Future of Work and Digital Management Journal

Article type:
Original Research

Article history:
Received 12 November 2024
Revised 09 February 2025
Accepted 16 February 2025
Published online 25 March 2025

# Organizational Trauma Management in Iranian Public Organizations: A Qualitative Exploration with Emphasis on Cognitive–Behavioral Interventions

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How to cite this article:
Khazaei Kohpar, S., Kia Kojouri, D., Haji Aghajani, A., & Mokhtari Bayekolaei, M. (2025). Organizational Trauma Management in Iranian Public Organizations: A Qualitative Exploration with Emphasis on Cognitive–Behavioral Interventions. *Future of Work and Digital Management Journal, 3*(1), 1-18. https://doi.org/10.61838/fwdmj.3.1.10



## ABSTRACT

Organizational trauma, as a complex and multidimensional phenomenon in the field of management and organizational psychology, describes the psychological, social, and functional damages arising from sudden or prolonged crises. In Iranian public organizations, this trauma has become a chronic challenge due to bureaucratic structures, political and economic pressures, and resource constraints, leading to reduced productivity, increased job burnout, and a decline in the quality of public services. Although previous studies have identified trauma-related factors, they lack a comprehensive indigenous model with a focus on practical interventions. This study was conducted with the aim of designing a conceptual model of organizational trauma management using a cognitive–behavioral approach in Iranian public organizations. The research methodology was qualitative and based on thematic analysis (Braun & Clarke, 2006). The study population consisted of experts in management, human resources, and organizational psychology with at least five years of relevant experience. Purposeful and snowball sampling resulted in 19 semi-structured interviews until thematic saturation was reached. Data were analyzed using MAXQDA 2020 software, and validity was ensured through member checking, transferability, confirmability, and reliability (with an inter-coder agreement of 81%). The findings extracted four main dimensions: cognitive dimensions (cognitive restructuring, metacognitive awareness, cognitive flexibility, problem-solving); behavioral and emotional dimensions (self-control, adaptive and coping behaviors, emotional regulation, emotional intelligence, mood improvement); social and interactive dimensions (interpersonal communication, team cohesion, social problem-solving); and organizational and structural dimensions (cultural change, safe environment, managerial support, organization). This model demonstrates the reciprocal interaction of these dimensions in enhancing organizational resilience. The novelty of the study lies in presenting a localized model by integrating a cognitive–behavioral approach, which contributes new knowledge to the studied context, including the interpretation of the role of modifying thought patterns in reducing the effects of trauma under Iranian cultural pressures.

**Keywords:** Organizational trauma management, Cognitive–behavioral interventions, Self-control, Team cohesion, Managerial support

## Introduction

Organizational trauma has increasingly been recognized as a profound and multifaceted phenomenon that affects not only the psychological health of employees but also the structural resilience and long-term performance of institutions. As organizations encounter crises—whether acute disruptions such as pandemics, economic downturns, or systemic stressors including bureaucratic inefficiencies and cultural rigidity—the resulting trauma manifests across cognitive, behavioral, social, and organizational dimensions. This is particularly salient in public organizations where employees operate under high levels

of political pressure, limited resources, and societal expectations for service delivery. Addressing these challenges requires models of trauma management that are both theoretically grounded and practically adaptable. Recent scholarship highlights the necessity of integrating cognitive–behavioral frameworks into organizational settings, offering structured and evidence-based strategies for mitigating trauma's effects on individuals and institutions alike [1-3].

Trauma at the workplace can be conceptualized as the collective psychological and structural harm triggered by sudden, prolonged, or systemic crises that compromise organizational well-being and functionality [4]. Unlike individual trauma, organizational trauma extends beyond personal experience to become embedded in the structures, cultures, and relational dynamics of institutions. This duality means that employees' mental health outcomes are tightly interwoven with organizational norms, processes, and leadership behaviors [5]. For example, forensic medical staff and welfare workers frequently report exposure to occupational trauma, which in turn undermines commitment, efficiency, and resilience within their organizations [1, 5]. The recognition of this link has pushed management scholars and practitioners to explore models that situate trauma not merely as an individual mental health issue, but as a collective organizational challenge requiring systemic responses [6, 7].

The literature highlights that organizational trauma emerges from multiple sources, including structural misalignments, leadership failures, cultural rigidity, and systemic oppression. Research indicates that factors such as inadequate managerial support, lack of trust-based cultures, and over-centralized bureaucracies exacerbate the persistence of trauma [8, 9]. In educational contexts, for instance, both novice and experienced teachers demonstrate vulnerability to trauma due to organizational pressures and systemic stressors [10-12]. Similarly, structural issues in public institutions frequently amplify employees' susceptibility to burnout and stress, highlighting the critical need for effective trauma management frameworks [4].

Cognitive–behavioral interventions (CBIs) have been proposed as one of the most promising approaches to managing trauma in organizational contexts. These interventions rest on the premise that dysfunctional cognitions and maladaptive behavioral patterns can be identified, challenged, and restructured, thereby fostering resilience and adaptive functioning [2, 3]. For individuals, cognitive–behavioral therapy has long been recognized as effective in addressing post-traumatic stress, guilt, and anxiety symptoms [2]. When applied at the organizational level, CBIs can enhance employees' self-awareness, emotional regulation, and coping strategies, which in turn reduces the collective burden of trauma [13]. Indeed, a growing body of literature suggests that trauma-informed organizational practices rooted in cognitive–behavioral principles can shift organizational culture toward safety, trust, and empowerment [13, 14].

Recent empirical studies have expanded this conversation by developing tools and models for organizational trauma assessment and resilience-building. For example, the Organizational Trauma Resilience Assessment (OTRA) provides a validated instrument to measure trauma's impact across organizational dimensions and to evaluate resilience capacity [7]. Complementary to this, Tavana and colleagues propose an integrated data mining framework for resilience assessment and quality management optimization in trauma centers, offering innovative analytic strategies to guide organizational decision-making [15]. These contributions illustrate how interdisciplinary methods—ranging from psychometric evaluation to operations research—can enhance our ability to understand and address trauma at systemic levels.

Moreover, the interplay between trauma and organizational culture has been emphasized as central to resilience. A positive work environment characterized by trust, collaboration, and shared values enables institutions to mitigate trauma's

effects and foster recovery [8, 16]. In contrast, rigid and fragmented cultures often exacerbate employees' sense of vulnerability and alienation, reinforcing cycles of dysfunction [6]. Evidence also points to the critical role of leadership in trauma management: supportive leaders who demonstrate empathy, transparency, and commitment to staff welfare are more likely to foster resilient environments [17, 18]. Leadership behaviors aligned with cognitive–behavioral principles—such as encouraging reframing of irrational beliefs, promoting adaptive coping, and facilitating collaborative problem-solving—contribute to sustainable organizational recovery [3].

The Iranian context provides a unique lens through which to examine organizational trauma. Public organizations in Iran are often marked by bureaucratic complexity, centralized decision-making, and exposure to sociopolitical pressures. These systemic conditions amplify employees' vulnerability to trauma, leading to chronic issues such as reduced productivity, burnout, and service delivery decline. While international research has provided generalizable insights into organizational trauma and resilience, localized models are necessary to account for specific cultural, political, and structural features [16, 19]. For instance, the adaptation of behavioral models in technology adoption or cooperative structures in Iranian institutions highlights the significance of context-sensitive designs [16, 19]. This underscores the need for indigenous frameworks of trauma management that not only integrate global cognitive–behavioral principles but also reflect the realities of Iranian public organizations.

Studies within Iran have begun to lay the groundwork for this endeavor. Research by Ebrahimi and colleagues has proposed models of organizational trauma management in the education sector, emphasizing the role of grounded theory and mixed-method approaches to capture both cognitive and structural dimensions of trauma [10, 11]. Similarly, Ghafoori and collaborators identified trauma-inducing factors among elementary teachers, revealing systemic stressors that transcend individual coping strategies [12]. These findings highlight the limitations of imported models and stress the importance of designing interventions rooted in Iran's institutional landscape.

The cognitive–behavioral approach offers a particularly relevant strategy in this context. By focusing on the reconstruction of maladaptive thought patterns, enhancement of self-control and emotional regulation, and development of collective resilience, this approach aligns with both psychological and organizational needs. As Jonker and colleagues emphasize, frameworks for trauma management must integrate psychological interventions with organizational-level strategies to be effective in high-risk professions [17]. Likewise, Young's work on guilt-focused CBT interventions demonstrates how targeting cognitive distortions can reduce emotional burdens after trauma [2]. When applied to Iranian public organizations, such strategies can empower employees to navigate systemic pressures while simultaneously fostering healthier institutional cultures.

An additional dimension of relevance is the growing discourse on resilience in organizational studies. Resilience is increasingly viewed not as a static trait but as a dynamic capacity developed through proactive adaptation and learning [18]. Studies of organizational resilience during crises, such as COVID-19, demonstrate that trauma can serve as both a source of vulnerability and a catalyst for innovation [14]. For example, trauma-informed care interventions have shown effectiveness at the organizational level in creating safer, more responsive institutions [13]. In Iran, integrating resilience into trauma management models could provide a pathway for transforming crisis into opportunity, aligning with broader reform agendas in public administration [4].

Furthermore, the use of advanced methodologies, such as optimization algorithms and hybrid modeling techniques, illustrates how trauma management can be supported by technological and analytical innovations [20-22]. While such approaches have primarily been applied in fields like operations management, tourism, and sports, their underlying principles of systematic analysis and efficiency enhancement are applicable to organizational trauma contexts as well. Incorporating these methods into trauma management frameworks could enable Iranian public organizations to better predict, monitor, and respond to crises in a structured manner.

In summary, the growing body of research demonstrates that organizational trauma is a multidimensional phenomenon that requires integrative and context-sensitive models for effective management. Cognitive–behavioral approaches provide robust theoretical and practical tools for restructuring dysfunctional cognitions, enhancing coping behaviors, and fostering resilient organizational cultures [2, 3]. Empirical evidence from diverse contexts underscores the necessity of embedding these strategies into systemic frameworks that account for leadership, culture, structure, and employee well-being [7, 13, 17]. For Iranian public organizations, developing an indigenous conceptual model that synthesizes global insights with local realities represents both an urgent necessity and an opportunity for innovation [16, 19].

The present study aims to contribute to this discourse by designing a conceptual model of organizational trauma management based on a cognitive–behavioral approach within the context of Iranian public organizations.

## Methods and Materials

The present study was designed with a qualitative approach based on thematic analysis to provide a conceptual model of organizational trauma management using a cognitive–behavioral approach in Iranian public organizations. This study is applied in nature and aimed to identify and extract the dimensions, components, and sub-indicators related to organizational trauma management in Iranian public organizations. The research methodology was designed in such a way as to reflect the views of experts and practitioners accurately while ensuring the validity, comprehensiveness, and practical applicability of the results.

The study population included experts and scholars in the fields of management, human resources, organizational psychology, and behavioral sciences with expertise in organizational trauma, crisis management in organizations, or issues related to employee mental health in Iranian public organizations. Additionally, senior managers and experts from public organizations who were familiar with the challenges and opportunities of organizational trauma management in the workplace formed part of the study population. Sampling was conducted through a combination of purposive (judgmental) and snowball methods. In the first stage, six key experts were purposively selected based on the research team's knowledge of their expertise and academic and practical background in managing public organizations and familiarity with organizational trauma issues and cognitive–behavioral approaches in organizations. Subsequently, using the snowball method, 13 more participants were introduced by the initial experts, leading to a final sample of 19 participants. With 19 semi-structured interviews, thematic saturation was achieved, meaning that continuing interviews no longer generated new insights beyond the previously identified themes.

Inclusion criteria consisted of having at least five years of relevant executive or research experience in public sector management, human resources, or industrial and organizational psychology; familiarity with challenges and opportunities of organizational trauma management, particularly from a cognitive–behavioral perspective, in public workplaces; the ability to

provide in-depth and analytical perspectives on cognitive, behavioral, and managerial aspects of organizational trauma; and informed consent for participating in interviews and audio recording. To ensure data comprehensiveness, diversity in the selection of experts was considered in terms of work experience, academic expertise, and type of organization (research centers, universities, and government agencies).

Research data were collected through in-depth semi-structured interviews. The interview questions were open-ended and designed to explore participants' experiences, perspectives, and analyses on "organizational trauma management with a cognitive–behavioral approach in Iranian public organizations." The initial questions were developed based on a review of theoretical literature related to organizational trauma, human resource management, organizational behavior, and cognitive–behavioral psychology studies. Topics included cognitive and behavioral challenges in dealing with organizational trauma in public organizations, organizational culture, the role of leadership in creating resilient environments, and managerial strategies to enhance employee productivity and well-being under trauma. At the end of each interview, an open question such as "Is there any topic or issue in this area that we have not addressed?" was asked to allow for additional and more comprehensive viewpoints. The duration of each interview ranged from 40 to 100 minutes, with an average of approximately 60 minutes. For precise data recording, audio recorders were used alongside note-taking. Prior to each interview, verbal or written consent was obtained from participants for audio recording to ensure compliance with ethical considerations such as confidentiality and anonymity. Interview locations were selected in agreement with participants and were often conducted in quiet, private settings such as office spaces or university environments. To enhance preparedness, a letter containing research details, key objectives, and guiding questions was emailed to participants.

Data analysis was performed using thematic analysis following Braun and Clarke's (2006) six-phase framework. In the first phase (familiarization with data), full transcripts of the interviews were carefully read and reviewed multiple times to enable the researcher to gain a comprehensive understanding of the content. In the second phase (generating initial codes), key semantic units and important sentences relevant to the research topic were extracted from each interview, yielding 273 semantic units, which were further reduced to 88 open (initial) codes. In the third phase (searching for themes), open codes were grouped based on similarities, conceptual relationships, and semantic overlaps, resulting in 17 axial codes. In the fourth phase (reviewing themes), the identified preliminary themes were refined to ensure they had sufficient internal consistency and were distinct from one another. In the fifth phase (defining and naming themes), each theme was clearly defined and named, with its relationship to the research objectives specified, which ultimately led to four selective codes. In the sixth and final phase (producing the report), findings were presented in the form of a comprehensive conceptual model for organizational trauma management with a cognitive–behavioral approach in Iranian public organizations. MAXQDA 2020 software was used for data organization and analysis.

To ensure the validity, transferability, confirmability, and reliability of results in this qualitative study, the corresponding criteria were carefully addressed. For credibility, existing sources were used, and the transcribed interviews and extracted codes were sent to some participants for feedback to refine, correct, and validate the codes and themes. To ensure transferability, detailed documentation was provided for other researchers, including demographic reports, participant experiences, and descriptions of the research setting, enabling applicability to similar contexts. For confirmability, all research steps were transparently documented, allowing for external review. For reliability, inter-coder agreement between two

independent coders was calculated, with an agreement rate of 83% reported (see Table 1), demonstrating high consistency in the analysis process and reliability of the results.

Ethical principles were carefully observed throughout the research process. The identity of participants was kept confidential, and data were analyzed anonymously. Consent for audio recording was obtained, and research objectives were clearly explained to participants to ensure full understanding of the process.

**Table 1.**

*Results of Inter-Coder Reliability Check*

| Interview Number | Total Codes | Agreements | Disagreements | Reliability (%) |
|---|---|---|---|---|
| 2 | 25 | 21 | 4 | 84.0% |
| 9 | 20 | 17 | 3 | 85.0% |
| 12 | 27 | 22 | 5 | 81.5% |
| Total | 72 | 60 | 12 | 83.4% |

## Findings and Results

The findings of this qualitative study, conducted using a thematic analysis approach, present a conceptual model of organizational trauma management with a cognitive–behavioral approach in Iranian public organizations. This model was extracted based on in-depth analysis of interviews with 19 experts and specialists in the fields of management, organizational psychology, and behavioral sciences in Iranian public organizations. The thematic analysis process led to the identification of four main dimensions, including “cognitive dimensions of trauma,” “behavioral and emotional dimensions of trauma,” “social and interactive dimensions of trauma,” and “organizational and structural dimensions of trauma.” Each of these dimensions includes related components and sub-indicators, which are described in detail below. Table 2 presents the demographic information of the interviewees.

**Table 2.**

*Demographic Information of Research Participants*

| ID | Occupation | Education | Age | Gender | Field of Expertise | Relevant Experience (Years) |
|---|---|---|---|---|---|---|
| M1 | University Professor | PhD | 48 | Male | Human Resource Management, Organizational Behavior | 15 |
| M2 | Senior Public Sector Manager | PhD | 55 | Male | Public Administration, Public Policy | 20 |
| M3 | Organizational Psychologist | PhD | 42 | Female | Industrial & Organizational Psychology, Mental Health | 10 |
| M4 | Trauma Researcher | PhD | 40 | Female | Organizational Psychology, Crisis Management | 8 |
| M5 | Human Resource Consultant | MA | 50 | Male | Employee Empowerment, Workplace Mental Health | 18 |
| M6 | University Professor | PhD | 52 | Male | Organizational Behavior Management, Organizational Culture | 22 |
| M7 | Senior HR Expert (Public Sector) | MA | 37 | Female | Recruitment & Retention, Performance Management | 9 |
| M8 | Public Sector Project Manager | MA | 45 | Male | Crisis Management, Organizational Resilience | 12 |
| M9 | University Professor | PhD | 50 | Female | Industrial Psychology, Stress Management | 17 |
| M10 | Deputy Minister | PhD | 60 | Male | Administrative Reform, Organizational Development | 25 |
| M11 | Training & Development Specialist | PhD | 43 | Male | Organizational Training, Cognitive–Behavioral Skills | 14 |
| M12 | Clinical Psychologist | PhD | 47 | Female | Cognitive–Behavioral Interventions, Mental Health | 16 |
| M13 | Organizational Welfare Expert | MA | 39 | Male | Psychological Support, Public Services | 11 |
| M14 | University Professor | PhD | 53 | Male | Strategic Management, Organizational Resilience | 20 |
| M15 | Middle Manager (Public Sector) | MA | 41 | Female | Team Management, Intra-Organizational Communication | 13 |
| M16 | Psychology Consultant | PhD | 49 | Male | Organizational Pathology, Trauma Management | 15 |
| M17 | Director General (Ministry) | PhD | 58 | Male | Strategic Management, Organizational Transformation | 23 |
| M18 | Organizational Psychologist | PhD | 44 | Female | Organizational Behavior, Cognitive Interventions | 12 |
| M19 | Senior Public Sector Manager | PhD | 56 | Male | Public Policy, Crisis Management | 21 |

### A) Step One: Open Coding and Extraction of Axial Codes

In this phase, which constitutes the first step of thematic analysis based on Braun and Clarke’s (2006) method, the process began with deep familiarization with the data, followed by the generation of initial codes (open codes). After the precise

transcription of all 19 expert interviews, each transcript was carefully read multiple times to enable the researcher to gain a comprehensive understanding of their content. Then, all 273 meaningful statements and sentences that referred in some way to the subject of organizational trauma management with a cognitive–behavioral approach in Iranian public organizations—covering challenges, opportunities, dimensions, and related components—were extracted and identified as initial open codes. These open codes represented raw, unprocessed concepts directly drawn from the data. Subsequently, these 273 semantic expressions and 88 open codes were grouped into 17 axial codes (components) based on semantic and conceptual similarities as well as their interrelationships. The purpose of this phase was to summarize and organize the vast amount of raw data into broader concepts, which laid the foundation for the development of main themes in the subsequent stages of analysis. Table 3 illustrates the process of open coding, the extraction of semantic expressions, and the axial codes (components), along with the corresponding interviewee codes.

**Table 3.**

*Initial Codes and Axial Codes*

| Axial Codes (Components) | Open Codes | Interview Code | Frequency |
|---|---|---|---|
| Cognitive Restructuring and Trauma Processing | Correcting traumatic beliefs | M17, M13, M6 | 3 |
| | Changing traumatic thought patterns | M18, M14, M3, M1 | 4 |
| | Realistic thinking after trauma | M2, M19, M11, M1 | 4 |
| | Correcting traumatic self-talk | M8, M15, M1 | 3 |
| | Judgment and decision-making after trauma | M9, M4, M16, M1, M2 | 5 |
| Metacognitive Awareness and Understanding of Trauma Consequences | Understanding traumatic thinking | M7, M12, M5 | 3 |
| | Processing trauma-related information | M10, M3, M19 | 3 |
| | Decision-making factors after trauma | M14, M6, M1 | 3 |
| | Monitoring trauma-related mental processes | M17, M11, M8, M1 | 4 |
| Cognitive Flexibility in Facing Trauma | Adapting to traumatic conditions | M18, M2, M13 | 3 |
| | Changing perspectives on trauma challenges | M9, M15, M4 | 3 |
| | Acceptance of organizational changes (trauma) | M16, M7, M12, M1 | 4 |
| | Creative thinking in trauma management | M5, M10, M3 | 3 |
| | Adjusting to traumatic situations | M19, M14, M6 | 3 |
| | Learning from past trauma | M1, M17, M11 | 3 |
| Problem-Solving in the Context of Organizational Trauma | Identifying organizational trauma issues | M8, M18, M2 | 3 |
| | Analyzing trauma factors | M13, M9, M15, M2 | 4 |
| | Developing trauma-related solutions | M4, M16, M7 | 3 |
| | Evaluating trauma-related solutions | M12, M5, M10 | 3 |
| | Implementing and monitoring trauma management | M3, M19, M8, M14 | 4 |
| Self-Control Skills in Facing Trauma | Controlling trauma-related anxiety | M6, M1, M17 | 3 |
| | Managing trauma-related stress | M11, M8, M18 | 3 |
| | Patience and endurance after trauma | M2, M13, M9 | 3 |
| | Controlling impulsive trauma reactions | M15, M4, M16 | 3 |
| | Self-discipline in trauma | M7, M12, M5 | 3 |
| Adaptive Individual Behaviors After Trauma | Positive behavioral patterns after trauma | M10, M3, M19 | 3 |
| | Motivation and perseverance in trauma recovery | M14, M6, M1 | 3 |
| | Self-care after trauma | M17, M11, M8 | 3 |
| | Behavioral self-regulation in trauma | M18, M2, M13 | 3 |
| | Improved performance after trauma | M9, M15, M4 | 3 |
| Trauma-Focused Coping Skills | Trauma coping strategies | M16, M7, M12 | 3 |
| | Resistance to trauma-related pressure | M5, M10, M3 | 3 |
| | Trauma defense mechanisms | M19, M14, M6 | 3 |
| | Rapid recovery from trauma | M1, M17, M11 | 3 |
| | Individual resilience in trauma | M8, M18, M2 | 3 |
| Emotional Regulation After Trauma | Managing negative trauma-related emotions | M13, M9, M15 | 3 |
| | Controlling trauma-related anxiety and fear | M4, M16, M7 | 3 |
| | Enhancing positive emotions after trauma | M12, M5, M10 | 3 |
| | Controlling trauma-related emotional reactions | M3, M19, M14 | 3 |
| | Coping with occupational trauma | M6, M1, M17 | 3 |
| Individual Emotional Intelligence in the Context of Trauma | Emotional self-awareness in trauma | M11, M8, M18 | 3 |
| | Recognizing personal trauma-related emotions | M2, M13, M9 | 3 |
| | Impact of trauma-related emotions on behavior | M15, M4, M3 | 3 |

| | | | |
|---|---|---|---|
| | Impact of trauma-related emotions on performance | M7, M12, M5 | 3 |
| | Managing trauma-related affective states | M10, M3, M19, M4 | 4 |
| Mood and Affect Improvement After Trauma | Increasing positive emotions after trauma | M14, M6, M8 | 3 |
| | Reducing negative trauma-related emotions | M17, M11, M8 | 3 |
| | Boosting morale after trauma | M18, M2, M4 | 3 |
| | Confidence after trauma | M9, M15, M4 | 3 |
| | Positive work attitude after trauma | M16, M7, M12 | 3 |
| Improvement of Interpersonal Communication After Trauma | Professional communication skills | M5, M10, M3 | 3 |
| | Active listening in trauma | M19, M14, M6 | 3 |
| | Mutual understanding and empathy | M1, M17, M11 | 3 |
| | Conflict management after trauma | M8, M18, M2 | 3 |
| | Positive work relationships after trauma | M13, M9, M15 | 3 |
| | Recognizing others' emotions | M4, M16, M7 | 3 |
| | Managing emotional relationships | M12, M5, M10 | 3 |
| Strengthening Team Cohesion | Team cooperation and participation in trauma | M3, M19, M4 | 3 |
| | Mutual team trust | M6, M1, M17 | 3 |
| | Group belongingness | M11, M8, M18 | 3 |
| | Team spirit in trauma | M2, M13, M9 | 3 |
| | Team coordination in trauma | M15, M4, M3 | 3 |
| | Cooperation and participation in trauma | M7, M12, M5 | 3 |
| Social Problem-Solving Skills in Organizational Context | Negotiation skills (public organization) | M10, M3, M15 | 3 |
| | Social adaptation in public organizations | M14, M6, M1 | 3 |
| | Teamwork (social) skills | M17, M11, M8 | 3 |
| | Managing social tensions | M18, M2, M13 | 3 |
| | Collective decision-making | M9, M15, M4 | 3 |
| Organizational Culture Change Toward Trauma Management | Culture of trust | M16, M7, M12 | 3 |
| | Shared values (public organization) | M5, M10, M3 | 3 |
| | Positive work environment | M19, M14, M6 | 3 |
| | Organizational flexibility | M1, M6, M11 | 3 |
| | Culture of continuous learning | M8, M18, M2 | 3 |
| Creating a Safe Work Environment for Trauma Recovery | Employee psychological safety | M13, M9, M15 | 3 |
| | Reducing stressors | M4, M16, M7 | 3 |
| | Open climate for expression | M12, M5, M10 | 3 |
| | Employee support during trauma crisis | M3, M19, M14 | 3 |
| | Trauma support systems | M6, M1, M17 | 3 |
| Specialized Managerial Support for Trauma Management | Supportive leadership | M11, M8, M18 | 3 |
| | Effective communication systems | M2, M13, M9 | 3 |
| | Training programs (CBT) | M15, M4, M16 | 3 |
| | Availability of trauma management resources | M7, M12, M5 | 3 |
| | Feedback systems | M10, M3, M19 | 3 |
| Organization and Structure for Trauma Response | Optimizing trauma management processes | M14, M6, M1 | 3 |
| | Coordination across units | M17, M11, M8 | 3 |
| | Accountability systems | M18, M2, M13 | 3 |
| | Information systems | M9, M15, M4 | 3 |
| | Organizational transparency | M16, M7, M12 | 3 |

**B) Step Two: Searching and Reviewing Themes (Selective Codes)**

After extracting 17 axial codes from the open coding stage, this step involved further organizing and summarizing these codes. The axial codes, each representing a cluster of open codes, were classified into broader groups based on conceptual and logical relationships. This process led to the identification and formation of four main dimensions (selective themes), each covering a general domain of the conceptual model of organizational trauma management with a cognitive–behavioral approach in Iranian public organizations. These dimensions are: "Cognitive Dimensions of Trauma," "Behavioral and Emotional Dimensions of Trauma," "Social and Interactive Dimensions of Trauma," and "Organizational and Structural Dimensions of Trauma."

In the theme searching stage, efforts were made to group axial codes with shared or related concepts under one main theme. For instance, the axial codes "Cognitive Restructuring and Trauma Processing," "Metacognitive Awareness and

Understanding of Trauma Consequences," and "Cognitive Flexibility in Facing Trauma," all of which pointed to mental and cognitive processes associated with trauma management, were placed under the main dimension of "Cognitive Dimensions of Trauma." After forming these initial dimensions, the theme reviewing stage began. In this phase, each of the four identified dimensions (selective themes) was carefully examined to ensure internal coherence. Moreover, the distinctiveness of the dimensions and the absence of semantic overlap were evaluated. If necessary, some axial codes were moved between themes, or the naming of themes was revised to provide the most accurate representation of the axial codes contained within. This iterative process refined and clarified the conceptual model and ensured that the final dimensions best represented the interview data, providing a coherent framework for understanding organizational trauma management with a cognitive–behavioral approach in Iranian public organizations. Ultimately, these four main dimensions were established as the pillars of the study's conceptual model.

**Table 4.**

*Axial and Selective Coding*

| Axial Codes | Selective Codes |
|---|---|
| Cognitive Restructuring and Trauma Processing | Cognitive Dimensions of Trauma |
| Metacognitive Awareness and Understanding of Trauma Consequences | |
| Cognitive Flexibility in Facing Trauma | |
| Problem-Solving in the Context of Organizational Trauma | |
| Self-Control Skills in Facing Trauma | Behavioral and Emotional Dimensions of Trauma |
| Adaptive Individual Behaviors After Trauma | |
| Trauma-Focused Coping Skills | |
| Emotional Regulation After Trauma | |
| Individual Emotional Intelligence in the Context of Trauma | |
| Mood and Affect Improvement After Trauma | |
| Improvement of Interpersonal Communication After Trauma | Social and Interactive Dimensions of Trauma |
| Strengthening Team Cohesion | |
| Social Problem-Solving Skills in the Organizational Context | |
| Organizational Culture Change Toward Trauma Management | Organizational and Structural Dimensions of Trauma |
| Creating a Safe Work Environment for Trauma Recovery | |
| Specialized Managerial Support for Trauma Management | |
| Organization and Structure for Trauma Response | |

**C) Step Three: Defining and Naming Themes and Developing Sub-Indicators**

In this phase, which corresponds to the fifth stage of Braun and Clarke's (2006) six-phase thematic analysis, after identifying the four main dimensions (selective themes) in Step Two, the focus shifted to the precise definition and naming of these themes and the development of sub-indicators associated with each component (axial code). The aim of this step was to provide a comprehensive and clear description of each theme so that its relationship with the main research objective—designing a conceptual model of organizational trauma management with a cognitive–behavioral approach in Iranian public organizations—would be well articulated.

In this stage, each of the 17 components (axial codes) identified in the previous step was carefully reviewed to extract and define the sub-indicators embedded in the semantic expressions. These sub-indicators are essentially more specific and measurable concepts that clarify the content of the components and allow their operationalization within a conceptual model. For example, for the component "Cognitive Restructuring and Trauma Processing," sub-indicators such as "correcting irrational beliefs," "changing dysfunctional thought patterns," "cultivating realistic thinking," "correcting negative self-talk," and "improving judgment and decision-making" were identified, all of which refer to different aspects of cognitive

restructuring in response to organizational trauma. These sub-indicators were primarily defined in terms of keywords and indicators of behavioral, cognitive, or organizational processes.

Ultimately, the results of this step are presented in the table below, which shows the main dimensions, the components of each dimension, and the sub-indicators associated with each component. This table clearly demonstrates the final structure of the conceptual model derived from the qualitative data.

**Table 5.**

*Main Dimensions, Components, and Sub-Indicators of the Organizational Trauma Management Model with a Cognitive–Behavioral Approach*

| Main Dimensions (Selective Codes) | Components (Axial Codes) | Sub-Indicators |
|---|---|---|
| Cognitive Dimensions of Trauma | Cognitive Restructuring and Trauma Processing | Correcting irrational beliefs, changing dysfunctional thought patterns, cultivating realistic thinking, correcting negative self-talk, improving judgment and decision-making |
| | Metacognitive Awareness and Understanding of Trauma Consequences | Understanding trauma-related mental processes, processing threatening information, identifying decision-making factors, monitoring thought processes |
| | Cognitive Flexibility in Facing Trauma | Adapting to crisis conditions, revising perspectives, accepting organizational changes, creative thinking, learning from past experiences |
| | Problem-Solving in the Context of Organizational Trauma | Identifying root problems, analyzing trauma factors, generating practical solutions, evaluating solutions, monitoring and implementing trauma management |
| Behavioral and Emotional Dimensions of Trauma | Self-Control Skills in Facing Trauma | Managing anxiety and stress, patience and endurance, controlling impulsive reactions, self-discipline |
| | Adaptive Individual Behaviors After Trauma | Cultivating positive behaviors, motivation and perseverance, self-care, behavioral self-regulation, performance improvement |
| | Trauma-Focused Coping Skills | Coping strategies, resistance to pressure, defense mechanisms, rapid recovery, individual resilience |
| | Emotional Regulation After Trauma | Managing negative emotions, controlling anxiety and fear, enhancing positive emotions, managing emotional reactions, coping with occupational trauma |
| | Individual Emotional Intelligence in the Context of Trauma | Emotional self-awareness, recognizing personal emotions, effects of emotions on behavior and performance, managing affective states |
| | Mood and Affect Improvement After Trauma | Increasing positive emotions, reducing negative emotions, boosting morale, confidence, positive work attitude |
| Social and Interactive Dimensions of Trauma | Improvement of Interpersonal Communication After Trauma | Professional communication skills, active listening, mutual understanding and empathy, conflict management, positive work relationships, recognizing others' emotions, managing emotional relationships |
| | Strengthening Team Cohesion | Team cooperation and participation, mutual trust, sense of group belonging, team spirit, team coordination |
| | Social Problem-Solving Skills in the Organizational Context | Negotiation skills, social adaptation, teamwork, managing social tensions, collective decision-making |
| Organizational and Structural Dimensions of Trauma | Organizational Culture Change Toward Trauma Management | Culture of trust, shared values, positive work environment, organizational flexibility, culture of continuous learning |
| | Creating a Safe Work Environment for Trauma Recovery | Employee psychological safety, reducing stressors, open climate for expression, employee support during crises, trauma support systems |
| | Specialized Managerial Support for Trauma Management | Supportive leadership, effective communication systems, cognitive–behavioral training programs, availability of resources, feedback systems |
| | Organization and Structure for Trauma Response | Process optimization, inter-unit coordination, accountability systems, information systems, organizational transparency |

**D) Step Four: Comprehensive Description of Themes and Components (Content Analysis)**

In this step, a detailed and rich description of each of the four main dimensions (selective themes) and their underlying components is presented. This description includes the explanation of concepts, the semantic relationships and interconnections between components, as well as examples of semantic expressions extracted from the interviews for each component, in order to enhance the transparency and validation of the findings.

**Cognitive Dimensions of Trauma:** This dimension emphasizes the mental and cognitive processes related to organizational trauma management using a cognitive–behavioral approach. The findings indicate that cognitive restructuring and trauma processing through correcting irrational beliefs (M17) and changing dysfunctional thought patterns (M18) are essential for improving both individual and organizational performance. Metacognitive awareness, including understanding trauma-related mental processes (M7) and monitoring them (M11), helps employees manage their reactions in the face of trauma. Cognitive flexibility, such as adapting to crisis conditions (M18) and learning from past traumas (M1), enables organizations to adjust to sudden changes. Problem-solving in the context of trauma, by identifying root causes (M8) and generating practical solutions (M4), helps mitigate the negative effects of trauma. The absence of these skills can lead to the continuation of negative cognitive cycles and decreased productivity.

**Behavioral and Emotional Dimensions of Trauma:** This dimension focuses on employees' individual behaviors and emotions when confronted with organizational trauma. Self-control skills, such as managing anxiety (M6) and trauma-related stress (M11), are vital for reducing impulsive reactions and maintaining emotional stability. Adaptive individual behaviors, including self-care (M17) and behavioral self-regulation (M18), contribute to faster recovery of employees. Trauma-focused coping skills, such as individual resilience (M8) and coping strategies (M16), allow employees to withstand trauma-related pressures. Emotional regulation, including managing negative emotions (M13) and enhancing positive emotions (M12), supports mood and affect improvement. Emotional intelligence, with emotional self-awareness (M11) and managing affective states (M10), leads to better performance under crisis conditions. The absence of these skills can result in increased job burnout and decreased organizational commitment.

**Social and Interactive Dimensions of Trauma:** This dimension involves processes and contexts that contribute to improving intra-organizational interactions and reducing the social effects of trauma. Enhancing interpersonal communication, including professional communication skills (M5) and mutual understanding and empathy (M1), helps reduce conflicts and misunderstandings. Strengthening team cohesion, through teamwork and collaboration (M3) and mutual trust (M6), fosters a sense of group belongingness (M11). Social problem-solving skills, such as negotiation (M10) and collective decision-making (M9), assist in managing social tensions in public organizations. The absence of these skills can lead to social isolation, decreased team cooperation, and increased interpersonal conflicts.

**Organizational and Structural Dimensions of Trauma:** This dimension refers to the organizational structures and cultures governing public organizations that influence trauma management. Organizational culture change, including the creation of a culture of trust (M16) and shared values (M5), contributes to improving a positive work environment (M19). Creating a safe work environment, with psychological safety for employees (M13) and reducing stressors (M4), is essential for trauma recovery. Specialized managerial support, including supportive leadership (M11) and cognitive–behavioral training programs (M15), helps empower employees. Organization and structure for trauma response, including process optimization (M14) and organizational transparency (M16), lead to increased agility and accountability. Complex bureaucratic structures and

excessive centralization can hinder effective trauma management, whereas organizational flexibility (M1) and a culture of continuous learning (M8) contribute to organizational resilience.

This comprehensive description of dimensions and components, based on semantic expressions extracted from interviews, provides a coherent framework for understanding and managing organizational trauma with a cognitive–behavioral approach in Iranian public organizations. Examples of semantic expressions, such as “a careful review of irrational beliefs is essential” (M17) or “creating an environment where employees can express their opinions without fear is vital” (M13), highlight the depth and richness of qualitative data supporting this conceptual model.

**E) Step Five: Preparing the Final Report and Presenting the Conceptual Model**

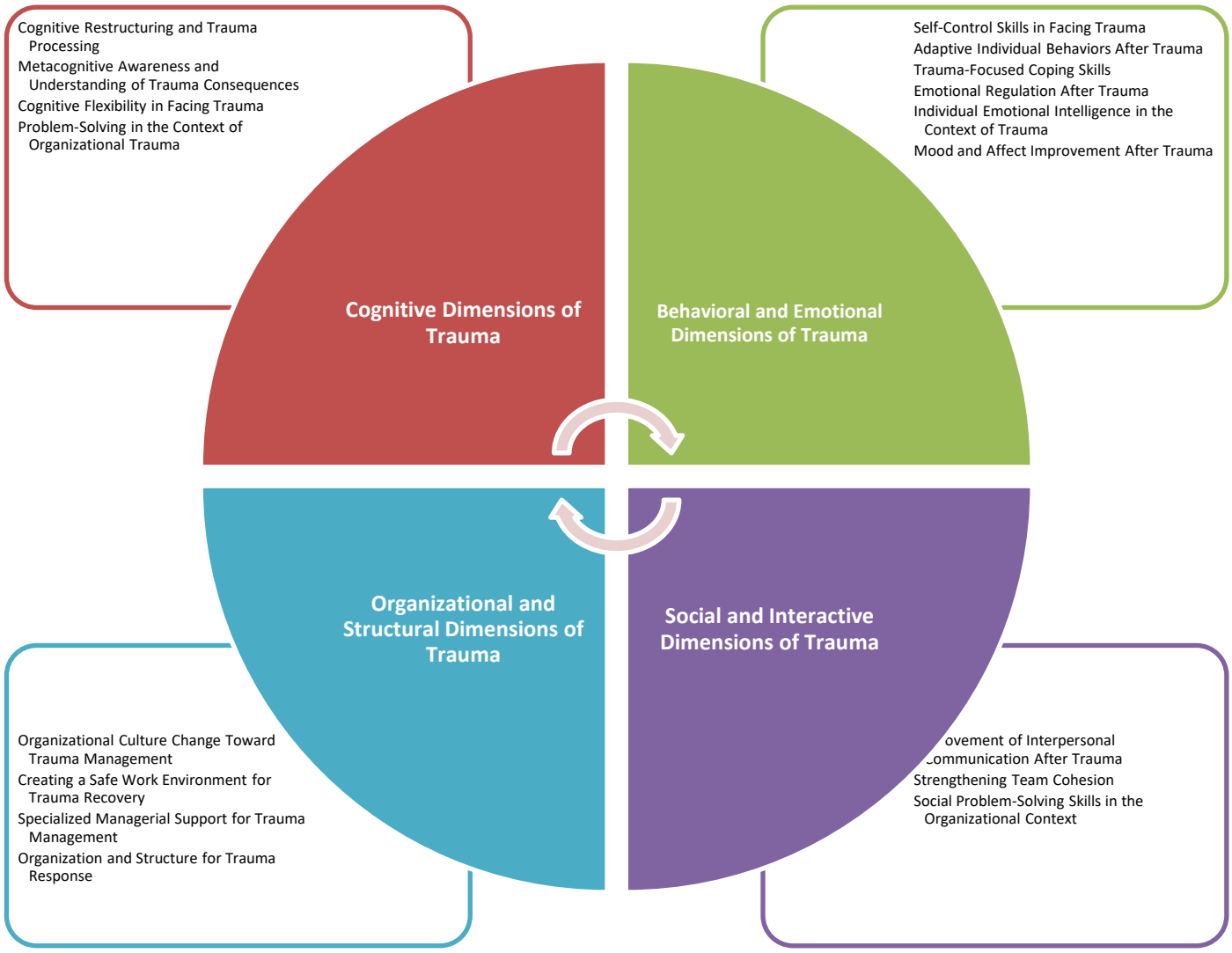
In this final step, the results from all stages of thematic analysis (familiarization with data, initial coding, searching and reviewing themes, and defining and naming themes and sub-indicators) are integrated into a coherent conceptual model for organizational trauma management with a cognitive–behavioral approach in Iranian public organizations. This model provides a comprehensive framework for understanding the various dimensions of the phenomenon and the factors influencing it.

The proposed conceptual model, derived from expert perspectives and developed through qualitative thematic analysis, not only describes the current situation (dimensions, components, and sub-indicators) but also serves as a roadmap for policymakers and human resource managers in Iranian public organizations. This model can serve as a foundation for developing targeted intervention programs, managerial policies to reduce the effects of trauma, and designing more resilient and efficient workplaces for employees affected by organizational trauma. In this section, the relationships among the four identified dimensions (cognitive dimensions of trauma, behavioral and emotional dimensions of trauma, social and interactive dimensions of trauma, and organizational and structural dimensions of trauma) and the ways they interact to overcome the challenges of organizational trauma in public organizations are comprehensively explained. The focus on these four dimensions provides the opportunity to establish a multidimensional and sustainable approach to effectively managing organizational trauma and enhancing the mental health and productivity of public organizations.

As illustrated in the conceptual model presented in Figure 1, this model consists of four main dimensions, each encompassing multiple components and sub-indicators. The complete details of these dimensions, components, and sub-indicators can be seen separately in Table 5.

**Figure 1.**

*Conceptual Model of Organizational Trauma Management with a Cognitive–Behavioral Approach in Iranian Public Organizations*




## Discussion and Conclusion

The purpose of this study was to design a conceptual model of organizational trauma management with a cognitive–behavioral approach in Iranian public organizations. The qualitative thematic analysis, based on interviews with 19 experts in management, psychology, and organizational sciences, revealed four main dimensions of organizational trauma: cognitive, behavioral and emotional, social and interactive, and organizational and structural. Each of these dimensions included multiple components and sub-indicators that together formed a comprehensive framework. The findings provide both theoretical insights and practical guidance for managing organizational trauma in contexts characterized by bureaucratic complexity, political and economic pressures, and cultural stressors.

The first dimension, cognitive trauma, underscored the importance of restructuring irrational beliefs, fostering metacognitive awareness, and promoting cognitive flexibility. The results highlighted that employees often internalize trauma through distorted thought patterns that perpetuate cycles of fear, hopelessness, and inefficiency. Interventions that emphasize realistic thinking, self-talk correction, and problem-solving strategies are essential for breaking these cycles. This aligns with research showing that cognitive restructuring is one of the most effective mechanisms in reducing trauma-related distress at both individual and organizational levels [2, 3]. The findings also resonate with the work of King [1], who demonstrated that trauma exposure in child welfare workers significantly impacts their mental health and organizational commitment, and that cognitive-focused interventions can mitigate such outcomes. Similarly, Brown and colleagues [7] introduced the Organizational Trauma Resilience Assessment, which emphasizes cognition and perception as central domains for resilience measurement, further validating the significance of cognitive dimensions in trauma management.

The behavioral and emotional dimension of trauma revealed the importance of self-control, emotional regulation, adaptive coping behaviors, and emotional intelligence. Participants described how the inability to regulate emotions under traumatic organizational conditions leads to impulsive reactions, burnout, and decreased organizational commitment. Conversely, when employees engaged in adaptive behaviors such as self-care, behavioral regulation, and resilience-focused coping, they were more capable of recovering and contributing productively. These findings support previous research stressing the necessity of emotional regulation skills in trauma management [13, 17]. Fernández and colleagues [13], in their systematic review, confirmed that trauma-informed care interventions at the organizational level are most effective when they integrate behavioral and emotional regulation mechanisms. Furthermore, Jonker and colleagues [17] developed an intervention framework for high-risk occupations, demonstrating that emotional resilience and coping strategies reduce long-term trauma outcomes.

The third dimension, social and interactive trauma, emphasized the improvement of interpersonal communication, strengthening of team cohesion, and development of social problem-solving skills. The findings revealed that trauma weakens trust, disrupts team functioning, and fosters interpersonal conflicts. However, interventions focusing on active listening, empathy, collaborative negotiation, and collective decision-making strengthened social cohesion and reduced conflict. These results are consistent with Lindsay's work [6], which explored the interplay of trauma and systemic oppression, showing that organizational healing requires systemic approaches that rebuild relationships and foster trust. Similarly, Wayland and colleagues [5] found that occupational trauma among forensic staff undermines collegial trust and collaboration, suggesting that addressing social dimensions is critical for effective trauma management. This is further echoed in Ghafoori et al. [12], who identified social isolation and diminished collaboration as key outcomes of organizational trauma among teachers, pointing to the universal relevance of the social dimension.

The fourth dimension, organizational and structural trauma, addressed issues related to organizational culture, managerial support, safe work environments, and structural processes. Participants stressed that rigid bureaucratic structures, lack of transparency, and inadequate leadership support exacerbated trauma effects. In contrast, organizations with cultures of trust, continuous learning, and supportive leadership demonstrated higher resilience. These findings confirm Moradi's conceptual work [4], which contrasted organizational health with organizational trauma, highlighting the role of supportive structures and positive culture in shaping organizational outcomes. They also align with the findings of Hovida and colleagues [8], who synthesized domestic studies to identify structural and cultural factors as primary causes of organizational trauma

in Iran. Internationally, De Oliveira Camilo [14] emphasized that organizational culture and human resource practices significantly influence trauma responses during crises such as COVID-19, validating the importance of organizational-level interventions.

The integrated model proposed in this study demonstrates the interdependence of the four dimensions. Cognitive restructuring facilitates emotional regulation, while improved social cohesion fosters cultural change and structural resilience. Organizational support, in turn, creates environments where individuals feel safe to engage in adaptive behaviors and cognitive reframing. This multidimensionality underscores that trauma cannot be addressed through fragmented interventions but requires a systemic approach that integrates cognitive–behavioral strategies at multiple levels. Such an integrative perspective is supported by Tavana and colleagues [15], who proposed a data-driven framework for resilience assessment in trauma centers, stressing that resilience is inherently multidimensional and systemic. Similarly, Rhone [18] argued that organizational resilience during trauma necessitates simultaneous interventions at individual, team, and structural levels.

The novelty of the present model lies in its localization to the Iranian public sector context, while also incorporating global cognitive–behavioral insights. Previous Iranian studies, including those by Ebrahimi and colleagues [10, 11], focused primarily on educational settings and novice teachers, offering foundational frameworks for trauma management. However, the current study extends this approach to broader public organizations and integrates behavioral, emotional, and structural dimensions in a unified framework. It also responds to Khushhal's call [9] for identifying specific factors affecting organizational trauma in local contexts, thereby addressing the gap in indigenous models. By combining global evidence [7, 13, 17] with local realities [8, 10], the proposed model offers both theoretical depth and practical relevance.

Moreover, the findings of this study highlight the critical role of leadership in trauma management. Supportive leadership was repeatedly identified as a determinant of resilience, aligning with Jonker et al. [17] and Rhone [18], who emphasized that leadership behaviors significantly shape organizational responses to trauma. Leaders who adopt cognitive–behavioral strategies—encouraging cognitive reframing, fostering open communication, and modeling adaptive coping—create environments that empower employees to manage trauma effectively. This also resonates with international perspectives, such as those of Lindsay [6], who highlighted the necessity of leadership in dismantling systemic oppression, and Fernández [13], who demonstrated that leadership commitment is central to the success of trauma-informed care interventions.

In addition to leadership, structural processes such as transparency, accountability, and optimized systems were identified as essential for trauma recovery. These findings align with Yazdani and colleagues [20], who demonstrated how optimization algorithms can enhance organizational efficiency under stressful conditions. They also reflect Salahi Kojour's work [21] on hybrid systems in tourism and Tarighi's analysis [22] of brand associations in sport organizations, both of which stress the importance of systematic and transparent structures for organizational resilience. Although these studies are in different domains, the underlying principle of structural efficiency and adaptability directly applies to trauma management.

Finally, this study contributes to the growing recognition that trauma, while damaging, can also serve as a catalyst for transformation. As De Oliveira Camilo [14] argued, crises such as COVID-19 can trigger innovations in human resource management and organizational practices. Similarly, the participants in this study emphasized that trauma recovery efforts often foster creativity, collaboration, and long-term resilience. This perspective aligns with Berenji et al. [19], who demonstrated that behavioral models, when adapted to public sector contexts, can drive organizational innovation and

acceptance of change. In this sense, the model presented here not only addresses trauma as a problem but also frames it as an opportunity for organizational learning and growth.

Despite its contributions, this study has several limitations. First, the qualitative nature of the research, while providing rich and context-specific insights, limits the generalizability of the findings. The sample size of 19 experts, though sufficient for thematic saturation, cannot fully represent the diverse perspectives across all Iranian public organizations. Second, the reliance on self-reported experiences and expert perspectives introduces the possibility of bias, particularly in how participants interpret and articulate trauma-related phenomena. Third, the study focused exclusively on Iranian public organizations, which means that cultural, structural, and political factors specific to this context may limit the applicability of the model to other countries or sectors. Finally, while the study emphasizes cognitive–behavioral approaches, it does not empirically test the effectiveness of specific interventions, leaving room for further experimental or longitudinal validation.

Future studies should aim to empirically validate the proposed conceptual model using quantitative or mixed-method designs. Large-scale surveys could test the relationships among the identified dimensions and components, providing statistical evidence for their interconnections. Longitudinal studies could track the effectiveness of cognitive–behavioral interventions in reducing trauma over time. Cross-cultural research would also be valuable, comparing trauma management models in Iranian public organizations with those in other national or organizational contexts. Additionally, future studies could explore the role of digital tools and artificial intelligence in trauma management, particularly in monitoring employee well-being and optimizing organizational processes under crisis conditions. Finally, experimental studies implementing specific cognitive–behavioral interventions at the organizational level could provide practical evidence of their effectiveness in enhancing resilience and reducing trauma-related outcomes.

From a practical perspective, the findings of this study offer clear guidance for policymakers and managers in public organizations. First, organizations should invest in training programs that equip employees with cognitive restructuring, emotional regulation, and adaptive coping skills. Second, leadership development initiatives should prioritize supportive and trauma-informed practices, ensuring that managers are capable of fostering trust, transparency, and resilience. Third, structural reforms aimed at reducing bureaucratic rigidity and enhancing organizational flexibility should be prioritized to create safe and adaptive work environments. Fourth, fostering cultures of collaboration, empathy, and continuous learning will strengthen team cohesion and reduce the social impact of trauma. Finally, integrating trauma management into broader organizational development strategies will ensure that resilience is not a reactive measure but a core aspect of organizational functioning.

## Acknowledgments

We would like to express our appreciation and gratitude to all those who cooperated in carrying out this study.

## 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.

## Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

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