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Identifying the Components of an Organizational Trauma Management Model with Regard to Knowledge Management Strategies among Healthcare Staff of Kerman University of Medical Sciences Hospitals

ABSTRACT

The objective of this study was to identify and conceptualize the core components of an organizational trauma management model by considering knowledge management strategies based on the lived experiences of healthcare staff in hospitals affiliated with Kerman University of Medical Sciences. This study employed a qualitative research design using a purposive sampling strategy to select healthcare professionals with substantial experience of organizational challenges and critical incidents. Data were collected through in-depth semi-structured interviews complemented by the analysis of relevant organizational documents and upstream records. Interviews continued until theoretical saturation was achieved. The collected data were analyzed using thematic analysis through a systematic three-stage coding process, including open coding, axial coding, and selective coding, in order to extract dimensions, components, and conceptual relationships relevant to organizational trauma management and knowledge management strategies. The inferential results revealed six interrelated core dimensions: psychological and emotional consequences of work-related trauma, lack of psychological–organizational support, high-tension and stressful work environment, informal knowledge sharing, weakness in organizational knowledge management, and the need for purposeful organizational learning. The findings indicate that unresolved psychological distress and chronic workplace stress intensify organizational trauma, while informal knowledge-sharing practices emerge as compensatory mechanisms in the absence of structured systems. Weak documentation, lack of incentives, and insufficient technological infrastructure were identified as key barriers to transforming individual experiences into collective organizational learning. The study concludes that effective organizational trauma management in healthcare settings requires an integrated approach that simultaneously addresses psychological support, organizational conditions, and systematic knowledge management. Embedding purposeful organizational learning and structured knowledge-sharing mechanisms can transform traumatic experiences into sources of resilience, adaptation, and sustainable organizational development.

Keywords: Organizational trauma, trauma management, knowledge management strategies, organizational learning, healthcare organizations

Introduction

Organizational environments in contemporary societies are increasingly exposed to complex, cumulative, and often invisible pressures that go beyond routine occupational stress and enter the domain of organizational trauma. Organizational trauma refers to deep, persistent, and collective psychological wounds that emerge when organizations and their members are repeatedly exposed to critical incidents, chronic crises, ethical failures, toxic leadership, structural injustice, or prolonged

uncertainty. Unlike individual trauma, organizational trauma is embedded in systems, routines, power relations, and shared meanings, and it gradually reshapes employees' emotions, behaviors, trust, and performance at both individual and collective levels [1, 2]. In recent years, scholars have emphasized that organizational trauma is not merely an episodic reaction to isolated events, but rather a cumulative process that can erode organizational health, resilience, and sustainability if left unrecognized and unmanaged [3, 4].

Healthcare organizations represent one of the most trauma-prone organizational contexts, as they operate at the intersection of human vulnerability, life-and-death decisions, ethical dilemmas, and persistent resource constraints. Hospitals, in particular, expose healthcare staff to repeated encounters with patient suffering, death, medical errors, moral distress, and high workloads, which can collectively produce profound psychological and emotional strain. When such experiences are compounded by inadequate organizational support, ineffective leadership, and weak learning mechanisms, they may crystallize into organizational trauma that extends beyond individual burnout and manifests as systemic disengagement, cynicism, reduced performance, and turnover [5, 6]. Empirical studies have shown that unresolved organizational trauma in healthcare settings can undermine mental health, intensify social burnout, and weaken professional commitment, thereby threatening both employee well-being and service quality [7, 8].

A growing body of research has attempted to conceptualize organizational trauma, identify its antecedents, and examine its consequences across different organizational contexts. Factors such as toxic leadership, organizational silence, emotional neglect, ethical violations, and systemic injustice have been consistently identified as key contributors to the formation of organizational trauma [9-11]. At the same time, scholars have highlighted that organizational trauma often operates invisibly, becoming normalized through routines and cultures that suppress emotional expression and discourage collective reflection [1, 2]. This invisibility makes organizational trauma particularly difficult to diagnose and manage, as its symptoms are frequently misattributed to individual weakness rather than structural dysfunction.

In response to these challenges, recent studies have increasingly focused on organizational trauma management as a strategic and systemic process aimed at mitigating psychological harm, restoring trust, and rebuilding collective capacity. Organizational trauma management encompasses a set of intentional policies, practices, and cultural interventions designed to recognize traumatic experiences, provide psychological and organizational support, and transform adverse experiences into opportunities for learning and resilience [12, 13]. Qualitative and grounded theory studies have demonstrated that effective trauma management requires more than short-term counseling or individual-level interventions; it demands organizational readiness, empathetic leadership, participatory communication, and institutionalized learning processes that allow organizations to process, remember, and learn from critical events [3, 8].

Despite these advances, many organizations—particularly in the public and healthcare sectors—continue to struggle with fragmented and reactive approaches to trauma management. In such contexts, trauma-related experiences are often addressed informally or ignored altogether, leading to the accumulation of unresolved emotional burdens and the gradual erosion of organizational cohesion [14, 15]. Research indicates that when organizational trauma is not systematically managed, it can interact with other dysfunctional dynamics such as organizational inertia, cynicism, and social abrasion, further reducing the organization's capacity for adaptation and innovation [16, 17]. These findings underscore the necessity of developing comprehensive models of organizational trauma management that are sensitive to contextual conditions and capable of addressing both emotional and structural dimensions.

One promising yet underexplored pathway for strengthening organizational trauma management lies in the integration of knowledge management strategies. Knowledge management refers to the systematic processes through which organizations create, share, store, and apply knowledge to enhance learning, decision-making, and performance. In dynamic and high-risk environments, knowledge management plays a critical role in transforming individual experiences into collective understanding and organizational memory [18, 19]. From this perspective, traumatic experiences—if properly captured and reflected upon—can become valuable sources of experiential knowledge that inform safer practices, ethical awareness, and adaptive responses.

Recent studies have emphasized that effective knowledge management can enhance organizational resilience by facilitating sense-making, reducing uncertainty, and supporting coordinated action in the face of crises [20, 21]. Knowledge-sharing practices, whether formal or informal, enable employees to articulate emotions, exchange coping strategies, and collectively interpret critical incidents, thereby reducing isolation and fostering psychological safety. Conversely, weak knowledge management systems—characterized by poor documentation, lack of feedback mechanisms, and absence of incentives—can exacerbate organizational trauma by silencing experiences and preventing learning from adverse events [12, 14].

The strategic role of knowledge management becomes even more salient in healthcare organizations operating under volatile, uncertain, complex, and ambiguous conditions. Research on organizational agility and innovation has shown that knowledge creation and sharing are central to navigating such environments and sustaining performance [18, 22]. In hospitals, where clinical knowledge, experiential insights, and emotional labor intersect, knowledge management strategies can serve as a bridge between individual suffering and organizational learning. Informal knowledge-sharing channels, such as peer discussions and digital communication platforms, often emerge organically in response to gaps in formal systems, highlighting both the resilience of healthcare staff and the shortcomings of institutional structures [19, 21].

However, existing literature suggests that the relationship between organizational trauma and knowledge management remains insufficiently theorized and empirically examined, particularly in non-Western and public healthcare contexts. While several studies have independently examined organizational trauma or knowledge management, few have explicitly integrated these constructs into a unified analytical framework [1, 2]. Moreover, much of the existing research has focused on educational or administrative settings, leaving a significant gap in understanding how organizational trauma is experienced and managed among healthcare professionals in hospital environments [3, 8].

In the Iranian context, this gap is especially pronounced. Hospitals affiliated with universities of medical sciences operate under intense pressure due to workforce shortages, increasing patient loads, economic constraints, and heightened public expectations. These conditions create fertile ground for organizational trauma, while simultaneously demanding high levels of coordination, learning, and adaptability. Yet, empirical evidence on how organizational trauma is managed in these settings, and how knowledge management strategies can support such management, remains limited and fragmented [11, 13]. Understanding these dynamics is crucial not only for improving employee well-being but also for enhancing the sustainability and effectiveness of healthcare organizations.

Given these considerations, there is a clear need for qualitative, context-sensitive research that explores organizational trauma management from the lived experiences of healthcare staff and examines how knowledge management strategies intersect with trauma-related processes. Qualitative approaches are particularly well suited to uncovering the meanings,

emotions, and informal practices that shape organizational responses to trauma, which are often overlooked in quantitative surveys [7, 12]. By identifying core components, dimensions, and mechanisms, such research can contribute to the development of integrative models that inform policy, leadership practice, and organizational design.

Accordingly, the present study aims to identify the components of an organizational trauma management model with regard to knowledge management strategies among healthcare staff of hospitals affiliated with Kerman University of Medical Sciences.

Methodology

The present study adopted a qualitative research approach, as this methodology is particularly appropriate for exploring complex organizational phenomena such as organizational trauma and knowledge management strategies through the lived experiences, perceptions, and meanings constructed by individuals. In qualitative inquiry, participants' interpretations and subjective understandings constitute the primary source of data, allowing for an in-depth and context-sensitive examination of the phenomenon under investigation. Accordingly, the study focused on eliciting expert perspectives from individuals who possessed direct and substantial experience with organizational challenges, trauma-related situations, and knowledge management practices within hospital settings affiliated with Kerman University of Medical Sciences. Participants were selected through purposive sampling, a strategy commonly employed in management and social science research to ensure access to information-rich cases. The inclusion criteria emphasized professional experience, familiarity with organizational processes, and involvement in managerial, supervisory, or clinical roles that exposed participants to organizational stressors and knowledge-related practices. Data collection continued until theoretical saturation was achieved, meaning that additional interviews no longer yielded novel concepts or insights relevant to the research objectives.

Data were primarily collected through semi-structured, in-depth interviews, which were considered the most suitable tool for uncovering and understanding individual and collective experiences related to organizational trauma management and knowledge management strategies. The semi-structured interview format allowed for a balance between consistency across interviews and flexibility to probe emerging issues in greater depth. This approach enabled the researcher to guide the discussion toward the study objectives while simultaneously allowing participants to articulate their experiences, interpretations, and insights in their own terms. Interviews were conducted in a conversational manner, with questions designed to explore perceptions of organizational trauma, coping and management mechanisms, knowledge creation and sharing practices, and the perceived relationships between trauma-related components and knowledge management strategies. In addition to interviews, relevant upstream documents, policy texts, organizational reports, and written records were reviewed and analyzed to provide contextual grounding and to support a more comprehensive understanding of the phenomenon. This triangulation of data sources enhanced the depth and credibility of the findings by integrating experiential data with documentary evidence.

The analysis of qualitative data, including interview transcripts and documentary materials, was conducted using thematic analysis supported by a systematic coding process. Data analysis followed a rigorous, iterative procedure involving open coding, axial coding, and selective coding. During open coding, interview texts were examined line by line to identify initial concepts and meaning units related to organizational trauma and knowledge management strategies. These codes were then compared and refined through constant comparison. In the axial coding phase, related codes were grouped into higher-order

categories by identifying conceptual relationships and patterns among them. This process facilitated the integration of individual concepts into broader dimensions and components. Finally, selective coding was employed to refine and consolidate the core categories, clarify the relationships among them, and develop a coherent explanatory framework. The analysis continued alongside data collection, allowing emerging insights to inform subsequent interviews and ensuring progression toward theoretical saturation. Through this systematic and iterative process, the final model of organizational trauma management components in relation to knowledge management strategies was developed and conceptually articulated.

Findings and Results

The qualitative phase of the study involved fifteen participants with diverse demographic and professional characteristics, ensuring a broad range of perspectives relevant to organizational trauma and knowledge management in healthcare settings. The sample consisted of eleven men and four women. Participants' professional experience ranged from nine to thirty years, indicating substantial exposure to organizational processes and critical events within hospital environments. In terms of educational background, the majority held advanced academic degrees, including several participants with doctoral or medical degrees, alongside others with master's and bachelor's qualifications, reflecting both clinical and managerial expertise. The duration of the semi-structured interviews varied from approximately thirty-five to fifty-eight minutes, suggesting sufficient depth and richness of data across interviews. Overall, the demographic composition of the participants demonstrated a well-balanced mix of gender, educational attainment, and extensive professional experience, contributing to the credibility and comprehensiveness of the qualitative findings.

Table 1

Open Codes Referred by Participants

Open Code (Initial Concept)	Open Code (Initial Concept)
Repeated patient deaths	Experience of exposure to death
Feelings of helplessness and anger	Negative emotions resulting from crisis
Work errors under stressful conditions	Reduced performance accuracy
Indifference and lack of motivation among staff	Job burnout
Resignation of some employees	Organizational consequence of work-related trauma
Lack of psychological support from the organization	Weakness in psychological support
Absence of counseling programs	Lack of specialized organizational intervention
Ignoring employees' emotions	Neglect of human dimensions of staff
Inadequate training for crisis coping	Weak psychological and organizational preparedness
High-pressure work environment	Chronic stressful environment
Informal conversations during shift handovers	Informal knowledge exchange
Experience transfer in WhatsApp groups	Informal digital knowledge sharing
Lack of a structure for recording experiences	Weak knowledge documentation
Scattered reports	Inefficient documentation
Suggestions for feedback sessions	Need for collective learning
Heavy workload as a barrier to knowledge sharing	Time constraints and work overload
Lack of rewards for experience sharing	Weak organizational motivation
Suggestion to create a knowledge bank	Need for technological infrastructure
Experience-sharing workshops	Peer learning

The open coding results reflect a wide spectrum of experiences and perceptions expressed by participants regarding organizational trauma and knowledge management practices. A significant portion of the codes highlights the traumatic nature of the work environment, including repeated exposure to patient deaths, intense negative emotions such as helplessness and anger, reduced performance accuracy under stress, and manifestations of job burnout, which in some cases

led to employee turnover. These experiences were frequently associated with perceived deficiencies in organizational support, such as the absence of psychological assistance, lack of counseling programs, insufficient crisis-related training, and neglect of the emotional needs of staff. In parallel, the findings reveal both formal and informal dimensions of knowledge management within the hospitals. While informal knowledge exchange occurred through shift handover conversations and digital platforms such as WhatsApp groups, participants emphasized structural weaknesses in systematic documentation, experience recording, and incentive mechanisms for knowledge sharing. Organizational barriers, including heavy workloads and time pressure, were repeatedly identified as obstacles to effective knowledge transfer. At the same time, participants proposed developmental solutions such as establishing feedback sessions, organizing experience-sharing workshops, and creating technological infrastructures like knowledge banks, underscoring the perceived need for collective learning and more structured knowledge management strategies in the context of organizational trauma.

Table 2

Dimensions, Components, and Indicators Derived from Selective Coding

Core Category	Axial Codes	Open Codes (Examples)
Psychological and emotional consequences of work-related trauma	Experience of psychological crisis, negative emotions, burnout, job turnover	Experience of exposure to death, repeated patient deaths, negative emotions resulting from crisis, feelings of helplessness and anger, indifference and lack of motivation among staff, reduced performance accuracy, work errors under stressful conditions, job burnout, resignation of some employees
Lack of psychological–organizational support	Absence of psychological support, organizational neglect, weak crisis preparedness	Lack of psychological support from the organization, absence of counseling programs, ignoring employees' emotions, inadequate training for crisis coping, weakness in psychological support, lack of specialized organizational intervention, neglect of human dimensions of staff, weak psychological and organizational preparedness
High-tension and stressful work environment	Chronic stress, excessive workload	High-pressure work environment, chronic stressful environment, heavy workload as a barrier to knowledge sharing
Informal knowledge sharing	Informal experience exchange, peer learning, digital tools	Informal conversations during shift handovers, experience transfer in WhatsApp groups, informal knowledge exchange, informal digital knowledge sharing, peer learning, experience-sharing workshops
Weakness in organizational knowledge management	Weak documentation, lack of formal experience transfer structures	Lack of a structure for recording experiences, scattered reports, inefficient documentation, weak knowledge documentation, lack of rewards for experience sharing
Need for purposeful organizational learning	Collective learning, creation of technological learning infrastructures, systematization of knowledge sharing	Suggestions for feedback sessions, suggestion to create a knowledge bank, need for technological infrastructure, need for collective learning

The results of selective coding reveal a coherent structure of dimensions and components that explain organizational trauma management in relation to knowledge management strategies. At the psychological level, participants emphasized profound emotional and mental consequences of work-related trauma, including repeated exposure to death, intense negative emotions, reduced performance accuracy, burnout, and eventual job turnover. These outcomes were strongly linked to a perceived lack of psychological and organizational support, reflected in insufficient counseling services, neglect of employees' emotional needs, inadequate crisis preparedness, and weak institutional interventions. In parallel, the findings highlighted the role of a persistently stressful and high-pressure work environment, where excessive workloads not only intensified trauma but also constrained opportunities for effective knowledge sharing. Despite these constraints, informal knowledge exchange emerged as a compensatory mechanism, occurring through peer interactions, shift handover conversations, and digital platforms, indicating the staff's reliance on experiential and relational learning. However, the absence of formal structures for documentation, incentives, and systematic transfer of experience underscored significant weaknesses in organizational knowledge management. Collectively, these patterns point to a critical need for purposeful organizational learning, supported by technological infrastructures and structured feedback mechanisms, to integrate trauma management with sustainable and systematized knowledge management practices.

Figure 1

Final Model of the Study

Discussion and Conclusion

The findings of the present study provide a comprehensive and integrated understanding of organizational trauma management in healthcare settings by revealing how psychological, organizational, and knowledge-related dimensions are deeply intertwined in the lived experiences of healthcare staff. The results indicate that organizational trauma among hospital personnel is primarily manifested through severe psychological and emotional consequences, including repeated exposure to patient death, intense negative emotions, emotional exhaustion, reduced performance accuracy, and, in extreme cases, withdrawal from the organization. These findings are consistent with conceptual and empirical studies that describe organizational trauma as a cumulative and systemic phenomenon rather than a series of isolated individual reactions [1, 2]. Prior research has similarly emphasized that continuous exposure to distressing events in emotionally demanding environments such as hospitals can gradually erode employees' psychological resources and professional commitment, transforming individual distress into collective organizational trauma [5, 6].

A central insight of the study is the critical role of insufficient psychological and organizational support in intensifying trauma-related outcomes. Participants repeatedly referred to the absence of formal counseling programs, neglect of emotional needs, lack of empathetic leadership, and weak organizational preparedness for crises as key factors that exacerbated their traumatic experiences. This finding aligns closely with studies demonstrating that toxic or indifferent leadership and emotionally neglectful organizational climates play a decisive role in the emergence and persistence of organizational trauma [9, 11]. Research has shown that when organizations fail to acknowledge employees' emotional experiences or provide structured psychological support, trauma becomes normalized and internalized, leading to cynicism, silence, and disengagement [10, 17]. The present findings reinforce the argument that trauma management must be embedded at the organizational level rather than delegated solely to individual coping capacities.

The results further highlight the significance of the work environment itself as a structural driver of organizational trauma. Participants described hospital settings as chronically stressful environments characterized by excessive workload, persistent time pressure, and constant exposure to high-stakes decisions. Such conditions not only intensified emotional strain but also constrained opportunities for reflection, dialogue, and learning. These observations are consistent with studies identifying

workload pressure and structural stressors as fundamental antecedents of organizational trauma, particularly in public service and healthcare contexts [3, 4]. From an organizational health perspective, this finding supports the view that trauma cannot be effectively managed without addressing environmental and systemic stressors that continuously reproduce psychological harm [1].

An important contribution of this study lies in its identification of informal knowledge sharing as a spontaneous yet fragile coping and learning mechanism in trauma-laden environments. Participants frequently referred to peer conversations, shift handover discussions, and digital communication platforms as primary channels for exchanging experiences, emotional support, and practical knowledge. This pattern reflects the tendency of employees to compensate for the absence of formal organizational learning structures by creating informal networks of sense-making and mutual support. Similar patterns have been documented in previous research, which shows that informal knowledge sharing often emerges in response to organizational silence, weak documentation systems, and insufficient leadership support [12, 21]. While such informal practices demonstrate the adaptive capacity of healthcare staff, the findings also suggest that reliance on informal mechanisms alone is insufficient for sustainable trauma management and organizational learning.

The study further reveals significant weaknesses in formal knowledge management systems, particularly in relation to documentation, structured experience transfer, and motivational mechanisms for knowledge sharing. Participants emphasized the lack of systematic processes for recording critical experiences, learning from adverse events, and transforming individual insights into organizational memory. This finding resonates with prior studies indicating that weak knowledge management infrastructures can exacerbate organizational trauma by preventing learning from mistakes and silencing emotionally charged experiences [14, 15]. From a strategic perspective, the absence of incentives and technological platforms for knowledge sharing undermines collective learning and reinforces feelings of invisibility and neglect among employees.

By integrating these findings, the study underscores the pivotal role of purposeful organizational learning as a bridge between organizational trauma management and knowledge management strategies. Participants explicitly articulated the need for feedback sessions, experience-sharing workshops, and technological infrastructures such as knowledge banks to institutionalize learning from both routine and traumatic experiences. This aligns with contemporary research emphasizing that knowledge management is not merely a technical function but a socio-emotional process that supports resilience, sense-making, and adaptive capacity in complex environments [18, 19]. Studies have shown that organizations that successfully integrate knowledge management with leadership practices and learning cultures are better equipped to transform crises into sources of innovation and resilience [20, 23].

In healthcare contexts operating under volatile and uncertain conditions, the strategic integration of knowledge management into trauma management becomes particularly critical. The findings support the argument that traumatic experiences, if systematically captured and reflected upon, can serve as valuable experiential knowledge that enhances organizational agility, ethical awareness, and service quality [7, 22]. Conversely, when such experiences remain undocumented and unacknowledged, they contribute to organizational inertia and entropy, reducing the organization’s capacity to adapt and respond effectively to future challenges [16]. The present study thus contributes to the literature by empirically demonstrating how organizational trauma and knowledge management are not separate domains but mutually reinforcing processes within healthcare organizations.

Overall, the discussion of findings suggests that effective organizational trauma management in hospitals requires a multidimensional approach that simultaneously addresses psychological support, organizational structures, work environment conditions, and knowledge management strategies. This integrative perspective is consistent with emerging models of organizational trauma management that emphasize empathy, participation, learning, and systemic change rather than fragmented or reactive interventions [8, 13]. By situating trauma management within the broader framework of knowledge creation and organizational learning, the study advances both theory and practice in the field of organizational behavior and healthcare management.

Despite its contributions, the present study has several limitations that should be acknowledged. First, the qualitative design, while appropriate for exploring lived experiences and complex organizational phenomena, limits the generalizability of the findings to other organizational contexts. Second, the study relied on self-reported data from participants, which may be influenced by recall bias or social desirability. Third, the focus on hospitals affiliated with a single university of medical sciences means that contextual factors specific to this setting may have shaped the findings.

Future research could build on the present study by employing mixed-methods or quantitative designs to test and validate the proposed organizational trauma management model across different healthcare and non-healthcare contexts. Comparative studies across regions, organizational types, or professional groups could provide deeper insights into contextual variations. Longitudinal research designs are also recommended to examine how organizational trauma and learning processes evolve over time and in response to interventions.

From a practical standpoint, healthcare organizations should prioritize the institutionalization of psychological support systems, including counseling services and emotionally responsive leadership practices. Managers should invest in formal knowledge management infrastructures that enable systematic documentation and sharing of experiences, particularly those arising from critical incidents. Creating safe spaces for dialogue, feedback, and collective reflection can help transform traumatic experiences into sources of learning, resilience, and sustainable organizational development.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Written consent was obtained from all participants in the study.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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