30		Takeaways	
Field Work	90 min	Coaching Practice, One-on-One Coaching Exercise in Triads (20 min each) Coaches choice of using #VQ or TGROW. Due date: Sometime between Workshop 2 and Workshop 3	

Key Take-Away: Coaching – What It Is and Isn't





Key Take-Away: 3VQ or T-GROW: Frameworks For Coaching Conversations



"Creative tension" between your desired outcome and current reality

1. VISION

What would you love to create? What outcomes would you like to achieve?

3. ASSETS

What assets do you have that you might leverage to achieve your desired outcomes: people, professional opportunities, life experience, etc.?

5. FIRST STEPS

What "baby steps" will you take toward achieving your desired outcomes?

4. CHALLENGES

What challenges do you face, and how might you turn them into/reframe them as opportunities for learning and growth?

2. CURRENT REALITY

Where are you now in relation to your desired outcomes?

Adapted from *3 Vital Questions: Transforming Workplace Drama* by David Emerald and Donna Zajonc.

Key Take-Away: Coaching Presence

Fully conscious and present, employing a style that is open, flexible, grounded, and confident; ability to create a safe, supportive environment that produces ongoing mutual respect and trust.

- ❑ Remains focused, observant, empathetic, and responsive
- ❑ Demonstrates curiosity
- ❑ Manages one's own emotions to stay present
- ❑ Demonstrates confidence in working with others' strong emotions
- ❑ Is comfortable in a space of not knowing
- ❑ Creates or allows space for silence, pause, or reflection

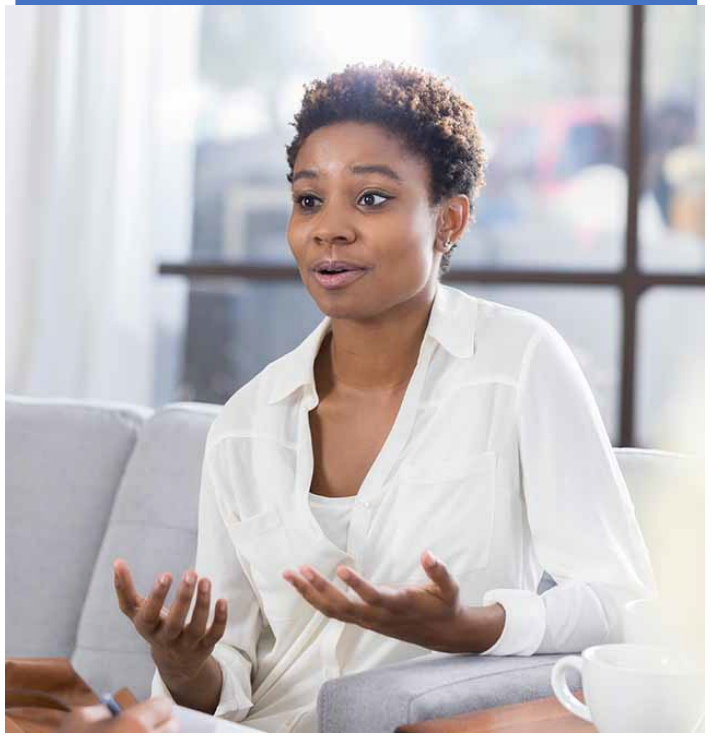
"Centering" along your three dimensions: Length, Width, Depth

Key Take-Away: Active Listening

Ability to focus completely on what the team/person is saying and is not saying, to understand the context and meaning of what is said

- Less than Active Listening: Listening to fix; refute or disagree; to your own thoughts; to get information you want; external distractions; get back to work; to make your own personal meaning out of this story, how you can benefit
- TIPS:
  - ❑ Set yourself up to listen
  - ❑ Ask, *"Who do I need to be in this conversation?"*
  - ❑ This person is "naturally creative and resourceful"
  - ❑ Center (…and clear) yourself; invite the others to center (…or clear)…be present
  - ❑ Increase your receptivity (e.g., soften your gaze, expand peripheral vision)
  - ❑ Notice your mind is wandering; recommit to active listening

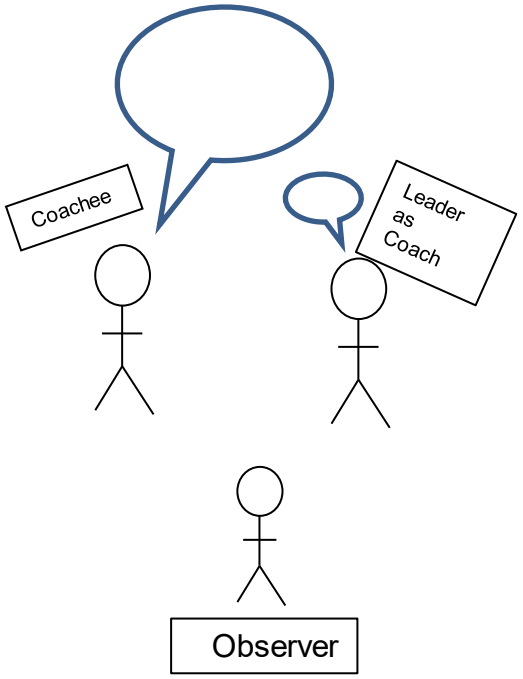
Key Take-Away: Powerful Questioning



- **Open-ended Questions:**
  - ❑ What, How, When, Who, Describe…
  - ❑ *"What might happen if…"*
  - ❑ *"In this situation, what would you do…?"*
  - ❑ *"How might you…?"*
  - ❑ *"What about…"*
- Less than Powerful Questions (aka Closed-ended, Yes/No): forms of the verb "to be" = is, are, was, will, have, would, should, could…
- Rhetorical (aka Fake) questions:
  - *"Have you thought about…?"*
  - *"Did you consider…?"*

Fieldwork: T-GROW or 3VQ Coaching Exercise

- Breakout rooms in triads.
- Take turns coaching for 20 min each using the T-GROW or 3VQ coaching model.
- Coachee states their Leadership Goal where they would like some coaching.
- Coach engage in a purposeful conversation (T-GROW or 3VQ) with the Coachee.
- Observers use Leader as Coach Observations sheet to record the coach's demonstration of T-GROW or 3VQ and coaching competencies.
- At end of 20 minutes, take ~5 min to QUICKLY debrief the conversation.
  - 1 Min – Coach how did it go for you? What went well? What would you do differently?
  - 1 Min – Client, how did it go for you? What feedback do you have for your coach?
  - 2 Min - Observers – share your Observation Sheet insights.
- ***Rotate*** roles so that each person serves in each role
- Debrief as a larger group @ Workshop #3.

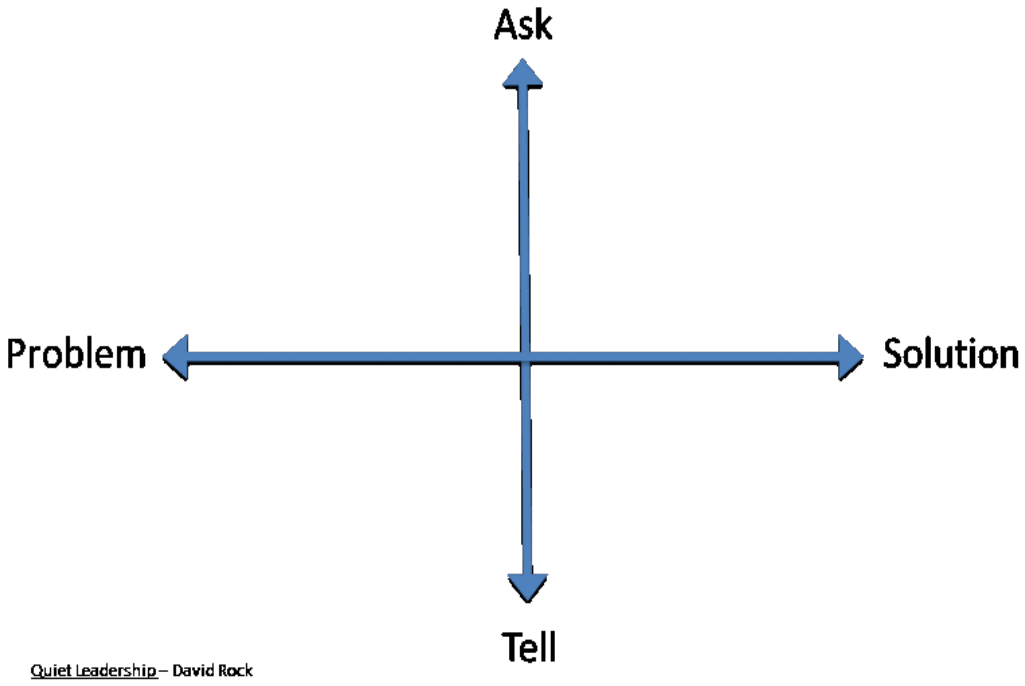


Leader as Coach Observations - TGROW

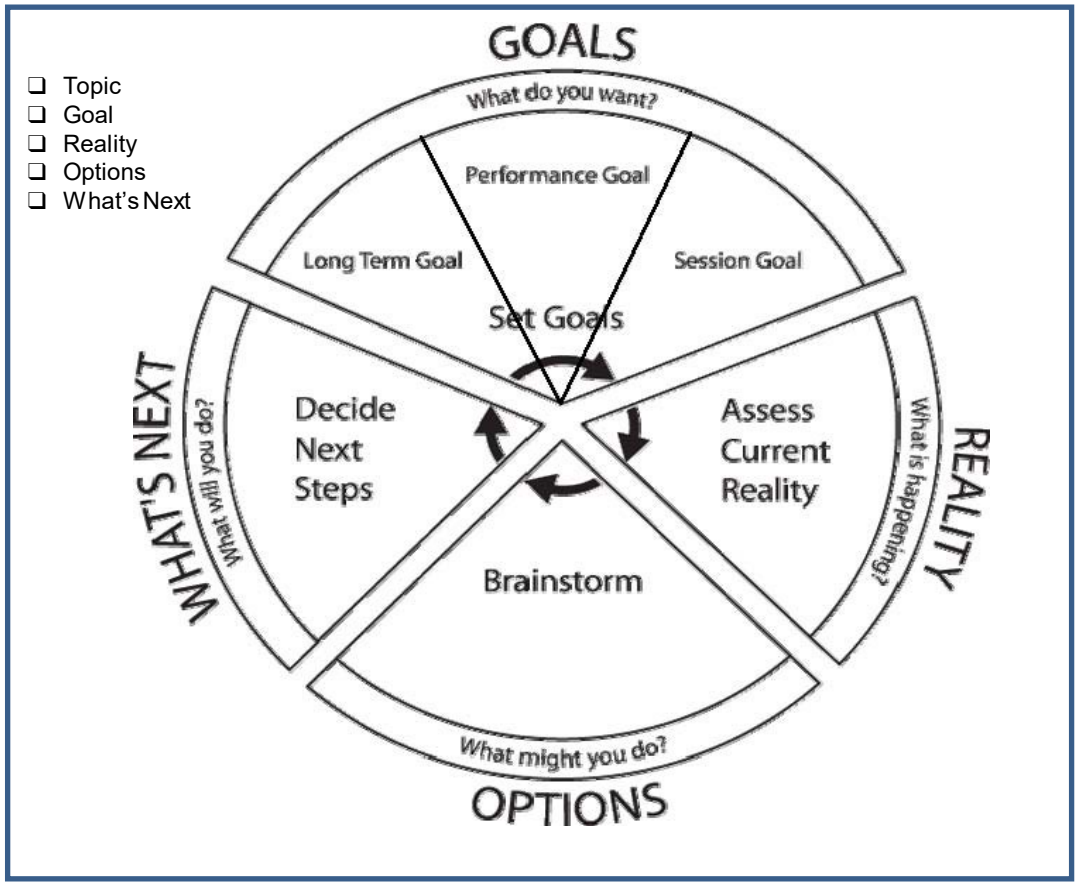
Coach: _____

Coachee: _____

Observer: _____



Quiet Leadership – David Rock



Who's doing the work? _____

❑ ***Deepen the Learning***

❑ ***Forward the Action***

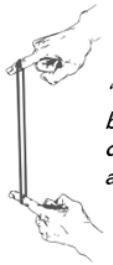
Source: Rock, D. (2007). *Quiet Leadership: Six Steps to Transforming Performance at Work* HarperCollins Publishers

Leader as Coach Observations – 3VQ

Coach: _____

Coachee: _____

Observer: _____



"Creative tension" between your desired outcome and current reality

1. VISION

What would you love to create? What outcomes would you like to achieve?

3. ASSETS

What assets do you have that you might leverage to achieve your desired outcomes: people, professional opportunities, life experience, etc.?

5. FIRST STEPS

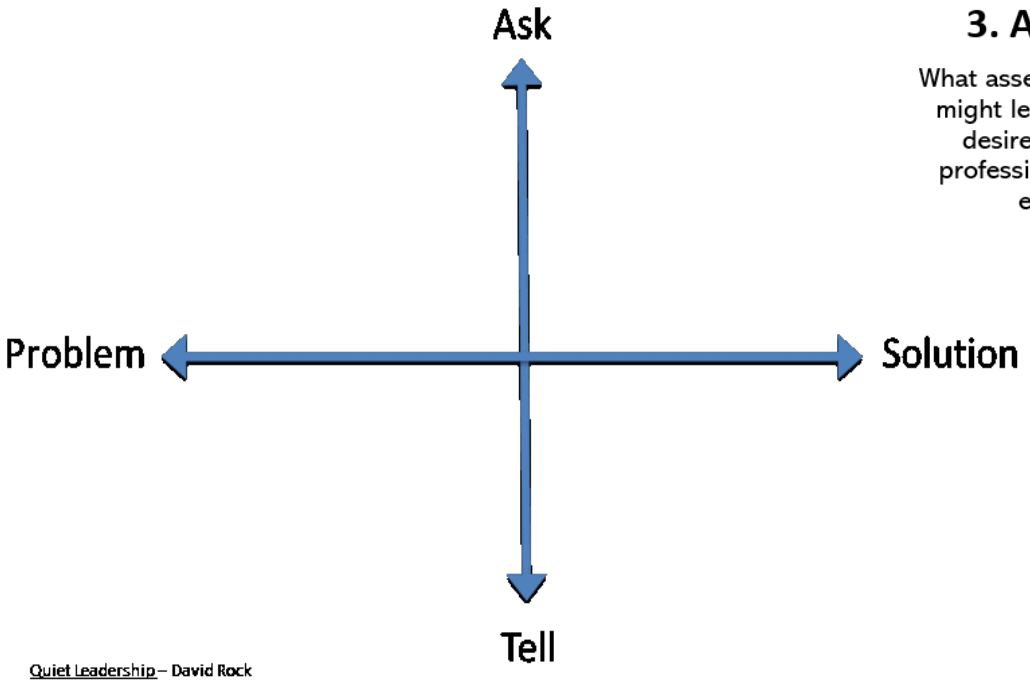
What "baby steps" will you take toward achieving your desired outcomes?

4. CHALLENGES

What challenges do you face, and how might you turn them into/reframe them as opportunities for learning and growth?

2. CURRENT REALITY

Where are you now in relation to your desired outcomes?



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