Dynamics of Change in Communities: The governance of organizational and cultural evolution

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Abstract

The Emmanuel Community, a long-standing Italian organization in the field of addiction, has undergone a significant transformation, mirroring changes in community-based organizations. It has shifted from hospitality-based care for marginalized users to structured treatment centers, moving from a total system logic to healthcare-oriented interventions. This study aims to map the organizational culture within the community, analyzing how cultural change interacts with organizational inertia and identifying models that guide professionals in integrating the autonomy of the network. Through the online administration of a battery of questionnaires, the responses of 95 participants were collected. The data was analyzed using Multiple Correspondence Analysis and Cluster Analysis. The results showed that the Emmanuel community is characterized by five symbolic universes: *Idealizers, Self-referential, Professional Communities, Disengaged, Disillusioned*. These clusters show how change has introduced standardized practices and responsibilities, improving the measurement of treatment but potentially

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weakening the relational and inclusive aspects, reducing empathy and patient participation. The results suggest the need to balance professionalization with the traditional values of the community to maintain an effective and human-centered treatment model.

Keywords: therapeutic community, organizational culture, dynamics of change, sense making, symbolic universe.

Introduction

As it is currently represented and organized, despite its variations, the therapeutic community for people with substance use disorders is the product of a complex process of experimentation and integration that is still ongoing.

The first developments in the Italian context, closely linked to the actions of religious groups and volunteer organizations, date back to the 1970s. These communities were initially not oriented by a well-defined model, distinguishing themselves more as life communities rather than therapeutic ones, guided by altruistic values and a strong social and political commitment. From this perspective, the founding of the Gruppo Abele by Don Luigi Ciotti, which in 1974 established the first Italian agricultural community for drug addicts in Murisengo, marks a key event. In 1982, Gruppo Abele also promoted the creation of the National Coordination of Reception Communities (CNCA), which today encompasses approximately 250 groups and associations. Among the most significant realities are also CeIS of Don Picchi, the Italian Federation of Therapeutic Communities (FICT), Emmaus, Samman, Incontro community, and Emmanuel community.

The communities have therefore witnessed a progressive expansion of their organizational structure, as well as of their diffusion and differentiation across the territory. This has served as evidence of the initial proposals of the value-based community model, leading in the 1990s to formal recognition by public services with the 1990 Agreement Act, followed by accreditation and funding of the structures by the relevant state agencies. This, in turn, led to the introduction of more stringent regulations and quality standards to be observed, requiring adjustments in terms of hygiene, service quality, and staff

qualifications. The communities thus became official partners of the Public Addiction Services (SerT), fully integrating into the Social-Health Services System.

This progressive expansion – in terms of the spread or structuring of the facilities, and the variability of the user base – has inevitably exposed the community model to the weakening of its original model. Several authors (Browne, 2001; De Leon, 2000; Sullivan & Moore, 2010; Ward & Allsop, 2004) have highlighted this significant process of change over the years, emphasizing the shift from an initial user base consisting of individuals with severe and chronic substance use disorders to an increasingly complex population with growing psychiatric comorbidities, mood disorders, anxiety syndromes, etc. Originally, the communities were characterized as places of hospitality, where value was attributed to internal relationships and the participation of residents in daily practices. Care was based on assimilation into the community system, following its regularities, and belonging to this reality. Today, the community has become a residential treatment center, required to meet all the demands of the National Health Service, creating an individualized therapeutic rehabilitation program (PTRI) for each user, and beginning to experiment with the idea that value is tied to the professional services provided, rather than to membership in the system.

This remains a significant challenge for the therapeutic community, representing an opportunity to develop its symbolic and relational heritage in order to integrate value-based models, rooted in meaning and foundational motivations, with professional models related to the integration of new professionals and organizational models. This is even more important if one considers that organizational culture plays a crucial role within organizations, influencing individual behavior, management concepts and the overall functioning of the organization (Chatman *et al.*, 2014; Morris *et al.*, 2015). Consequently, organizational culture can be understood as the degree to which the members of an organization construct, internalize and share fundamental values, which in turn influence the operational dynamics and organizational results (Cameron & Quinn, 2011).

In this context, the ongoing professionalization process and alignment with accreditation criteria, initiated in the 1990s, continues to drive therapeutic communities toward a transition from value-based

entities to organizations increasingly oriented toward professionalism. Our research group hypothesizes that this process, like all organizational processes, requires careful and structured governance to ensure inclusivity and generativity, avoiding the risk of exclusion or fragmentation. To explore this dynamic, we have conducted a case study within the Emmanuel community to understand the challenges and opportunities associated with adapting to the new required standards.

The research aims to analyze the organizational transformation process of the Emmanuel community, with the goal of integrating the cultural and value heritage accumulated over more than 40 years of activity. Specifically, it seeks to map the different organizational cultures within the community, identifying prevailing action models and possible directions for development.

Theoretical Framework

The present study adopted the Semiotic Cultural Psychology Theory (SCPT; Salvatore, 2016; Salvatore *et al.*, 2019; Valsiner, 2007), which integrate cultural psychology and psychoanalysis, providing a broader model of the relationship between mind, meaning, subject, behavior, and society (Salvatore *et al.*, 2022, 2024). The SCPT conceives of culture as a dynamic process and mental processes as a continuous activity of sensemaking that structures experience (Salvatore *et al.*, 2019). According to this perspective, individuals do not simply apply invariant cognitive rules in their interaction with reality, but orient their interpretation through generalized meanings, embedded in the cultural context (Reho, 2025). Meaning, therefore, is not an intrinsic attribute of objects, but rather the product of the sensemaking process, which shapes the way in which the world is perceived and represented by the mind (Reho & Salvatore, 2024). In other words, reality is not configured as a set of discrete entities to be represented and interpreted, but as a continuous flow of events, from which sensemaking selects and organizes specific elements, generating a relatively stable structure of experience (Salvatore *et al.*, 2024).

This process is based on generalized, affect-laden and culturally-grounded meanings that operate as latent hypotheses about the nature of the world and the criteria according to which it should be interpreted

and acted upon (Salvatore *et al.*, 2019). These meanings influence individuals' emotions, beliefs, attitudes, opinions and decisions, orienting their experience of the physical and social world.

The SCPT conceptualizes these meanings through the notion of "Symbolic Universes" (Cremaschi *et al.*, 2021; Salvatore *et al.*, 2018; 2019), understood as cultural and plural constructs, not reducible to mere individual representations, but rather internalized through participation in social and discursive practices (Salvatore *et al.*, 2019). According to this perspective, community culture emerges as a specific expression of symbolic universes, taking the form of a system of shared meanings that guide the practices and behaviors of the actors involved. Therefore, the specific way in which individuals interact with the community environment is influenced by the symbolic universes active within it (Salvatore & Zittoun, 2011; Salvatore *et al.*, 2024). It follows that community culture is configured as the product of sensemaking processes, which manifest themselves through individual and collective representations. The latter, in turn, shape the behavioral patterns and operational dynamics adopted within the community (Maitlis & Christianson, 2014).

According to this theoretical framework, community culture can be defined as a system of shared representations that not only guide individual and collective action, but also act as a vector of identity and cohesion within the community itself (Chatman & O'Reilly, 2016). Individual representations contribute to the definition of conceptions and attitudes towards the community, determining the ways in which the actors interpret and pursue the objectives, to the point of outlining specific community identities (Maitlis & Christianson, 2014).

Symbolic Universes, therefore, are not given structures nor constructions imposed through a top-down process, but rather emerge as the result of the meaning individuals attribute to the community context. These interpretive processes translate into specific modes of action, which, in turn, form the basis for the definition of shared norms and values. In other words, symbolic universes represent a system of implicit meanings that not only orient, but at the same time constrain the ways in which individuals interpret and act in the community context.

Method

Procedure and Participants

The directors of the various centers involved in the study collected the contact details of all members of their respective teams. The research team used these contact details to send a message containing a link to the Google Forms online platform, where participants completed a battery of questionnaires. Data collection took place between August and October 2023.

All participants read the objectives and procedures of the study and gave their voluntary consent to participate without any compensation. The study was approved by the Ethics Committee for Research in Psychology, Department of Human and Social Sciences, University of Salento (Protocol No. 0000472, 25/03/2022). The research adhered to the guidelines set out in the Declaration of Helsinki, adopted by the World Medical Association (WMA) during the 18th General Assembly of the WMA held in Helsinki, Finland, in June 1964. Furthermore, the study complied with the amendments to the Declaration made during the 64th General Assembly of the WMA held in Fortaleza, Brazil, in October 2013.

A total of 144 messages were sent, resulting in 95 responses, corresponding to a response rate of 65.97%. The sample consisted of 47 women and 47 men (1 participant preferred not to answer this question), with an average age of 50.58 years (SD = 12.76). Regarding education, 1.1% of participants had a primary school certificate, 9.5% had a lower secondary school diploma, 24.2% had a high school diploma, 38.9% had a bachelor's degree, and 25.3% had a master's degree or an equivalent qualification.

Participants had the following roles: 23.2% were social-health operators, 15.8% were volunteers, 1.1% were doctors, 16.8% were psychologists or psychotherapists, 12.6% were educators, pedagogists, or social animators, 6.3% were social workers or sociologists, 16.8% were in coordination or management, and 3.2% had support roles (e.g., receptionist, administrative staff, baker). Participants reported an average tenure at the community of 15.05 years (SD = 11.94) and an average weekly working commitment of 30.23 hours (SD = 16.08). Additionally, 71.6% of participants had not worked in other

communities previously. The work location for participants was: 49.5% in Puglia, 16.8% in Basilicata, 15.8% in Campania, 6.3% in Lombardy, 4.2% in Piedmont, and 1.1% in Calabria.

Measures

An ad hoc questionnaire was administered to collect socio-demographic characteristics of the participants (gender, age, education, role, years of service, working hours, and location).

To investigate the ways in which the community is represented, mapping the symbolic universes active within it, the Survey of Essential Elements Questionnaire (SEEQ; Melnick & De Leon, 1999) was used, adapting it to the specific research needs. The SEEQ is a validated tool for analyzing the distinctive characteristics of therapeutic communities, with particular attention to the fundamental elements that characterize their organization, therapeutic processes and community atmosphere. Using 5 and 7 point Likert scales, various thematic dimensions were evaluated such as drug addiction and treatment, community interventions, relationships between staff and users, community life, therapeutic actions, user commitment and organizational climate.

Data Analysis

A preliminary phase of data analysis focused on identifying how the community was represented by analyzing responses to the SEEQ questionnaire through Multiple Correspondence Analysis (MCA) and Cluster Analysis (CA). The main factors extracted from the MCA were used for aggregation in the CA, which in turn identified a particular way of combining the responses from a group of respondents (i.e., a specific representation of the community). These analyses were performed using SPAD software (version 5.5).

Next, to explore the association between different representations and the socio-demographic characteristics of the participants, Chi-square tests were conducted. In case of a significant Chi-square result, standardized adjusted residuals were used as post-hoc tests (Agresti &

Franklin, 2016). SPSS software (version 26) was used for these analyses.

Results

The MCA extracted six factors that contributed more than 10% to the cumulative inertia. These factors explained 76.88% of the total inertia (Benzecri, 1992) and were used as classification criteria in the CA, which identified five clusters. The clusters (Table 1) were interpreted by the research team through a consensus procedure (Harris *et al.*, 2012) as follows:

Idealizers (35.8%): Characterized by a strongly idealized vision of the community, perceived as redemptive. Their responses were highly positive, with complete agreement on the importance of communal values, personal support, and individual responsibility. They also believed that sharing daily moments, such as meals, was very important for treatment.

Self-referential (27.4%): They believe the community functions as an authority and a model of behavior. They highly value the importance of remission through the development of personal identity and a global change in lifestyle. They emphasize the role of charismatic leadership and the importance of community norms.

Professional Communities (18.9%): They recognize the value of human bonds in care. They positively evaluate interventions that promote participation, mutual aid, and the definition of personalized treatment plans. They believe in the integration of therapeutic goals and educational objectives.

Disengaged (7.4%): They show a low level of engagement and a neutral attitude towards the importance of interventions. They tend not to have strong opinions, and their level of participation is less significant.

Disillusioned (10.5%): They show skepticism towards the effectiveness of the treatment. They perceive the role of staff and the community values negatively. They have low expectations about the community's ability to produce significant changes.

Table 1. *Response Profiles Characterizing the Five Clusters Mapped*

Cluster 1. Idealizers			
Item	*Mode*	*V-test*	*p-value*
The staff acts as: a source of support and motivation	Extremely	6.06	< 0.001
The interventions at the therapeutic community emphasize: the community's values	Extremely	5.99	< 0.001
The interventions at the therapeutic community emphasize: the sense of belonging to the community	Extremely	5.98	< 0.001
The residents' job functions are related to clinical progress	Extremely	5.92	< 0.001
The interventions at the therapeutic community emphasize: the development of individual responsibility	Extremely	5.91	< 0.001
The community action promotes users' conflict resolution skills	Extremely	5.91	< 0.001
The community action emphasizes the development of personal decision-making skills	Extremely	5.89	< 0.001
The effectiveness of the therapeutic community: collaboration within the users' life context	Extremely relevant	5.81	< 0.001
Remission requires respect for personal values	Fully agree	5.67	< 0.001
Well-being reflects the quality of values	Fully agree	5.65	< 0.001
Cluster 2. Self-referential			
Item	*Mode*	*V-test*	*p-value*
The staff acts as: a behavioral model	Very	2.39	0.008
Remission from addiction involves the development of a personal identity and a global lifestyle change	Fully agree	2.38	0.009
The staff acts as: a reference of authority	Very	2.21	0.014
Community action: sharing mealtimes between staff and users	Missing response	2.08	0.019
Community action: peer discussions to change behaviors	Missing response	2.08	0.019
Therapeutic community effectiveness: availability of services and resources to support staff professionalism	Missing response	2.08	0.019
Community action: explicit and public discussions on behaviors	Missing response	2.08	0.019
Community action: peer discussions when community values are violated	Missing response	2.08	0.019
Community action: work is used as part of the therapeutic program	Missing Response	2.08	0.019

Therapeutic community effectiveness: the all-encompassing nature of the community experience for users	Missing response	2.08	0.019
Cluster 3. Professional Communitaries			
Item	*Mode*	*V-test*	*p-value*
Community action: promoting mutual aid and sharing among users	Quite positively	5.57	< 0.001
Job functions: promoting community values	Very relevant	5.13	< 0.001
Interventions at the therapeutic community emphasize: defining personalized treatment plans	Very	4.67	< 0.001
Community action: work is used as part of an educational process	Very	4.67	< 0.001
Remission requires respect for significant personal and collective values	Fully agree	4.41	< 0.001
Community action: users are taught to control their emotions	Very	4.33	< 0.001
Community action: daily activities have both therapeutic and educational goals	Quite positively	4.11	< 0.001
Job functions: developing a collaborative attitude toward the community	Very relevant	4.10	< 0.001
Interventions at the therapeutic community emphasize: participation in community life	Very	3.99	< 0.001
Community action: the community has a written set of rules to regulate user behavior	Quite positively	3.99	< 0.001
Cluster 4. Disengaged			
Item	*Mode*	*V-test*	*p-value*
Interventions at the therapeutic community emphasize: the multidimensionality of interventions (medical therapy, psychoeducational interventions, etc.)	Neutral	4.60	< 0.001
Interventions at the therapeutic community emphasize: the professionalism of the staff	Neutral	3.77	< 0.001
Job functions: moral growth of the user	Quite relevant	3.62	< 0.001
Remission from addiction involves the development of personal identity and a global lifestyle change (behaviors, attitudes, and values)	Quite agree	3.60	< 0.001
Community action: progress in treatment is reinforced by gaining more autonomy in community life	Neither positively nor negatively	3.39	< 0.001
The staff acts as: a facilitator of internal relationships in the community	Neutral	3.20	0.001

Climate scale (f4): interpersonal conflict (collected)	Medium	3.12	0.001
Community action: users are taught to control and express their emotions in appropriate ways and places	Quite	2.88	0.002
Community action: promoting mutual aid and sharing among users	Neither positively nor negatively	2.82	0.002
The staff acts as: a source of support and motivation	Neutral	2.82	0.002
Cluster 5. Disillusioned			
Item	*Mode*	*V-test*	*p-value*
The staff acts as: a source of support and motivation	Little	5.03	< 0.001
Interventions at the therapeutic community emphasize: community values	Little	5.03	< 0.001
Interventions at the therapeutic community emphasize: the development of individual responsibility	Little	4.65	< 0.001
Interventions at the therapeutic community emphasize: a sense of belonging to the community	Little	4.65	< 0.001
Interventions at the therapeutic community emphasize: the professionalism of the staff	Little	4.13	< 0.001
Interventions at the therapeutic community emphasize: the multidimensionality of interventions (medical therapy, psychoeducational interventions, etc.)	Little	4.06	< 0.001
The staff acts as: a behavioral model	Little	3.93	< 0.001
The problem the intervention must address is not the substance but the person	Quite disagree	3.82	< 0.001
Therapeutic community effectiveness: staff competence	Very little relevant	3.82	< 0.001
Interventions at the therapeutic community emphasize: participation in community life	Little	3.82	< 0.001

Note. Each cluster contains the 10 most representative items.

Chi-square analyses revealed a significant association between the clusters and gender ($\chi^2 = 15.96$, $p = 0.003$). The adjusted standardized residuals indicated that men were more likely to be associated with the "Professional Communitaries" cluster (adjusted standardized residual = 2.1) and the "Disengaged" cluster (adjusted standardized residual =

2.0), while women were more likely to be associated with the "Idealizing" cluster (adjusted standardized residual = 2.6) and the "Disillusioned" cluster (adjusted standardized residual = 2.0). No significant associations were found between the clusters and the participants' age ($\chi^2 = 6.70$, $p = 0.569$), education level ($\chi^2 = 8.67$, $p = 0.926$), geographic area ($\chi^2 = 60.15$, $p = 0.205$), length of service ($\chi^2 = 7.33$, $p = 0.501$), or weekly working hours ($\chi^2 = 9.89$, $p = 0.273$).

Discussion

The present study aimed to map the different organizational cultures within the Emmanuel community, operationalized in terms of symbolic universes, identifying the prevailing models of action and possible directions of development.

By combining multiple correspondence analysis and cluster analysis, five symbolic universes were mapped: I*dealizers, Self-referential, Professional Communities, Disengaged, Disillusioned*.

It emerges that for the *Idealizers* cluster, the community appeared to be fully aligned with the ideals of the participants, perceived as salvific and untouchable in its perfection. Within the relationships between operators, it can be hypothesized that when a critical issue arises, it may not be possible to consider the community itself as the object to be improved. Instead, the external world of the community was seen as the one that must change, in order to maintain the community as an entirely good object. If this were not the case, and there was the possibility of recognizing its fallibility, the risk would be to move from idealization to total devaluation.

The *Self-referential* cluster focused on the treatment model and the effectiveness of the community solely in terms of authority and behavior management. Treatment works if the patient follows the instructions given; rehabilitation is effective when educational actions focus on behavior. Other components, such as values, relationships, and sharing, appeared to be of little significance.

The *Professional Communitaries* cluster operated through a "maternage" approach, meaning the caregivers take responsibility for the patient. In this case, it seemed that the operator substituted for the community, and the relevance of daily activities as key elements for

rehabilitation fades in favor of personalization and the individual's growth and personal maturation.

The *Disengaged* cluster seemed to engage with the concreteness of events, adopting an evaluative perspective. They appeared to discern between the proposed elements but, at the same time, seemed unable to identify alternative solutions. It was as if they found themselves in a contemplative position, observing and evaluating without taking action.

The *Disillusioned* cluster seemed to have a "disillusioned" view of the phenomenon of "addiction" in a broad and general sense, as if the disillusionment and skepticism they experience are all-encompassing. It can be hypothesized that these individuals struggle to imagine solutions to problems, instead perceiving these problems as "obvious," an inherent part of the experience. Everything is experienced as "disillusioning." Therefore, both the identity aspect and the potential for integrative evolutionary growth are perceived within the same framework of meaning marked by distrust. It can be hypothesized that there is no space for potential change, as their actions are in relation to an object that will disappoint.

Thus, it emerges that, in the absence of governance, personal meaning resources are amplified to cope with the complexity of events, as meaning constitutes the experience by shaping reality. This plurality, which could become a critical issue if it persists without understanding, can be an evolutionary resource if managed with conscious awareness of the process. This process requires highlighting the constraints that influence meaning dynamics.

The exploration of the emerging segments allowed for the development of a sense-making framework for the Emmanuel community. What might initially appear as a plurality of cultures that are distant from each other, is actually a multiplicity of responses to the same evolutional issue; namely, the processing of grief related to the loss of the idealized object.

Indeed, the Emmanuel community system is in a phase of transition, moving from a charismatic model that has characterized its history, toward a network-based organizational structure that emphasizes the integrated autonomy of individual operational units. The weakening of the model that has guided the structure from its inception to the present, due to a variety of factors such as territorial expansion, professional development, social evolution, and relative autonomy, has

led to the consolidation of local cultures as a coping mechanism for the present moment.

The findings highlights how the absence of a sense of anchorage, which had been a resource for the Emmanuel community system – characterized by a sense of certainty regarding what was being done, why it was being done, and how it should be done, based on a value system that also served as a method – has led to the search for substitutes in the symbolic forms available. Specifically, it emerges that the group no longer produces the anchorage, but rather the context of belonging or personal characteristics. Symbolic universes describe how, on one hand, there is the rigidification of the previous anchorage, as seen in the *Idealizers* group with the risk of ritualization and loss of value, and on the other hand, in the anomie, we find the *Disillusioned*. The *Professional Communitaries* absolutize professionalism, while the *Self-referential* group extremizes the norms. Therefore, a complex articulation emerges, with a clear difficulty in sharing the logics of meaning for a common project.

The management of this process involves the consideration of three elements: organization, culture, and competence. The organizational aspect requires an initial phase of analysis of the practices in place, to define structures that foster certain more functional logics over others. Culture, in light of what has emerged, requires practices that promote the integration of the profiles outlined. Competence pertains to the promotion of shared criteria in the delivery of services. To promote the objectives outlined, the necessary devices are as follows: internal monitoring of activities, organizational analysis through the exploration of the micro-dynamics of the organizational process, training, and supervision of operators. These operations should become an integral part of activity management, thus integrating into the process with a governance perspective.

This study has some limitations that should be mentioned. The cross-sectional design of the study and the small sample size limit the generalizability of the results to the specific community under study. Future studies could be replicated on larger samples and considering different communities, to obtain detailed information on the functioning of communities on the Italian territory. The use of an online questionnaire may have induced a sampling bias, excluding personnel who do not have access to electronic devices. Finally, the use of a self-

report questionnaire could be susceptible to social desirability bias. Future studies could consider the integration of additional methodologies, such as semi-structured interviews and focus groups, in order to integrate a qualitative dimension in the study.

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