# MANAGEMENT AND LEADERSHIP IN TRAUMA SERVICES: A REFLECTION ON INDIVIDUAL AND ORGANIZATIONAL FACTORS

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**Abstract**

Over time, organizations that work with children, young people, and families in situations of social vulnerability, adversity and trauma have faced enormous challenges and demands. The evolution of evidence-based practices, in its most diverse disciplines and specific areas of knowledge, has constantly brought new tools to understand and intervene in social phenomena. It is this development that allows professionals who work daily for the well-being of people and communities to progressively improve their ability to face the challenges and demands that teams and organizations face.

This chapter, which seeks to integrate theoretical concepts and practical knowledge, reflects on aspects related to professionals, teams, organizations, management, and leadership, in the sense of a more qualified intervention in line with people's needs. that they serve. From the definition and framing of social and human organizations that work to protect children and youth, on the one hand; and adversity, trauma, and its consequences for people who experience it directly or indirectly, on the other; we present a set of reflections around individual and organizational factors.

**Keywords:** management; leadership; trauma; stress and anxiety; organizational climate; power; authority; autonomy.

**Authors Note:** On occasion, in this chapter and for the sake of economy, we use the masculine gender when the feminine or a non-binary term could also be used.

## Individual and Organizational Stress

Social and human organizations that operate and intervene with at-risk children, young people, and families, deal daily with people in situations of social vulnerability and with life paths marked by exposure to adversity and trauma. The concept of trauma has been approached over time by different authors[1], and since the original study on adverse childhood experiences, conducted by the Center for Disease Control and Prevention and the Kaiser Permanente (CDC-Kaiser ACE Study) and published (Felitti, et al., 1998), much has been researched in the field. It is a complex concept and for that reason, it has had different interpretations and formulations. In this chapter, we assume the formulation of Ungar and Perry (2012), who define trauma as an extreme experience that "overwhelms and alters the individual's stress-related physiological systems in a way that results in functional compromise" (p.125).

[1] We suggest reading Winnicott (1965), Freud (2006), Perry and Szalavitz (2017), Van der Kolk (2015), Porges (2017), Dana (2018), and Treisman (2021).

In organizations that intervene in trauma, the situations with which professionals and teams deal are of children, young people, and families[2] with more or less precocious, more or less continuous histories of adversity and relational trauma, associated with insufficiently good parenting practices, negligent and/or abusive. These disrupt children's feelings and needs for safety and belonging and are associated with low overall levels of health and adjustment difficulties throughout their lives (National Center for Injury Prevention and Control, 2021).

Adverse childhood experiences and trauma influence attachment patterns, and individuation-separation processes and, in a general and transversal way, are linked to the way children (later adults) relate to others (Delhaye et al., 2012). Secure attachment relationships are the strongest protective factor against trauma, so it is not surprising that trauma and attachment are strongly related to each other (Van der Kolk, 1994; Perry, 2016).

In turn, professionals in social organizations are relationship and communication professionals, that is, professionals who use relationships and communication as fundamental and essential tools in the daily performance of their tasks and duties. Moreover, they deliver themselves in the relationship with the others they serve (Zosky, 2010 in Bolić, 2019), providing them with the appropriate and necessary care according to the diagnosis, to promote their rehabilitation, empowerment and/or social reintegration.

Work is extremely challenging and demanding when performed with rigor and quality, and professionals and the organization itself can begin to mirror stress-related responses that children and families develop to deal with trauma (Bloom, 2005; Kezelman & Stavropoulos, 2012). An organization that is in a state of anxiety will contribute to the anxiety of the people who are part of it. At the same time, people's stress and anxiety will also have an impact on the organization's emotional climate. As pointed out by Glisson and Green (2011), professionals involved in child and family protection respond to a variety of problems that arise daily in the provision of their services, while at the same time having to remain attentive to the unique needs of each child, the bureaucratic imperatives of the existing legislation and regulations, and the establishment of trusting relationships with a group of children and families that are very different from each other. Tasks are carried out in highly stressful situations that may involve angry families, emotionally disturbed children, and aggressive and demanding social partners and magistrates.

Intervening daily with children and families in situations of vulnerability and trauma, who are often unwitting clients of professionals, teams, and services – as they have not requested the psychosocial intervention offered to them themselves – has potential consequences. Burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress stand out among these consequences (Bloom, 2003; Bolić, 2019; Figley, 1995).

**Professional Wear and Tear Phenomena**

Burnout is a well-known and widely used term, which seems to have already become part of a common lexicon of professionals linked to human resources management in

[2] To assist the reader, throughout this chapter we do not use the word "young person" and refer to "children" to mean anyone under 18 years of age. Whenever we refer to "children" or "families" we are referring to children and young people, and families, in contexts of social vulnerability, adversity and trauma.

particular, and even of civil society in general. First appearing in the 1970s in articles published by Freudenberger (1974, 1975) and Maslach (1976), burnout designates a phenomenon that occurs as a consequence of work and is characterized by emotional exhaustion and loss of motivation and commitment. It is a term currently considered generic, used to describe situations that can occur with any professional, in any organizational context, and that is related to factors as diverse as personal fulfillment, professional satisfaction, workload, remuneration, supervision and training opportunities, social support, interpersonal relationships in the workplace, ethical dilemmas, recognition and participation in decision-making, job security and stability, and level of responsibility (Melo et al., 1999).

Secondary traumatic stress, compassion fatigue and vicarious trauma designate specific phenomena to which relationship and communication professionals may be more vulnerable, due to the nature of the activity they carry out – particularly those who are responsible for ensuring the well-being of others. These are phenomena that can also occur in informal and family caregiving relationships (Thorson-Olesen et al., 2019).

Caregivers of children or the elderly, psychologists, social workers, nurses, and doctors, among others, are some examples of professionals who care for people who are or have been exposed to traumatic situations and it is common for them to experience traumatization as a result of their professional activity. They may witness or be directly involved in adversity situations, or simply know of their existence without direct involvement. The effect of this exposure, experience and/or knowledge can lead to compassion fatigue. This is a very specific form of burnout (Ainsworth & Sgorbini, 2010) which, according to Figley (1995), appears as an undesired, although natural, predictable, and preventable and treatable consequence of working with people in distress.

Specifically, in the field of residential care for children and young people, the results found by Audin and colleagues (2018) reinforce that compassion fatigue harms the well-being of professionals and is associated with turnover, absenteeism, low motivation, and low morale, as well as difficulties in decision making, poor professional performance and low quality of care – regardless of years of service. On the contrary, compassion satisfaction and work engagement – opposites of compassion fatigue and burnout, respectively – proved to be important protective factors.

According to Maslach and Leiter (1997 in Bakker et al., 2014), engagement is characterized by energy, involvement, and effectiveness, that is, direct opposites of the three dimensions of burnout (exhaustion, depersonalization, and lack of personal fulfilment). In burnout situations, energy turns into exhaustion, engagement into cynicism, and effectiveness into inefficiency.

In an important literature review, Bakker and colleagues (2014) indicate that burnout seems to be caused mainly by high professional demands. Low engagement, in turn, is due to the lack of professional resources available. Individual characteristics such as personality and personal resources are also related to burnout and engagement, although in the opposite way: although both are associated with professional outcomes, burnout is mainly associated with health-related outcomes of professionals and engagement with results related to their motivation.

According to Bloom (2003), vicarious trauma refers to the cumulative and transformative effect of third-party trauma on the professional, because he works continuously and over time with people who have survived profoundly adverse and traumatic experiences. Common signs and symptoms in these professionals are: difficulty managing emotions; fatigue, drowsiness or changes in sleep patterns; pain, malaise and low immunity; easy distraction; hopelessness and loss of meaning in life; relational problems; feelings of vulnerability or excessive concern for the well-being of loved ones; irritability and changes in mood and behavior; destructive or addictive coping strategies; decreased participation in recreational activities that were usually pleasurable; avoidance of work and the relationship with clients; a combination of symptoms compatible with a diagnosis of Post-Traumatic Stress Disorder (Office for Victims of Crime, 2022).

Finally, secondary traumatic stress is the common phenomenon through which professionals are indirectly traumatized because of developing supportive relationships, both in an institutional context (Hatcher et al., 2011) and in the natural environment (Bride, 2007). Unlike vicarious trauma, this type of stress can occur immediately after exposure to a traumatic situation that is occurring or has occurred. Knowledge of an event can cause trauma even if a person is not present. (Saakvitne & Pearlman, 1996 in Bolić, 2019). It can be caused by the severity of the situation and/or a trigger, such as association with a past personal experience (Bloom, 2003).

Additional data suggest that professionals who establish helping relationships (notably psychotherapists) tend to focus exclusively on their client's needs and ignore signs and symptoms associated with these phenomena in themselves, as well as some resistance to seeking help (Figley, 2002). We, therefore, consider that the challenges and requirements related to the intervention with people who are victims of adverse experiences and trauma, reinforce the importance of the organizations providing support mechanisms and support to their professionals. That is, if the professional activity is in itself a promoter of stress and anxiety, this could mean that the containment of this same anxiety will be a condition to promote the well-being of professionals and, consequently, the quality of their practices. In this sense, the results found by Glisson and Green (2011) show that professionals in the field of child and family protection who work in organizations with more positive and engaging climates are more likely to be able to deal with the daily challenges and demands, as well as in achieving better results.

**Interpersonal relationships, anxiety, organizational climate, and outcomes**

In helping relationships within the scope of psychosocial intervention, we believe that in a very particular way in the relationships of providing care to involuntary clients, transference, countertransference, projection, projective identification, and splitting mechanisms are constantly present and at play. These mechanisms concern non-conscious processes but are extremely influential in the relational dynamics between the professional and the people with whom he intervenes[3]. We understand that a professional must recognize their existence and influence in the relationship and communication they establish with other people, as well as learn to manage them in an effective, non-reactive and therapeutic way – recognizing the attachment styles of individuals, evidencing cultural humility and respect by differences, and ensuring

[3] For more information on these psychodynamic concepts associated with the childcare relationship, we suggest reading Barton and colleagues (2012).

therapeutic presence, as ways to create a therapeutic alliance with their clients (Grad, 2022).

Maintaining the ability to think and act constructively can be especially difficult when working with traumatized people (Tomlinson, 2005), as in this field, in both residential and community settings, it is necessary to constantly deal with uncertainty, confusion, complexity, doubt, and the anxiety that comes from carrying out the task of caring for others (Balbernie, 1974; Whitwell, 2010).

Professionals can feel deep sadness, despair, and hopelessness at not being able to help others and make a significant difference in their lives. They may feel overwhelmed by these same feelings and even, given the difficulty of managing them internally, show hostility towards children and families for whom they have technical and ethical responsibilities. They may, on the other hand, externalize their guilt to teammates or to other levels of their organization, which will harm interpersonal relationships and the quality of work (Mawson, 2019).

Studies conducted in the field of neuroscience in recent years have helped to understand more clearly the conditions that trigger stress reactions in individuals. They have also contributed to understanding how feelings of security or insecurity impact people's well-being and their ability to function effectively and adaptively. For example, Porges and the Polyvagal Theory (2017) mention how the environment can trigger stress responses, especially in people who have experienced traumatic situations. On the other hand, it is widely recognized that professionals, in any occupation, will perform more effectively if they feel psychologically safe (Edmondson, 2019; Clark, 2020; Kim et al., 2020). Thus, if psychological safety is vital in any setting to achieve positive outcomes, we can perhaps infer that it is likely to be even more so in psychosocial work, as clients are fundamentally insecure children and families. It is our understanding that their insecurities can only be addressed and contained if the intervention is carried out within a safe context and in a safe relationship, by professionals who are themselves properly safe, contained, and supported in their doubts, uncertainties, and anxieties, by their teams and organizations.

Teams sometimes develop defenses to deal with the painful realities they encounter daily and thus try to manage their uncertainties and anxieties. Depending on the specific contexts in which they operate, the specific functions they perform and the way they organize their work, different teams develop different strategies, as the sources of their anxiety are different (Menzies Lyth, 1959; Obholzer, 1987). Indeed, high levels of uncertainty and anxiety tend to generate more reactive and primitive behaviors (Trist & Murray, 1997 in Lawlor & Sher, 2022), so we consider it most important that teams seek strategies to promote positive emotional climates in organizations, recognizing the need to contain the anxiety of their professionals. However, as stated by Mawson (2019), the change in the climate alone does not, and should not, result in the extinction of anxiety:

> The shift in emotional climate does not, however, result in freedom from anxiety. Instead, our fears of what others are doing to us are replaced by a fear of what we have done to others. This is the basis of genuine concern, but guilt and facing one’s insufficiency are painful to bear. If these anxieties are not contained – and we therefore cannot bear them – there is likely to be

a return to more primitive defenses, to the detriment of our work and mental health. (p. 87)

But in organizations dealing with trauma, stress and anxiety can also play a role. They are by nature stressful and anxiogenic contexts. Recognizing this can pave the way for professionals to be tolerant of their doubts, uncertainties and even ignorance, thus ensuring that the work always proceeds in a critical and reflective manner (Rollinson, 2012).

Silva et al (2022a, 2022b), when analyzing the context of residential care for children, found a relationship between the organizational social climate (measured through the analysis of factors such as involvement, positive attitudes towards work, hierarchy, and stress) and the quality of care. On the one hand, the engagement of professionals and their positive attitudes towards work, as well as the existence of a clear and structured organizational hierarchy, emerged associated with better organizational social climates. On the other hand, and perhaps in a less linear or even expected way, stress did too. Similarly, to results found in other investigations, in the specific context studied, high levels of stress may reflect positive characteristics of professionals, such as engagement, commitment, concern for their role and functions, and awareness of the importance of providing quality care to children. The organizational social climate was thus found to promote the quality of the relationship between professionals and children, which, in turn, promoted children's behavioral adjustment (Silva et al., 2022a) and school results (Silva et al., 2022b).

As mentioned by Magalhães et al. (2021), the professionals' ability to establish quality therapeutic relationships with children in residential care, for example, results from individual as well as organizational factors (e.g., organizational social context). Aspects related to organizational management (e.g., processes and procedures, work organization, communication flows, leadership, among others) may then emerge as important to consider for the support of professionals and teams (Menzies Lyth, 1979), as well as for changing the social contexts of organizations that work with children and families, and achieve positive results (Williams & Glisson, 2014).

## Organizational Management and Leadership

Intervention within the scope of the Promotion and Protection System needs to be highly specialized, so the teams must be composed of qualified and trained professionals. All intervention methods and methodologies must be framed and supported by evidence from studies and scientific research (Daly et al., 2018; Whittaker et al., 2016), and the practices of the services themselves, promote professional and organizational development. Learning organizations are those in which professionals strive for better results, think creatively about managing the impact of organizational dynamics, have common aspirations and goals, and learn collectively as a team (Senge, 1990). Among several factors that seem to contribute to the success of organizations that deal with adversity and trauma, we consider there are four particularly relevant: therapeutic model, reflective and collaborative practices, support, and leadership. Next, we explore each of them.

## Therapeutic Model

A therapeutic model is a method for intervening with human suffering, intending to achieve results associated with the promotion of well-being. The term has been

increasingly used to designate the well-considered and coherent way of providing a service. Although the concept is not new, it seems to have somehow replaced other terms previously used, such as framing, philosophy, and approach, among others. We consider important requirements of a therapeutic model to be: i) knowledge and understanding of client's needs; ii) clarity on the methods and interventions used to meet these needs; iii) evidence regarding the adequacy and effectiveness of these methods and interventions; iv) rigorous and reliable evaluation of the results obtained (Tomlinson, 2021a).

We also consider that there are four levels to consider when implementing, developing, and evaluating a therapeutic model so that results can be achieved in: 1) direct intervention with children and families; 2) the management and leadership processes in the organization; 3) the culture of each context; and 4) the organization's relationship with the social partners (Tomlinson, 2021b).

Since psychosocial intervention with at-risk children and families is carried out as a team, therapeutic, that is, transformative, action depends on the concerted action of all professionals. According to Leichtman and Leichtman (2003), in individual therapeutic contexts (e.g., psychotherapy, medical follow-up), the process is usually *centripetal*, because what matters is the dyadic relationship between therapist and patient. Everything converges to that relationship and even sometimes important for the clinician to protect the consultation space from external stimuli and biases. In different contexts of psychosocial intervention (e.g., residential care homes for children, intervention with families in the community), on the contrary, therapeutic processes are *centrifugal*. This is because the therapeutic agent is not an individual professional, but a group of professionals: the team.

In our view, this centrifugal nature of therapeutic processes reinforces the need for a shared model from which and for which professionals work. Without a therapeutic model, a service could become fragmented, inconsistent, confusing, and potentially conflicting. This would be extremely detrimental in intervening with traumatized people, as fragmentation, inconsistency and conflict are characteristics and dynamics found in contexts where trauma occurs. On the contrary, children and families need consistency and predictability on the part of caregivers, professionals, and teams for the course of their therapeutic processes (Szalavitz & Perry, 2010).

The consistency and coherence of the intervention require the existence of a therapeutic model, written and well-known by all professionals in the organization, in which the principles and strategies of action are established clearly.

Portugal, like the rest of the world, is constantly changing. Its numerous social institutions, although some of the oldest are already secular, are also changing – even if at a pace that can sometimes be considered too slow when compared to the velocity of social changes to which they need to respond. In our country, social organizations play a fundamental role, and their action is necessary to guarantee support to populations, especially the neediest. Most of them are linked to the State (central or local) or the Church. In some cases, they may even be linked to both. Notwithstanding its need to exist, the greater or lesser stability of its connections and its sustainability, in its inevitable processes of adaptation and updating, each organization must define what

differentiates it from others, clarifying its mission, vision and values[4]. In addition, we consider it extremely important to have clarity about the primary task.

The term primary task was introduced by the Tavistock Institute of Human Relations as a concept very close to the concept of mission and applied to different types of for-profit and non-profit organizations. It has been widely used in organizations that work with at-risk children, and perhaps, particularly in those that provide services in residential care. One of the definitions of primary task that, in our opinion, remains more current is that of Menzies Lyth (1979):

> […] the task which the enterprise must perform in order to survive […]. Quite simply, unless the members of the institution know what it is they are supposed to be doing, there is little hope of their doing it effectively and getting adequate psychosocial satisfactions from this. Lack of such definition is likely to lead to personal confusion in members of the institution, to interpersonal and intergroup conflict and to other undesirable institutional phenomena[5] […]. (p. 222-223)

The primary task then designates what the organization needs to do above and beyond everything else, hence the importance of its rigorous and precise definition. In addition, permanent attention and vigilance are needed so that organizations, teams, and professionals remain 'on task'. This requires the avoidance of tendencies that are constant in the emergence of 'anti-task' behaviors and dynamics – a phenomenon that occurs mainly when the task is not clear to everyone, or when it is defined inappropriately or unrealistically (Menzies Lyth, 1979; Barton et al., 2012).

In short, we believe that the organization's success regarding the implementation of its therapeutic model will depend on a) the clarity that the organization, its teams, and professionals possess regarding its mission and primary task; b) the discipline with which they work to achieve their vision; and c) the consistency with which they own their values and principles and incorporate them into their intervention.

**Reflective and Collaborative Practices**

Child protection and intervention with abusive families is a work of great and increasing complexity, not compatible with linear perspectives or approaches to the social problem of child abuse (Hassett & Stevens, 2014). In our view, it requires continuous investment in professional development through different qualification tools: frequency of training in areas relevant to the functions (Bunting et al., 2019; Lenz et al., 2022); self-training through reflective reading and writing (Bolton, 2010; Bailey & Rehman, 2022); and attendance of supervision and consulting groups (Giddings et al., 2008; Caras & Sandu, 2014). We also believe that, given the demands and challenges associated with psychosocial intervention in trauma services, professional development can also benefit greatly from personal development tools, such as psychotherapy or other forms of therapeutic accompaniment (Mackey & Mackey, 1994; Pincus et al., 2022).

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[4] For more information on mission, vision, and values, we suggest reading Mirvis and colleagues (2010).

[5] These phenomena can include low staff morale, absenteeism, turnover, mirroring organizational confusion on the part of children and families through aggressive or inappropriate behavior, among others (Macleod, 2010).

Notwithstanding the importance and need for each professional to assume their responsibilities and actively seek these and other development tools, we believe that the organizations themselves can also make them available to their teams. Or, in the impossibility of making them available directly, they may find ways to support their attendance by professionals, granting them the hours for this purpose and/or sharing the associated costs.

It is also our understanding that all operations performed, and all relationships established in the organization need to be in tune with the therapeutic task. As such, all professionals, from administration to caregivers, including all those who intervene directly and indirectly with children and families (e.g., human resources, finance, maintenance, marketing, and fundraising, among others), must understand the complexity of the primary task and support the work of teams within their specific areas of activity and responsibility (Barton et al., 2012). The dimension of sharing and collaboration is of great relevance in psychosocial intervention, mainly in the field of childcare: collaboration between professionals from the same team, between professionals from different teams from the same organization, between professionals from different organizations, and between professionals and the children and families with whom they work (Willumsen, 2006).

Alongside collaboration and as a way of promoting and sustaining it, we consider it essential that there are open and transparent communication flows in the teams and that this occurs in a clear, respectful, and responsible way among all. Therefore, team meetings should be frequent and all professionals who work directly with children and families should participate. We believe that it is in the time and space of the meeting and with respect for its limits, that professionals should communicate with each other and discuss solutions to act on the diagnosed problems. It is also in this time and space that they will be able to reflect on themselves and on the impact that work has on them as individuals and as a collective. The weaknesses and the conflicts inherent to teamwork can thus function as potentially strengthening and constructive elements, rather than potentially destructive ones (Janzing, 1991).

We believe that the combination of these factors can provide the conditions for professionals to develop ownership of all relevant information about the children and families with whom they work. The decision-making processes can then be carried out in a shared way among all, and the practices can be collaborative, prevailing effectively cooperative and democratic work dynamics.

According to Audin (2018), professionals who find meaning in their work tend to experience more compassion satisfaction and, as such, organizations should encourage reflective practices in their teams, to deepen the knowledge they have about children and families with who they intervene and remain aware of their reason for existing and the value of the work they develop with them.

**Support And Development**

As has been mentioned throughout this chapter, intervention with children and families in situations of social vulnerability and with paths marked by adversity and trauma is a work that involves great demands and challenges. These occur on a technical level, and emotional level – with emotions being central to work in these contexts (Roberts, 2019). In addition to the challenges directly presented by children and families, other factors

significantly contribute to the demands of the profession: the possible experiences and traumatic experiences of the professionals themselves; its framework of values, principles, and expectations; their coping strategies; the support provided by the organization; the structures and systems of the organization and/or the institution of which it is part (Barton et al., 2012).

Awareness of these difficulties and demands can and should lead to empathy and the implementation of support strategies associated with the already widely recognized concept of the importance of "caring for the caregiver". Results found by Assouline and Attar-Schwartz (2020) reinforce the importance of all professionals being properly supported in the work they carry out, as they daily deal with highly complex and stressful situations.

In line with Friedman (2007), we believe, however, that empathy should not override responsibility and that an important way of providing support to teams and promoting the professional development of its elements is through the definition and concentration on their tasks and responsibilities. According to Menzies Lyth (1979), this promotes their feeling of self-efficacy and job satisfaction, protecting them from the anxiety, guilt and depression that can come from insufficiently or inadequately task-oriented work.

Bearing in mind that professionals are subject to aggressive behavior (latent and explicit) on the part of children and families, it is common to find in teams and organizations a concern to keep the climate free of conflicts. It seems to us that this concern is sometimes associated, on the one hand, with difficulties in reconciling reality with previously constructed perceptions and representations, idealized about what the professional helping relationship is in these contexts. On the other hand, in recognizing and integrating the relationship between the dimensions of power, authority and autonomy, which are expressed in a very particular way in working with traumatized populations (Obholzer, 2019).

As mentioned above, the work demands naturally lead to the emergence of defenses in people. As a result, in frequent conflict situations, there seems to be a tendency among professionals towards defensive mechanisms such as avoidance and intellectualization, and among children and families towards more confrontational and omnipotent mechanisms. In the words of Menzies Lyth (1985):

> It seems a fault in many children's institutions that they do not handle authority effectively. There may be too much permissiveness, people being allowed or encouraged to follow their own bent with insufficient accountability, guidance, or discipline. If this does not work (and frequently it does not, leading to excessive acting out by both staff and children) it may be replaced in time by an excessively rigid and punitive regime. Both are detrimental to child development. The 'superego' of the institution needs to be authoritative and responsible, though not authoritarian; firm and kindly, but not sloppily permissive. (p. 242)

The confusion made between autonomy and permissiveness on the one hand, or between power and authoritarianism on the other, may lead to the adoption of inappropriate, ineffective and/or incoherent practices concerning the defined primary task and the responsibilities and competencies distributed among the team.

The leader plays a key role in integrating these aspects of power, authority, and autonomy (Obholzer, 2019), as well as supporting professionals, promoting their development, and building the team's work dynamics. According to Lencioni (2002), the leader must support professionals so that they develop trust in each other and know how to constructively conflict with one another. This will be necessary for them to be able to commit to the decisions taken together and to be accountable for the tasks and competencies that are assigned to them. Only then, will they be able to pay attention to the results and effectively achieve them.

The leader also plays a crucial role in building strong and positive organizational climates and cultures. Based on an investigation conducted in the context of a child mental health service, Green and colleagues (2014) state exactly that (transformational) leadership is associated with the organizational climate, and this, in turn, with the alliance established between professionals and children. That is, leaders capable of inspiring and motivating their teams to follow an ideal or a specific course of action, manage to promote organizational environments characterized by a perception of justice, growth and evolution, and clarity of roles. The positive organizational climate, in turn, provides the necessary conditions for professionals to develop positive alliance relationships with clients.

We believe that inverted organograms (that place the leader at the bottom of the organizational pyramid, in contrast to more conservative conceptualizations, in which the hierarchical superior is seen as the one who dictates orders and commands operations[6]), represent what is most important in social organizations, particularly those that deal with adversity and trauma: support. The leader who is usually represented hierarchically above all others, is actually the one who can support, guarantee the consistency and coherence of the team's practices, and promote the development of professionals.

**Leadership**

The leader is the one who is responsible for maintaining the vision of the organization while containing the anxiety involved in the work and allowing the team to overcome obstacles and challenges. It is beneficial that, in all their leadership roles, leaders have a high level of emotional intelligence, seeking to constantly learn and improve through their practices (Goleman, 1995). Furthermore, the leader needs to have a calm and non-anxious presence within the organization, shaping and regulating emotional intelligence and psychological safety (Friedman, 2007; Tomlinson, 2021c). We believe that this requires the leader to perform reflectively, as this way should influence the functioning of the team and the organization. The cohesion of reflective and collaborative intervention will be greater if it takes place around a therapeutic model, which will imply providing reliable support and guidance to all team members, as well as providing the necessary conditions for each professional to remain focused on the primary task and in the full assumption of their responsibilities.

Leadership is a complex and demanding task that requires the leader's ability to operate simultaneously at different levels. It also requires self-awareness and agility to move between those levels, as the volatility of social reality is high and priorities change

[6] For more information on inverted organograms, and organizational integration and disintegration, we suggest reading Tomlinson (2020).

frequently, and strategies need to be continually adjusted (Ward, 2014). However, more than action, it is the constant presence of the leader with the team at all times of organizational life that tends to calm the anxiety of professionals and provide them with the feeling of security necessary for the responsible exercise of their roles (Friedman, 2007).

Organizing and prioritizing the intervention, influencing, motivating, and guiding professionals and, at the same time, managing the emotional atmosphere of the team, is, in our opinion, a task that is as essential as it is gratifying and exhausting. Among the various existing analogies or metaphors to qualify a leader and approaches to the role of leadership, Friedman (2007) seems particularly suitable for the type of organizations analyzed in this chapter: "… the leader is the organization's immune system" (p. 182). Indeed, considering the toxicity of these contexts, the leader has an irreplaceable role in maintaining the health of individuals and the system of relationships and communication established between them.

In our understanding, effectiveness in managing the health of others by the leader, individually and collectively, requires a set of personal and professional attributes, as well as self-care. It is necessary to recognize that transferential and counter-transferential mechanisms, as well as the development of more or less mature or primitive defense mechanisms, also occur with the leader himself (Ward, 2014). As part of the organization and as with all professionals, the leader's performance can also benefit from access to guidance and support. Only in this way will he/she be able to maintain balance in the complex set of tasks that belong exclusively to him/her and provide *good enough leadership* (Rollinson, 2012).

A 'good enough' leader needs *full enough authority* (Obholzer, 2019) to use his power responsibly and make autonomous decisions. In this empowered way, it will be possible to promote the autonomy of professionals and teams. Autonomous professionals (free/responsible), who themselves hold power and authority, will in turn be able to promote the autonomy of the children and families with whom they work, recognizing their power and authority to make responsible decisions about their own lives.

According to Ward (2014), professionals tend to maintain a certain relationship of dependence on the leader: they rely on him/her for advice and guidance regarding decision-making processes, procedures, and intervention practices, as well as for the construction of shared senses of vision and mission, which will make it possible to fulfil goals and achieve results. We, therefore, consider it important to support professionals continuously and consistently, encouraging them to fully assume their responsibilities, autonomously and authoritatively.

Just as the processes of empowerment of children require individuation and separation, so do the processes of empowerment of professionals. Consequently, and from a systemic perspective, each organization, each team, and each professional needs their own space, not invaded, for individuation, separation, and differentiation (Friedman, 2007). This space will allow each one to assume their specific responsibilities, without overlapping on the part of others, and add value to the intervention of the collective, being the leader who establishes and maintains the limits – inside, outside and around the organization (Ward, 2014).

As Van der Kolk et al. (1996) emphasize,

> Since interpersonal trauma tends to occur in contexts in which the rules are unclear, under circumstances that are secret, and in conditions where issues of responsibility are often murky, issues of rules, boundaries, contracts, and mutual responsibilities need to be clearly specified and adhered to (Kluft, 1990; Herman, 1992). Failure to attend strictly to these issues is likely to result in a recreation of aspects of the trauma itself in the therapeutic situation.

**Conclusion**

Professionals and teams that work with at-risk children and families, protecting them and promoting their rights, are confronted daily with highly complex social situations. The work involves major challenges, and the sustainability of quality practices requires organizations to provide an integrated set of resources, solutions, and forms of support. Throughout this chapter, we have presented a set of reflections that we consider important for the qualification of the intervention and for the possibility of achieving and maintaining practices of excellence in social and human organizations that intervene in adversity and trauma. We believe that it is based on the integrated analysis of elements related to individual factors (children, families, and professionals), community (communities, territories), organizational and institutional (teams, intervention models, governance, leadership), as well as the dynamics established between all of them, that it becomes feasible to find consensual and sustainable answers to deal with the complex profile of needs of children and families.

Organizations dealing with trauma must pay close attention to their boundaries, how agreements are established, the clarity of the roles, functions, tasks and responsibilities of their professionals, and how the intervention is carried out; they must contain the anxiety of professionals and clients, and work according to a therapeutic model in which mission, vision, values, primary task, and specific intervention methodologies are affirmed; finally, they must recognize the importance of adopting effective management and leadership practices to carry out the therapeutic, transformative work they develop with the children and families they serve.

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