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Informal Leadership as Distributed Task Orchestration in Addiction Services

Barbara Menara

Abstract

Purpose: This ethnographic study explored the orchestration of tasks by informal leaders in multidisciplinary addiction services in Northern Italy. This explains how informal leaders establish, share, and challenge authority based on their credibility. This is achieved by mobilizing situated expertise, influencing interactions, and adapting relationships within dual leadership settings. This study is situated within the relational leadership theory, which examines how influence emerges through everyday interactions rather than formal roles.

Methodology: This research adopted a seven-month ethnography combining participant observation of twenty-two clinical meetings, semi-structured interviews across four services, and a reflexive diary.

Findings: Three microprocesses structured informal leadership: First, actors seek situated expertise using ‘credibility tracing’ (identifying who holds relevant knowledge) and ‘coordination artifacts’, such as documentation and meetings. This allowed experienced peers to shape their understanding of the case outside the formal hierarchy. Second, influence in interaction occurs through rule setting, silences, and consensus, accelerating coordination and imposing costs through voice suppression and an informal hierarchy. Third, relational adjustments and shifts between interpersonal warmth and professional distance supported emotional resilience, while structuring expectations and voice safety, particularly under dual leadership where formal and informal authority coexist.

Originality: This study advances relational leadership theory by detailing how credibility-based authority is assembled and travels via interactional pathways in multidisciplinary healthcare. Informal leadership is framed as an ambivalent distributed task orchestration, revealing how boundary work, interactional risk, and relational adjustment shape collaboration in resource-pressured addictive services settings.

Keywords: Informal Leadership; Relational Leadership; Credibility Based Authority; Influence in Interaction; Interprofessional Collaboration.

Introduction

Multidisciplinary addiction services operate under persistent uncertainty, emotional strain, and resource scarcity. Professionals are required to integrate medical, psychological, and social interventions while managing chronic patient trajectories, relapse risks, and institutional pressures for efficiency and accountability. In such settings, coordination cannot rely solely on formal hierarchies or standardized procedures; instead, it is accomplished through everyday interactions, informal routines, and the situated judgment of experienced professionals (Menara, 2025). Thus, informal influence plays a critical role in shaping how multidisciplinary work unfolds in practice, particularly in settings where professional logics collide and formal authority alone is insufficient to sustain coordination.

Relational leadership research has been especially influential in directing attention to these dynamics by conceptualizing leadership as an emergent, interactional, and relational accomplishment rather than a function of individual roles (Uhl-Bien, 2006; Denis *et al.*, 2012). Ethnographic and practice-based studies in healthcare have shown that leadership emerges through communication patterns, collaborative routines, and everyday boundary negotiations rather than through formal leadership positions (Morrill and Fine, 1997; Pope, 2005; Uhl-Bien and Ospina, 2012; Gordon *et al.*, 2016; Verhoeven *et al.*, 2023).

However, while relational and shared leadership perspectives have sensitized scholars to the collective and interactional nature of leadership, they provide limited guidance for understanding how informal influence becomes consequential in practice. In particular, we still know relatively little about how credibility comes to concentrate authority, how some interpretations gain traction over others, and how coordination is accomplished under conditions in which participation may entail relational risk. This gap is especially salient in multidisciplinary healthcare settings characterized by dual leadership arrangements, where formal authority coexists with powerful informal influence.

Medical sociology has long shown how healthcare teams negotiate boundaries, construct shared meanings, and manage everyday work across occupational differences (Reeves and

Lewin, 2004; DiBenigno and Kellogg, 2014). However, even within this literature, the micro-level interactional processes through which informal authority is assembled and exercised remain unspecified.

This study addresses this gap by examining how informal leadership operates in Italian public addiction services. By focusing on everyday interactions, documentation practices, routines, and relational adjustments, this study seeks to advance relational leadership theory by specifying the microprocesses through which informal leadership enables coordination and reshapes participation in multidisciplinary clinical work.

Theoretical contribution

This study contributes to relational leadership theory by identifying three interactional microprocesses—credibility-based authority, influence-in-interaction, and relational stance calibration—that explain how leadership is enacted and negotiated in multidisciplinary clinical work. While existing relational and shared leadership scholarship emphasizes interdependence, this analysis introduces interactional risk and informal hierarchy as central dynamics that shape how influence travels. The findings theorize that informal leadership is an ambivalent form of distributed task orchestration that simultaneously enables coordination and constrains voice, thereby extending relational leadership beyond collaborative ideals to its tensions and boundaries. This study offers an ethnographically grounded account of how leadership emerges through everyday boundary work by foregrounding the roles of documentation, silence, micro-rituals and credibility tracing. This advances relational leadership theory by providing a fine-grained, practice-based explanation of how formal and informal authorities are co-produced in healthcare settings.

This study breaks leadership down into three core microprocesses. Each process illuminates a distinct facet of how credibility-based authority is established and challenged in everyday multidisciplinary interactions: (1) seeking and mobilizing situated expertise to construct case understanding; (2) enacting and responding to influence in interaction through reframing, alignment, silence, and rule setting; and (3) adjusting relational orientations (from interpersonal warmth to professional distance) to sustain collaboration under dual leadership (i.e., where formal and informal leaders coexist). It extends existing theories by demonstrating how boundary work, interactional risk, and informal hierarchy shape leadership enactment in multidisciplinary care settings. Thus, this study moves relational leadership beyond the macro

descriptions of interdependence to interactional pathways through which influence becomes consequential in practice.

Research Aim and Objectives

Grounded in this theoretical framework, this study aimed to systematically unpack the micro-level practices underpinning informal leadership and boundary spanning in addiction care teams.

Overall aim. To explain how informal leadership orchestrates distributed tasks in multidisciplinary addiction services, particularly by mobilizing situated expertise, influencing interactions, and adjusting relationships.

Objective 1: Identify and analyze the micropractices through which actors seek, recognize, and mobilize situated expertise to assemble case understanding and coordinate action beyond formal role authority.

Objective 2: Examine how influence is enacted, aligned with, resisted, or silenced in interactions, and to specify the conditions under which credibility-based authority is successfully mobilized or resisted.

Objective 3: Explain how professionals calibrate relational orientations (from interpersonal warmth to professional distance) to sustain pace, standards, and resilience in dual leadership settings and how these calibrations shape boundary work, voice safety, and task orchestration.

Leadership as Relational Accomplishment

This study defines leadership as relationally accomplished, emerging through interactions rather than residing in individuals. Based on this conceptual foundation, empirical research in healthcare settings has revealed how leadership emerges dynamically through daily interactions and collaborative practices (Uhl-Bien and Ospina, 2012; Maritsa *et al.*, 2022). Expanding on these insights, Verhoeven *et al.* (2023) examined how relational leadership manifests in hospital environments. They demonstrated that collaboration depends on knowing and relating, and that leaders enact leadership through communication patterns, not merely through formal roles. Subsequent research has also highlighted the critical role of board-level communication, showing how leadership is shaped by professional identities and collaborative relationships (Verhoeven *et al.*, 2024). Studies on shared and dual leadership, alongside work

on boundary practices in healthcare, show that coordination and direction are co-produced by both formal and informal leaders (Adams-Robinson, 2021; Sweeney, 2024). Building on these contributions, this study elucidates the microprocesses informal leaders use to leverage expertise and foster cross-professional collaboration in clinical decision making.

Ethnographic insights on informal leadership

The relational view of leadership informs ethnographic methods, which have increasingly illuminated how leadership is enacted in healthcare organizations' daily operations (Morrill and Alan Fine, 1997; Pope, 2005; Goodson and Vassar, 2011). Expanding on these insights, recent studies have highlighted the growing importance of informal leadership, illustrating how professionals actively negotiate leadership roles through formal and informal interactions (Cupit *et al.*, 2018). These negotiations involve not only interacting with people but also engaging with materials such as documentation, artifacts, and organizational routines, all of which shape the leadership dynamics (Gordon *et al.*, 2016). Individuals without official titles but with professional expertise, interpersonal credibility, or extensive social networks often play crucial roles in an organization's functioning (Rowan *et al.*, 2022). Such informal leadership roles become particularly critical in interprofessional settings, where the integration of diverse professional perspectives is essential for effective teamwork (Weiss *et al.*, 2023). Informal leaders routinely engage in boundary-spanning by navigating professional differences, facilitating cross-disciplinary communication, and bridging organizational divides to support patient care (Chreim *et al.*, 2013). These boundary-spanning functions are especially vital in addiction services, where aligning medical, psychological, and social approaches is necessary for comprehensive patient care.

Limits of relational and shared leadership accounts

Relational and shared leadership perspectives have productively redirected scholarly attention away from hierarchical authority and individual leaders toward leadership as an emergent, interactional, and collective accomplishment grounded in relationships rather than roles (Uhl-Bien, 2006). By foregrounding interdependence, mutual influence, and collaborative sensemaking, these approaches have offered an important corrective to leader-centric models, particularly in complex and professionally pluralistic settings.

Nevertheless, this literature remains limited in its ability to account for how influence becomes uneven, stabilized, and consequential in everyday practices. While relational accounts

acknowledge plurality and tension, they tend to assume that influence remains fluid, revisable, and broadly accessible to all (Denis *et al.*, 2012). Consequently, they offer limited conceptual tools for explaining how informal authority becomes anchored around particular actors, how credibility is translated into de facto decision rights, and how collective coordination can persist even in the absence of symmetrical participation.

Existing theories provide insufficient analytical detail on the interactional mechanisms through which authority is legitimized and insulated from challenge over time. They rarely specify how certain interpretations gain dominance, how participation becomes relationally risky, or how coordination may be sustained through selective engagement rather than open deliberation.

Therefore, what is missing is an interactionally grounded account of how informal leadership simultaneously enables coordination and constrains participation. Without specifying the microprocesses through which credibility is assembled, authority is enacted, and interactional risk is navigated, relational leadership remains analytically optimistic and insufficiently attentive to the ambivalent and exclusionary dynamics of everyday organization.

This study addresses this gap by theorizing informal leadership as *distributed task orchestration* enacted through three interrelated microprocesses: credibility tracing, influence-in-interaction, and relational stance calibration. By foregrounding interactional risk, informal hierarchy, and boundary work, the analysis re-specifies relational leadership as an ambivalent practice through which coordination is accelerated while the space for voice is selectively shaped. This study extends relational leadership beyond descriptive accounts of interdependence toward a practice-based explanation of how influence becomes consequential in multidisciplinary work.

Challenges and Ambivalences of Informal Leadership

Informal leadership, which is significant for its enabling functions, is inherently ambivalent, posing both benefits and challenges that extend beyond individual informal leaders and affect team dynamics and organizational performance (Gordon *et al.*, 2016). Informal leaders may experience reduced job satisfaction, particularly when they do not receive adequate support or recognition from their formal leadership structures. This lack of support, manifested as limited resources, unclear expectations, or insufficient acknowledgment, can diminish informal leaders' motivation and engagement (Chiu *et al.*, 2021), impeding their capacity to effectively orchestrate the distribution of tasks (Sweeney, 2024). Furthermore, the disconnect between

informal leaders and formal leadership structures may create tension or confusion regarding decision-making processes and authority, further complicating organizational dynamics (Pielstick, 2000). Given these complexities, healthcare organizations must find ways to better integrate and support informal leadership within their existing structures.

Informal Leadership within Relational Approaches

Relational perspectives emphasize that leadership effectiveness arises from the capacity to build, sustain, and mobilize social connections (Carter *et al.*, 2015). This relational perspective helps explain why informal leadership exemplifies influence grounded in relational authority rather than formal authority (Oedzes *et al.*, 2019). Informal leaders navigate social networks, employ interpersonal skills, and strategically use verbal behavior to construct a leadership identity over time (Carnabuci *et al.*, 2018). Such processes illustrate the fluid and context-dependent nature of influence in contemporary organizations (Curşeu *et al.*, 2025). Gerpott *et al.* (2019) argued that informal leadership emerges through interaction, highlighting its adaptive nature in groups. Adaptability is especially critical in fields such as addiction services, where multidisciplinary collaboration relies on ongoing negotiations across professional boundaries. By examining how formal and emergent leaders shape team dynamics, this study offers key insights into the functioning of addiction treatment teams and the quality of patient care.

Research Methods

Viewing knowledge as co-constructed (Madden, 2022), this ethnographic study examined leadership not as a static attribute but as a relational process that emerges from interactions, routines, and situated practices. Therefore, it employed an ethnographic design combining participant observation and semi-structured interviews to capture how leadership was enacted and negotiated in the everyday lives of Italian public addiction services. This section introduces the research setting, ethnographic approach, researcher positioning, data collection phases, and analytical strategy, including reflexivity and ethical considerations.

Research Setting

This research was conducted in addiction services in Northern Italy, which are characterized by multidisciplinary teams with professional expertise. Physicians handled the medical aspects of treatment, psychologists provided counselling, social workers addressed socioeconomic

factors, nurses offered care, and administrative staff ensured service operation. Physicians typically hold formal leadership roles and oversee clinical governance and administration. However, frontline professionals collaboratively performed daily work under formal and emergent informal leaders, highlighting team leadership. The services offered medical, psychological, and social interventions for complex addiction-related needs of the patients. Patient care was coordinated through microteams of physicians, nurses, social workers, and psychologists who met weekly to review cases, monitor progress, and plan interventions to ensure collaborative treatment.

Addiction services are key to examining informal leadership because they combine task interdependence, uncertainty, and demands. Outcomes are rarely linear, professional logics clash, and formal authority cannot stabilize decision-making. These conditions heighten the reliance on informal credibility, experiential judgment, and interactional alignment, revealing how informal authority emerges and becomes consequential. Thus, addiction services are a case for examining relational leadership under dual leadership and constrained coordination.

Ethnographic Approach and Researcher Positioning

This study employed participant observation and semi-structured interviews with the participants. Following ethnographic principles, the researcher entered the field as a participant observer, adopting a perspective that illuminated the practices, routines, and interactions through which collaborative work emerged (Spradley, 2016). The researcher's dual role as a consultant and social worker provides deep insight into the organizational culture and how professionals interpret practices and dynamics. However, this dual positioning method requires careful consideration of the following factors.

A reflective diary was maintained throughout the seven months of fieldwork (June 2017 to January 2018). To ensure reflexivity and rigor, immediately after each team meeting and interview, the researcher recorded analytic impressions, possible biases, and moments in which their personal background or professional identity might have shaped the interactions. This practice is consistent with established ethnographic methodology (e.g., Guest *et al.*, 2012; Spradley, 2016). Weekly reviews of the reflective diary and periodic peer debriefs with a qualitative method colleague were used to question and refine the emerging interpretations. These reflective practices reveal significant nuances in the data. Initially, the researcher, as a social worker, interpreted interactions such as silence or informal boundary work as signs of

agreement or collegial ease. However, reflexive diary work and peer debriefing later revealed these moments as instances of relational caution and subtle influence, refining the early interpretations of team dynamics. Another example is when moments of humor observed during coffee breaks indicate subtle forms of identity-building rather than mere sociability. Furthermore, peer debriefing sessions challenged initial assumptions about the authority of formal leaders, and through discussions, it became clear that informal leaders often enacted influence through boundary work practices that were less visible during the initial data collection. Consequently, this analysis was strengthened by considering alternative data perspectives. This iterative process highlights the complex and ambivalent nature of everyday interactions.

Data Collection

The data were generated in two complementary phases, which together provided a multilayered view of leadership dynamics across the four addiction services. The participant observation phase consisted of attending 22 weekly clinical meetings over seven months. Each meeting lasted approximately two hours and involved discussions of patient cases, sharing updates, and negotiating treatment plans. Detailed field notes documented verbal exchanges and nonverbal cues (silence, body language, emotional tone), capturing the interactional dynamics through which leadership emerged momentarily.

To broaden the scope and gather individual perspectives that might not be evident through observation alone, 28 semi-structured interviews were conducted in four public addiction services in Northern Italy. Participants were selected using purposive sampling (Saunders *et al.*, 2015) to ensure representation across professional roles and varying levels of observed informal influence, including those identified as key informal leaders during participant observation and those less central to informal networks. The participants included seven physicians, eight nurses, six social workers, and seven psychologists. The interviews lasted between 60 and 90 minutes and explored perceptions of inter-professional collaboration, leadership practices, team functioning, and organizational tensions.

Before data collection, the researcher secured ethical approval from the appropriate authorities for each participating service and informed all professionals of the study's objectives. Confidentiality and anonymity were maintained, with fictional names used.

Data Analysis

A multi-cycle inductive analytical strategy was used to guide the analyses. First-cycle coding initially adhered closely to the participants' words and field notes, documenting actions, interactional cues, and experiences. These initial codes were subsequently compared and refined into second-order data-near themes, which reflected broader relational patterns such as seeking situated expertise, alignment work, mutual support, and relational risk. Building on this, the final analytic step integrated these themes into higher-level interpretive dimensions, offering an explanation of how informal leadership emerged as distributed task orchestration. Throughout this process, the analysis unfolded iteratively through constant comparison, memo writing, and reflexive reviews, ensuring rigor and depth (Guest *et al.*, 2012).

The reflective diary played a critical role in challenging early interpretations and surfacing alternative explanations, thereby enhancing analytical distinctiveness. For instance, preliminary themes were discarded for being too thin, redundant, or merged when cross-data comparisons revealed coherent patterned practices, such as combining trust in experienced colleagues, credible knowledge of how-to, and requests for advice to seek situated expertise. In contrast, behaviors such as silence, conflict avoidance, and boundary setting were clustered under relational risk and voice suppression, highlighting the complexity of interpersonal dynamics in the workplace.

To illustrate the analytic pathway and demonstrate how each interpretive claim was grounded in empirical material, the Results section presents short vignettes along with data structure tables I, II, and III in the Appendix.

Results

This ethnographic study revealed how organizational work in Italian public addiction services was shaped by the interplay between felt needs and coordination within the system, dynamics significantly influenced by dual leadership, and relational approaches to work. These organizational patterns emerged in practice through dynamic elements such as conversation, small rituals, documentation, alignment, and moments of silence. These elements collectively shape the daily conduct of the casework.

The following subsections elaborate on these dynamics through field-based vignettes and the professionals' own words. The results illustrate how formal and informal leaders coordinate tasks, how team needs influence the direction of organizational work, and how relational approaches foster a collaborative environment. Each subsection was anchored in a data

structure table, offering a grounded interpretation closely linked to the raw material (see Appendix).

Mobilising Situated Expertise to Assemble Case Understanding

This subsection examines how credibility-based authority is constituted through everyday practices of seeking and mobilizing expertise. This microprocess extends relational leadership by showing that expertise does not merely circulate but is actively traced and stabilized through informal routines, creating early asymmetries in influence prior to collective deliberation.

To better understand how informal leadership orchestrates work, it is important to consider how experiential needs influence professionals' interactions and their help-seeking behaviors. These needs, particularly the strong desire for recognition, shape individual motivations. They also influence the broader workplace culture surrounding addiction, fostering trust and collaboration. The desire for recognition was consistently expressed across different roles, highlighting its significance in maintaining morale and commitment to the job. For instance, a psychologist articulated this sentiment by stating, '*We deserve respect and credit for what we do*', underscoring the need for acknowledgment of their work. Similarly, a nurse pointed out that while patients rarely express gratitude, '*at least a well done from colleagues would be nice*', emphasizing peer recognition. Another illustrative perspective came from a social worker who further elaborated on these experiential needs and their impact on workplace climate:

'We spend so much time working with patients, we do not just administer medications, we do so much more, we talk to them, we help them to get on their feet again, find a job, we support them for months [...] it would be nice to hear a well done, or just a recognition of our abilities and our hard work in front of the other colleagues, instead I feel like other colleagues (from other professions) just think my work is easy and does not require much skills just common sense, which is frustrating sometimes'.

The desire for recognition stemming from these experiential conditions fosters a relational substrate. Staff consistently turned to colleagues perceived as credible, trustworthy, or experienced, irrespective of the formal hierarchy. For instance, a nurse noted, '*When in doubt, I just ask a colleague, someone I can trust*'. Similarly, a social worker observed, '*You work well with people who know what they are doing*', and a psychologist added, '*If you need advice, you go to the person with experience, not necessarily the line manager*'. This reliance on

demonstrated expertise, often cultivated in response to underlying needs, forms the basis for mobilizing situated expertise by informal leaders. For example, a social worker recounted:

'When Carlo (physician and formal leader) was off for a couple of weeks, we managed anyway, we did what we always do, and asked Elena (social worker and informal leader) for directions if we were in doubt'.

Social and material practices supported the ongoing production and circulation of situated expertise that enabled the teams to create a shared understanding, even without formal direction. Central to this process, staff relied on documentation and weekly meetings as coordination artifacts: *'Everything we do has to be documented'* and *'That's why we meet every week, to share information'*, as one physician noted, that helped to stabilize knowledge across time and role rotation. This process highlighted that expertise was not merely assigned but was actively constructed through ongoing interactions. These daily interactions, particularly informal routines such as coffee breaks, played a crucial role in fostering connections and providing emotional support to staff. Such small social moments were vital to alleviate stress and enhance teamwork. When these routines were disrupted, individuals tended to feel more isolated, complicating collaboration. Thus, preserving these social rituals was essential to maintaining the shared knowledge and coordination necessary for addiction-related work. Collectively, these practices served as the initial cornerstone of distributed task orchestration, thereby laying the groundwork for the influence that subsequently travels in meetings. Understanding this microprocess was crucial for informal leadership. It demonstrated how authority based on credibility developed as individuals sought and shared their daily expertise. Through this dynamic, certain individuals naturally assumed the role of de facto coordinators, whose judgements subtly shaped case understanding, long before formal influence was exerted. This microprocess thus demonstrated boundary work in action, as staff selectively recognized credible experts across occupational lines, relied on coordination artifacts such as documentation and meetings to stabilize cross-professional knowledge, and utilized informal rituals to soften or reinforce the boundaries that shaped whose expertise became actionable in practice.

Enacting and Responding to Influence-in-Interaction

Building on relational leadership's emphasis on influence as an interactional accomplishment, this subsection examines how authority travels from moment to moment through

conversational moves, pauses, and alignment cues, revealing how influence in addiction services is enacted through subtle yet consequential interactional practices, rather than overt acts of leadership. This microprocess challenges the assumption that shared influence necessarily enhances voice by showing how alignment is often secured through silence, hesitation, and self-restraint.

A nurse's observation, *'If we have to look at who can make a difference around here, then I would say Gloria (psychologist), you can see that her opinion matters more than others'*, demonstrates how influence extended beyond formal organizational boundaries and tended to be concentrated around individuals who were seen as clinically credible, socially confident, or skilled in interpretation, traits often associated with informal leadership.

To illustrate this dynamic interaction, one particular clinical meeting (reported in the vignette from field notes 73) was emblematic: an informal leader (Gloria, psychologist) challenged the planned discharge of a patient with a personality disorder. In this instance, Gloria reframed the discharge decision and, through conversation, converted the suggestion into a binding coordination rule (mandatory weekly sessions). Following this intervention, after a brief silence, the colleagues aligned.

The physician's irritated acquiescence signalled that influence travelled, but not without friction: This episode exemplifies how credibility-based authority travels quickly, particularly when others hesitate or pause, thereby creating an opening for influential intervention and highlighting the interactional nature of the moments of influence.

Vignette from fieldnotes 91 reported another clinical meeting in which informal leaders exerted a heavy, even intimidating, influence. The psychologist's didactic response to the physician's question was followed by smirks and topic shifts. These dynamics led to an apparent alignment without genuine deliberation. Reflecting on the episode later, a physician remarked, *'We have not actually discussed it, have we?'* A social worker also noted, *'Perhaps we should not go along with it, but sometimes pushing back does not seem worth the tension'*. These interactions demonstrate how informal leadership can subtly and powerfully shape meeting dynamics. Team members explicitly acknowledged self-silencing to avoid conflict with untouchable colleagues, as one social worker explained:

'It is important to consider the personalities at play, the personalities and the roles, because in addition to the professional role, there is a role linked more to the amount of experience, and

therefore, sometimes, you cannot enter into open conflict with some people because there is this recognition of the role by others’.

This micro-tactic revealed that, while informal authority could accelerate decision-making, it simultaneously risked restricting voice and narrowing the space for deliberation, highlighting a critical tension between efficiency and comprehensive input in team dynamics. One psychologist said, *‘You would not want to fall out with Elena’*. Similarly, a nurse noted that *‘Pushing back would make tomorrow impossible’*. Another nurse added, *‘This is just a job, I keep reminding myself, it would be a nightmare if you had problems with colleagues you see every day. It is better to remain quiet and do your work’*.

Influence-in-interaction thus appeared as a dual-edged coordination process, essential for pace, yet potentially undermining the team’s ability to surface alternative views. When dissent became costly, consensus was sometimes reached rather than being deliberate. This microprocess also performed boundary work by redefining who held decision rights in practice, policing the limits of acceptable challenges through silence and alignment cues, and redrawing the boundary between formal authority and credible influence during interactions.

Fieldnotes 73 (names are fictional)

During the meeting, Gloria (psychologist) presented two cases, one involving Mario (drug addict 51 patient) who was on the verge of being discharged because he had been on a very low dose of prescribed methadone for a while. Gloria expresses her disagreement, ‘I do not think Mario is ready to be discharged.’ Filippo (physician) responded, ‘Why not? He is taking such a low dose of methadone now, and he is also working as far as I know, is that so Emma?’ Emma (social worker) replies, ‘Yes, he is working just a few hours per week at the Gaia social cooperative. It seems he is doing all right there, I visited him a couple of weeks ago and he was preparing fruits and other products to be delivered to local shops.’ Gloria continued, ‘I understand he has made good progress, but he still has unresolved mental health issues, so we cannot say he is fully recovered. I think he should continue to be in our care, I want to have more sessions with him and 11 maybe involve the family.’ Filippo replies: ‘I am not sure, we tried already, he does not seem interested in anything else than methadone.’ Gloria remarked, ‘Exactly my point. He is not yet ready to be dismissed. We need to find a way to make clear to him that attending psychotherapy is part of the treatment, not an option.’ Livia (nurse) adds: ‘I told him to contact you Gloria last time he came for his prescribed dose, but he just shrugged

his shoulders.’ Gloria continues, ‘That is because he thinks it is optional. We have to make it clear that if he does not attend my sessions, we will stop his methadone.’ [Silencing for a few seconds]. Then Emma speaks: ‘I agree with Gloria, we should try this again before discharging him, or he will come back in a state worse than before. Filippo tentatively responds: ‘All right, we will keep him in our 27 care a bit longer...’ Gloria interrupts: ‘And what about psychotherapy? You, Filippo, are the one who should talk to him and make weekly sessions with me mandatory.’ Filippo replies, ‘Yes, ok, I will do it, 30 Gloria (his tone communicates irritation). Livia can you please remind me when you see Mario next time? Livia: ‘Sure’.

Fieldnotes 91 (names are fictional)

At some point during the meeting, Gloria (psychologist) reported on the progress of one patient, and Sergio (physician) interrupted, saying, ‘I do not believe Luigia (alcohol addict patient) is engaging enough. ’ I have only seen her once, and there is not much I can do, but she has been seeing you (Gloria) for quite a while now, and I do not see much change in her condition. [...] We cannot force people to change, I suppose’. There was an awkward silence after this comment, during which the other staff members looked at each other. Gloria, trying her best to be polite despite her hardened face, replies by explaining how the therapeutic process works, the time needed before we can see the results, and what encouraging signs we can see. She explained all of this in a weird way, as if she was talking to a child. Gloria then looked at the other participants and noticed that Emma (social worker), Giulia (social worker), and Lucia (psychologist) had smirked. The other participants appeared embarrassed and did not make eye contact with any other participant (s). Then, Sergio speaks up and changes the subject.

Adjusting Relational Orientations to Sustain Collaboration under Dual Leadership

By foregrounding relational stance calibration, this subsection illustrates how leadership dynamics are shaped through shifting interpersonal orientations, consistent with the relational leadership theory’s emphasis on how interactional positioning structures voice. Thus, relational orientation emerges as a third microprocess through which work is orchestrated, as staff continually move between interpersonally and professionally centered stances to balance inclusion, efficiency, and authority in everyday coordination. This microprocess refines

relational leadership accounts by showing how relational warmth and distance are strategically deployed to regulate participation and manage interactional risk under the dual leadership.

This relational orientation was reflected in daily interactions that fostered emotional sustenance and support among the staff members. Central to this dynamic were micro-rituals and selective friendships that functioned as coping mechanisms for the emotional demands of addiction care (*'...invest in building friendships... with those you feel a connection'*). By engaging in simple acts, such as coffee breaks and light conversations, staff members built a collective resilience that mitigated burnout (*'We have coffee together every morning'*, psychologist).

Moreover, professionals emphasized the significance of maintaining a pleasant and warm environment, which served as a protective buffer against the inherent pressures of clinical work: *'It is important to work in a pleasant environment; otherwise, you get depressed here'* (nurse). Conversely, others emphasized maintaining professional boundaries to ensure discipline and efficiency (*'We are here to work; friendships are for outside'*). These varying approaches reflect the balance that professionals seek between collegiality and task focus (*'They are colleagues, not automatically friends'*, a physician said). These varying approaches have created a spectrum of views, ranging from fostering camaraderie to preserving formality. Each orientation was strategically deployed to manage emotional labor, maintain professional standards, and facilitate a streamlined task performance.

Informal leaders known for their high expectations appeared to deepen this stance by setting a tone of rigor and close monitoring: *'With Anna you have to work hard; she asks a lot of questions'* (social worker). These stance oscillations affected voice safety; a climate of interpersonal ease could support open dialogue, yet episodes showing silence after challenges highlighted how an overly professionalized or rigid stance could suppress participation. This was particularly evident as formal leaders were expected to sustain interpersonal distance because of their institutional role (*'We do not socialize much; it is expected, he's the manager'*, nurse), reinforcing a structure where warmth circulated horizontally among peers while authority travelled through more distant relations.

Discussion and Conclusion

This study identified three interrelated microprocesses through which informal leadership orchestrates multidisciplinary work in addiction services: First, professionals engaged in credibility tracing and turned to colleagues who were seen as knowledgeable and trusted.

Through documentation, meetings, and routines, expertise was stabilized, and certain actors emerged as de facto coordinators, regardless of hierarchy. Second, influence was enacted through interactional practices such as reframing issues, setting coordination rules, securing consensus, and leveraging silence. Although these practices often accelerated coordination, they also made dissent harder and contributed to informal hierarchies that shaped whose voices carried weight in the meeting. Third, leadership depended on calibrating relationships to manage emotional demands, sustain collaboration, and safely regulate participation.

Building on these three microprocesses, this study re-specifies key assumptions of relational leadership theory and examines the role of credibility-based authority in multidisciplinary healthcare work. The findings show that leadership in multidisciplinary public addiction services is not simply a diffuse sharing of influence, but an emergent, practice-based, and relational accomplishment shaped through everyday interactions rather than formal roles. Through the intertwined microprocesses of mobilizing situated expertise, influencing interactions, and adjusting relationships, credibility-based authority is dynamically constructed, negotiated, and at times constrained, reflecting the fluidity and ambivalence of informal and multiple leadership configurations. While such patterned concentrations of informal leadership can accelerate coordination and sustain distributed task orchestration, often stabilized through documentation and routine meetings as coordination artifacts (Gordon *et al.*, 2016; Horlait *et al.*, 2022), they may also consolidate informal hierarchies, secure alignment without debate, and suppress dissent through silence, alignment cues, and rule-setting, echoing research on interactional risk and voice suppression (Gerpott *et al.*, 2019; Oedzes *et al.*, 2019). In doing so, informal leadership operates as boundary work that selectively amplifies some voices while silencing others, challenging the normative portrayal of shared leadership as inherently inclusive and collaborative. These dynamics extend plural, dual, and relational leadership perspectives by demonstrating how formal and informal authority are co-constitutive and negotiated in real time, often constraining formal leaders' decision space through entrenched informal influence networks (Pielstick, 2000; Günzel-Jensen *et al.*, 2018; Van de Mierop *et al.*, 2020). Relational leadership theory must therefore account not only for interdependence and mutuality, but also for how influence becomes costly, how credibility hardens into authority, and how boundary work reshapes participation and deliberation in multidisciplinary care.

Implications for Practice

These findings suggest strategies for enhancing multidisciplinary collaboration in addiction services while cautioning against the uncritical celebration of informal leadership. Organizations can cultivate credibility-based expertise through structured knowledge sharing and reflection, such as rotating case discussions, peer mentoring, and micro-training. These help to distribute expertise, reduce overreliance on informal leaders, and strengthen collective capacity. While credibility-based influence accelerates coordination, it may also consolidate informal hierarchies, suppress dissent, and unevenly distribute voice. Therefore, interventions should leverage informal expertise while attending to how credibility becomes authority and how voice safety is shaped in the workplace. Formal leaders play a crucial role in modeling openness to divergent perspectives, inviting challenges, and legitimizing hesitation or disagreement as valued contributions. Finally, sustaining collaboration in resource-constrained settings requires attention to emotional and relational scaffolding; everyday micro-rituals, workplace friendships, and social interactions function as essential coping mechanisms supporting resilience, cohesion, and effectiveness, requiring a balance between accountability and a supportive climate.

Limitations and Directions for Future Research

While this seven-month ethnographic study provides rich, contextually grounded insights into informal leadership dynamics within Italian addiction services, its findings offer theoretical propositions regarding credibility-based authority and distributed task orchestration that can be explored and tested in diverse healthcare settings, thus contributing to broader relational leadership theory. While the researcher's dual role as both a consultant and social worker offered advantageous deep access and nuanced understanding, it may also have introduced subtle observational or interpretive biases, despite rigorous reflexivity and peer debriefing.

Future research could build on these findings by employing mixed-method approaches that combine qualitative depth with quantitative breadth, enabling the assessment of the prevalence and impact of the identified microprocesses across larger and more diverse samples. Comparative ethnographic studies in various cultural and organizational settings would further elucidate how informal leadership manifests and interacts with formal authority in different healthcare environments. Additionally, longitudinal research could explore how informal leadership dynamics evolve over time, particularly during organizational changes and crises.

Studies on interventions to enhance distributed expertise and voice safety can provide practical guidance.

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Appendix

[Tables I, II, and III – Supplementary File]