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The sociology of organizational failure: how institutions collapse from within

ABSTRACT

Objective: this reflection article examines why well-resourced, apparently well-managed organizations collapse from causes that were visible internally long before they became visible externally, arguing that organizational failure is typically a slow social process rather than a sudden technical event. **Methodology:** the study draws on a critical, interpretive synthesis of classical and contemporary organizational sociology — theories of structural inertia, normalized deviance, organizational silence, escalation of commitment, and interactive complexity — read alongside documented case evidence from disasters and corporate collapses, treating these sources as primary material for conceptual analysis rather than as data for statistical testing. **Main findings:** across settings as different as space agencies, airlines, hospitals, and startups, collapse follows a recognizable sequence in which early warnings are locally rational to ignore, dissent is costly to voice, and commitment escalates precisely where reversal would be most prudent. **Applications:** the argument speaks to organizational sociology, management and safety science, corporate governance, and public administration, offering a shared vocabulary for recognizing incubating failure before it becomes irreversible. **Novelty:** the article integrates disaster sociology and corporate-misconduct research, usually treated as separate literatures, into a single account of internal collapse, showing that technical accidents and ethical scandals share the same underlying social mechanics.

Keywords: organizational failure; normalization of deviance; organizational silence; structural inertia; escalation of commitment; sociology of organizations.

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Sociología del fracaso organizacional: cuando las instituciones colapsan desde dentro

RESUMEN

Objetivo: este artículo de reflexión examina por qué organizaciones bien dotadas de recursos y aparentemente bien gestionadas colapsan por causas que eran visibles internamente mucho antes de hacerse visibles externamente, argumentando que el fracaso organizacional suele ser un proceso social lento y no un evento técnico súbito. **Metodología:** el estudio se apoya en una síntesis crítica e interpretativa de la sociología de las organizaciones clásica y contemporánea —

teorías de la inercia estructural, la normalización de la desviación, el silencio organizacional, la escalada del compromiso y la complejidad interactiva— leída junto con evidencia documentada de desastres y colapsos corporativos, tratando estas fuentes como material primario para el análisis conceptual y no como datos para pruebas estadísticas. Hallazgos principales: en entornos tan distintos como agencias espaciales, aerolíneas, hospitales y startups, el colapso sigue una secuencia reconocible en la que ignorar las primeras señales de alerta resulta localmente racional, expresar el desacuerdo es costoso, y el compromiso escala precisamente donde la reversión sería más prudente. Aplicaciones: el argumento interesa a la sociología de las organizaciones, la ciencia de la gestión y la seguridad, el gobierno corporativo y la administración pública, y ofrece un vocabulario compartido para reconocer el fracaso en incubación antes de que se vuelva irreversible. Novedad/originalidad: el artículo integra la sociología de los desastres y la investigación sobre mala conducta corporativa —tratadas habitualmente como literaturas separadas— en un único relato del colapso interno, mostrando que los accidentes técnicos y los escándalos éticos comparten la misma mecánica social subyacente.

Palabras clave: fracaso organizacional; normalización de la desviación; silencio organizacional; inercia estructural; escalada del compromiso; sociología de las organizaciones.

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Sociologia do insucesso organizacional: quando as instituições colapsam por dentro

RESUMO

Objectivo: Este artigo reflexivo examina por que razão as organizações bem financiadas e aparentemente bem geridas entram em colapso devido a causas que eram visíveis internamente muito antes de se tornarem visíveis externamente, argumentando que o fracasso organizacional é tipicamente um processo social lento, em vez de um evento técnico repentino. **Metodologia:** O estudo baseia-se numa síntese crítica e interpretativa da sociologia organizacional clássica e contemporânea — teorias da inércia estrutural, da normalização do desvio, do silêncio organizacional, do comprometimento crescente e da complexidade interativa — lidas em conjunto com evidências documentadas de desastres e colapsos corporativos, tratando estas fontes como material primário para análise conceptual, em vez de dados para testes estatísticos. **Principais conclusões:** Em ambientes tão diversos como agências espaciais, companhias aéreas, hospitais e startups, o colapso segue uma sequência reconhecível em que ignorar os primeiros sinais de alerta é racional localmente, expressar discordância é dispendioso e o compromisso aumenta precisamente onde a reversão seria mais prudente. **Aplicações:** O argumento é relevante para a sociologia das organizações, a ciência da gestão e segurança, a governação corporativa e a administração pública, e oferece um vocabulário comum para reconhecer falhas incipientes antes que se tornem irreversíveis. **Novidade/Originalidade:** O artigo integra a sociologia dos desastres e a investigação sobre má conduta empresarial — geralmente tratadas como campos separados — num único relato de colapso interno, mostrando que os acidentes técnicos e os escândalos éticos partilham os mesmos mecanismos sociais subjacentes.

Palavras-chave: falha organizacional; normalização do desvio; silêncio organizacional; inércia estrutural; escalada do compromisso; sociologia das organizações.

INTRODUCTION

Organizations rarely fail the way a bridge fails. A bridge collapses at a locatable point in time, under a load its designers can specify in retrospect. Organizations, by contrast, tend to fail the way a slow leak empties a tire: the moment anyone would point to as "the failure" is usually just the moment the accumulated damage finally became impossible to hide. NASA did not wake up one morning in January 1986 and decide to launch the Challenger into a known design flaw; Wells Fargo did not wake up one morning and decide to open several million unauthorized accounts; Theranos did not wake up one morning and decide that its blood-testing technology worked when it did not. In each case, the organization had been making smaller versions of the same mistake for months or years, absorbing each repetition as evidence that the practice was survivable rather than as a warning that it was not (Vaughan, 1996; Stephenson & Bolden, 2025).

This article asks what these very different failures — a shuttle disaster, a banking scandal, a medical-technology fraud, an aircraft-design catastrophe — have in common, and argues that the answer lies less in the technical or financial specifics of each case than in a shared social architecture of organizational collapse. Sociologists and organizational scholars have been describing pieces of this architecture for over four decades, under a series of separate labels: structural inertia (Hannan & Freeman, 1984), permanent failure (Meyer & Zucker, 1989), the Icarus paradox (Miller, 1990), normal accidents (Perrow, 1984), the normalization of deviance (Vaughan, 1996), organizational silence (Morrison & Milliken, 2000), and escalation of commitment (Staw, 1976, 1981). Read separately, these look like a loose family of case-specific insights. Read together, they describe a single recurring sequence: success breeds confidence, confidence breeds the tolerance of small deviations, tolerance breeds silence about the deviations that remain, and silence removes the one mechanism — internal dissent — that could have stopped the escalation before it became irreversible.

The central claim of this article is that organizational collapse is best understood as a social process of accumulating and unacknowledged risk, not as a sudden technical or moral event. This reframing matters because it changes where an organization should look for its own vulnerability. A purely technical account of the Challenger disaster stops at the O-ring; a purely moral account of Theranos stops at Elizabeth Holmes. Both accounts are accurate as far as they go, and both stop short of the more uncomfortable finding that recurs across the literature: the information needed to prevent the failure was usually already inside the organization, sometimes for years, before the failure occurred (Morrison & Milliken, 2000; Tourish & Willmott, 2023).

Three qualifications bound the argument from the outset. First, not every organizational failure fits this pattern; some failures really are single bad decisions, or genuinely unforeseeable external shocks, and forcing every case into a slow-collapse narrative would be as misleading as ignoring the pattern where it does apply. Second, identifying a shared social architecture across cases is not the same as claiming a single cause; each case examined here retains its own technical, legal, and historical specificity, and the theories reviewed complement rather than replace case-specific explanation. Third, and most importantly, this is a work of theoretical synthesis rather than new primary research: the case evidence is drawn from existing, cited scholarship and public investigative record, not from original data collection, and the argument should be read as an interpretive framework rather than as a tested causal model.

The remainder of the article proceeds in two steps. The next section reviews the core theoretical building blocks of organizational-failure sociology and situates them against documented cases, summarized in Table 1. The following section then assembles these building blocks into a single sequential model of collapse, presented in Figure 1, and uses it to argue that technical accidents and ethical scandals — usually studied by separate research communities — are better understood as variations on one underlying process. A final section draws conclusions, notes the

limits of the argument, and points to directions for research that could test the model more directly than a synthesis of secondary sources allows.

DEVELOPMENT OF THE TOPIC

Theoretical and Empirical Background

Success, inertia, and the seeds of collapse

The paradox at the center of organizational-failure sociology is that failure is frequently seeded by success. Hannan and Freeman (1984) provide the structural half of this paradox: organizations survive by reliably reproducing their own structure, since reliability and accountability — the very qualities that make an organization trustworthy to clients, regulators, and investors — depend on doing tomorrow largely what was done today. The same property that lets an organization be trusted also makes it slow to notice when the environment underneath it has shifted, because noticing would require dismantling the structural reliability the organization depends on for its legitimacy. Meyer and Zucker (1989) extend this insight into their theory of permanent failure, showing that organizations do not simply choose between success and failure; internal actors with different interests — owners wanting returns, managers wanting job security, workers wanting stable employment — can each be served well enough by an organization's continued existence that no single interest ever mobilizes to fix the underperformance that all of them privately recognize.

Miller (1990) supplies the cultural and cognitive half of the same paradox in what he termed the Icarus paradox: the specific competencies that produce a company's early, spectacular success — engineering discipline, sales aggression, or visionary product design — tend to intensify over time into rigid, self-reinforcing orthodoxies that blind the organization to disconfirming information precisely because that information threatens the identity built around the original success. Xerox's own research center invented the graphical user interface and the computer mouse, yet the company's stated strategic frame — built on its photocopier success — could not accommodate the opportunity its own scientists had created, and competitors captured it instead. The common thread across structural inertia and the Icarus paradox is that neither requires incompetence or malice; both describe how the ordinary, locally rational behavior of a well-functioning organization can, over time, manufacture its own blind spot.

Interactive complexity and the normalization of deviance

Perrow's (1984) theory of normal accidents adds the technical half of the picture that pure culture-and-structure accounts leave out. In systems that are both tightly coupled — where a change in one part propagates quickly to others — and interactively complex — where components interact in ways operators cannot fully anticipate — some level of catastrophic failure becomes a structural property of the system rather than an aberration attributable to any single faulty part or careless operator. Perrow developed the theory partly in response to the Three Mile Island nuclear accident, arguing that no amount of additional safety redundancy can fully eliminate risk in systems whose complexity guarantees that operators will occasionally face novel, unanticipated failure combinations. Reason (1990) complements this structural account with a model of how such systems nonetheless usually hold: multiple, imperfect layers of defense — procedures, training, supervision, design safeguards — each contain gaps that are normally offset by the layers around them, so that a catastrophic outcome typically requires the rare alignment of weaknesses across several layers at once rather than the failure of any single safeguard.

Vaughan's (1996) landmark study of the Challenger disaster shows how that structural vulnerability interacts with organizational culture over time. Vaughan's central concept, the

normalization of deviance, describes the process by which a technical anomaly — in this case, O-ring erosion on the shuttle's solid rocket boosters — is observed, discussed, and accepted as a manageable risk after each flight in which it does not cause disaster; because the outcome is not catastrophic, the anomaly is retroactively reclassified from a danger sign into an accepted operating parameter, and the threshold for what counts as an acceptable risk quietly shifts. Critically, Vaughan's account explicitly rejects the "bad apple" narrative in which reckless individuals overrode safety rules: NASA and Morton Thiokol engineers and managers were, by her account, conforming to internally developed cultural norms that had, over dozens of prior flights, redefined the deviation as normal. Subsequent applications of the same concept to the Boeing 737 MAX program (Cusumano, 2021; Khashe & Levy, 2020) and to healthcare safety incidents suggest that normalized deviance is not specific to any one industry or historical period; it recurs wherever an organization repeatedly gets away with a known risk.

Silence, escalation, and the collapse of collective sensemaking

Normalized deviance alone does not explain why an organization's own internal skeptics fail to stop the drift toward disaster; for that, Morrison and Milliken's (2000) theory of organizational silence supplies the missing mechanism. They argue that many organizations develop structural and cultural forces — hierarchical distance, fear of retaliation, and a shared, often unspoken belief that raising concerns is pointless or dangerous — that cause employees at every level to systematically withhold information about problems, even when they possess it. Because silence is collective rather than individual, it can feel to any single employee like solitary caution rather than organization-wide dysfunction, which is precisely what makes it self-perpetuating: everyone privately suspects a problem, and everyone privately concludes that voicing it is not worth the risk.

Where silence removes the correction mechanism, Staw's (1976, 1981) theory of escalating commitment explains why leadership, once alerted to a problem, often responds by doubling down rather than reversing course. Staw's original experiments showed that decision-makers who felt personally responsible for an initial choice tended to commit more resources to that choice after receiving negative feedback, not less, largely to justify the resources already invested and to avoid the psychological and reputational cost of admitting the original decision was wrong. Applied to organizational collapse, escalation of commitment explains a pattern documented across many of the cases reviewed here: the response to early evidence of trouble is often an intensification of the very behavior that produced the trouble, since reversing course would require the organization to publicly acknowledge a mistake it has, by that point, invested heavily in denying.

Weick's (1993) analysis of the Mann Gulch wildfire disaster, in which thirteen firefighters died after their shared understanding of the situation disintegrated faster than they could adapt, adds a final piece: collapse is not only a failure of individual judgment but a failure of the group's shared sensemaking structure itself. When events move faster than an organization's collective framework for interpreting them, role structure and coordinated action can unravel simultaneously, leaving individuals who might, alone, have recognized the danger unable to act on that recognition because the organizational structure that would have translated recognition into a coordinated response has already come apart.

From technical accidents to ethical scandals

A separate research tradition has examined organizational misconduct — fraud, safety violations, and regulatory breaches — largely independently of the disaster-sociology literature just reviewed, but the two traditions converge on strikingly similar mechanisms. Greve et al. (2010), reviewing decades of research on organizational misconduct, argue against treating wrongdoing as the product of a few deviant individuals, showing instead that misconduct is frequently an emergent property of organizational structures, incentive systems, and the diffusion of

questionable practices across peer organizations. Edwards et al. (2019) apply a similar lens to Enron, arguing that the collapse reflected a pervasive organizational culture built around projecting success and suppressing anything that looked like failure, a dynamic they trace to the same silencing of dissent that Morrison and Milliken (2000) describe in general terms and that Tourish and Vatcha (2005) had earlier documented specifically at Enron under the label of corporate cultism.

The Theranos case, examined recently in a systematic dispositional analysis by Stephenson and Bolden (2025), shows the same convergence with unusual clarity. Rather than treating the company's collapse as the story of a single dishonest founder, their analysis identifies an interacting network of organizational and environmental factors — a Silicon Valley culture that normalized "fake it till you make it" optimism, an advisory board that received early warnings about the technology as far back as 2007 yet did not act on them, a press that had little incentive to scrutinize a celebrated founder's claims, and a legal environment that placed the burden of due diligence on investors rather than founders — that collectively enabled the deception to persist for years. Tourish and Willmott (2023), examining the same case through the lens of what they term hegemonic totalism, show how concentrated authority and an enforced unifying narrative suppressed internal dissent inside the company itself, echoing Morrison and Milliken's (2000) organizational silence at the level of everyday interpersonal interaction. Read alongside Vaughan's (1996) NASA studies, the Theranos case suggests that the organizational conditions that produce a fatal engineering decision and the conditions that produce a fraudulent product claim are not different in kind: both require early warning signs to be locally reasonable to dismiss, and both require the people best positioned to raise the alarm to have good reason to expect that raising it would cost them more than staying silent.

Table 1 summarizes these theoretical building blocks alongside their illustrative cases, showing that despite their disciplinary and historical distance from one another, they describe overlapping and mutually reinforcing mechanisms rather than competing explanations.

Table 1:
Core theories of organizational failure and their illustrative cases

Theory / mechanism	Originator(s)	Core claim	Illustrative case
Structural inertia	Hannan & Freeman (1984)	Reliability and accountability require organizations to reproduce structure faithfully, which makes rapid adaptive change costly and rare.	Long-established firms slow to restructure after environmental shifts.
Permanent failure	Meyer & Zucker (1989)	Organizations can persist indefinitely without achieving their goals when competing stakeholder interests favor maintenance over performance.	Chronically underperforming public agencies and legacy institutions.
The Icarus paradox	Miller (1990)	The very capabilities that produce early success harden into rigidities that later cause decline.	Xerox's PARC innovations that the firm itself failed to commercialize.
Normal accidents	Perrow (1984)	In tightly coupled, interactively complex systems, failure is a structural property of the system, not merely of the people who operate it.	Three Mile Island nuclear accident.

Theory mechanism /	Originator(s)	Core claim	Illustrative case
Normalization of deviance	Vaughan (1996)	Repeated deviation from a safety standard without catastrophic consequence gradually redefines that deviation as acceptable.	NASA's Challenger and Columbia shuttle disasters.
Organizational silence	Morrison & Milliken (2000)	Structural and cultural forces cause employees to systematically withhold concerns, leaving management with a distorted picture of risk.	Whistleblowers ignored or silenced before major scandals.
Escalation of commitment	Staw (1976, 1981)	Decision-makers increase investment in a failing course of action to justify the resources already committed to it.	Continued funding of doomed capital projects after failure signs appear.
Collapse of sensemaking	Weick (1993)	When events outrun a group's shared framework for interpreting them, coordinated action and organizational structure disintegrate together.	The Mann Gulch wildfire disaster.
Organizational misconduct	Greve et al. (2010)	Misconduct emerges from organizational structures and incentives, not only from individually deviant actors.	Wells Fargo's unauthorized-account sales-quota scandal.
Hegemonic totalism / ideological control	Tourish & Willmott (2023)	Concentrated authority combined with an enforced unifying narrative can suppress internal dissent long enough for a fraudulent premise to persist.	Theranos's blood-testing technology claims.

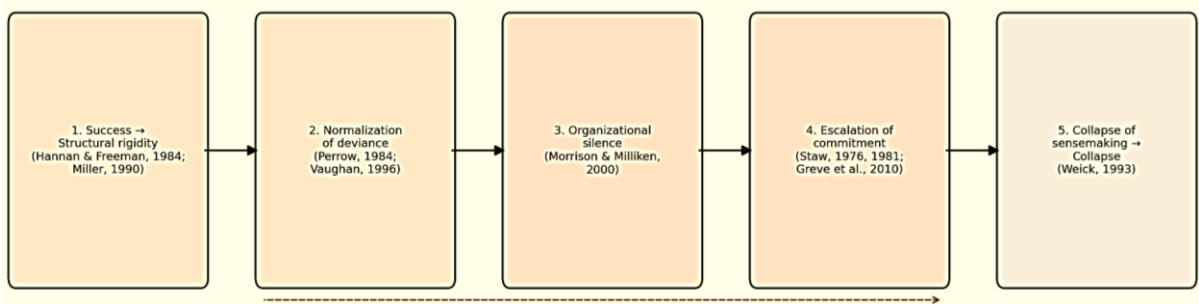
Note. Compiled by the author(s) from the sources cited in the text.

A Sequential Model of Organizational Collapse

Building on the literature reviewed above, this section assembles a single sequential account of how organizations collapse from within, summarized in Figure 1, and then considers what the model implies for detecting incubating failure before it becomes irreversible.

Figure 1

A five-stage sequential model of organizational collapse.



Note. Author-constructed conceptual diagram synthesizing the theoretical arguments cited in the boxes; it does not represent new empirical data. The dashed line marks the stages during which intervention can still reverse the sequence before collapse becomes unavoidable.

The sequence begins, counterintuitively, with success. Early achievement generates the resources, reputation, and internal confidence that Hannan and Freeman (1984) and Miller (1990) each identify as the source of later rigidity: the organization comes to trust its established routines precisely because those routines have already been validated by results, which is what makes the organization slower than it should be to question them when conditions change. This is not a failure of intelligence or effort; it is what a well-run organization looks like from the inside, right up until the environment it was built for stops matching the environment it now faces.

Confidence built on past success interacts with Perrow's (1984) structural condition of tight coupling and interactive complexity to produce the second stage: an early technical or ethical deviation occurs, is noticed, and does not immediately produce catastrophe. Vaughan's (1996) normalization of deviance describes what happens next with unusual precision — the absence of an immediate catastrophic consequence is read, retrospectively, as evidence that the deviation is manageable rather than as a warning that the underlying conditions have not been tested to their limit. Each repetition without disaster lowers the perceived risk of the next repetition, a dynamic documented in engineering contexts from the Challenger program (Vaughan, 1996) to the Boeing 737 MAX (Cusumano, 2021; Khashe & Levy, 2020) and in commercial contexts from Enron (Edwards et al., 2019; Tourish & Vatcha, 2005) to Theranos (Stephenson & Bolden, 2025).

The third stage is where the organization loses its own capacity for self-correction. As the gap between the sanctioned narrative and the accumulating evidence widens, the people best positioned to notice — engineers, mid-level managers, junior employees, board members — face a structurally discouraged choice: Morrison and Milliken's (2000) organizational silence describes the collective, self-reinforcing calculation by which each individual privately suspects a problem but concludes that raising it is personally costly and organizationally futile. Where formal channels for dissent exist on paper but are known informally to be ineffective or risky to use, silence is not a failure of individual courage so much as a locally rational response to an environment that has made voice expensive and continued compliance cheap — precisely the dynamic identified in the Theranos advisory board's documented inaction after 2007 (Stephenson & Bolden, 2025) and in the well-documented suppression of dissent inside Enron (Tourish & Vatcha, 2005).

The fourth stage converts accumulating risk into active momentum toward collapse. Once early warning signs surface, even briefly, to people with authority to act on them, Staw's (1976, 1981) escalation of commitment predicts intensification rather than correction: reversing course would require acknowledging that resources already committed were wasted and that a leadership decision already publicly defended was mistaken, both of which carry immediate reputational and psychological costs that a continuation of the existing course of action defers, if only temporarily. This stage is where Greve et al. (2010) account of organizational misconduct converges most clearly with Vaughan's (1996) disaster sociology: whether the escalating commitment takes the technical form of continuing to fly a shuttle with a known design flaw or the commercial form of continuing to sell a product whose technology does not yet work, the underlying decision calculus — sunk-cost justification compounding an existing silence problem — is structurally the same.

The final stage, collapse itself, arrives not as a single decisive moment but as the point at which Weick's (1993) collective sensemaking finally fails to keep pace with events: the shared organizational framework for interpreting what is happening disintegrates, coordinated correction becomes impossible, and what were previously survivable anomalies compound into a failure that can no longer be absorbed, denied, or explained away. From the outside, this final stage is often mistaken for the whole story — the O-ring failure, the MCAS malfunction, the fraudulent blood test, the fake bank account — when in fact it is merely the visible tip of a

process that had been running, largely unnoticed by external observers and substantially known internally, for months or years beforehand.

This sequential model carries a direct practical implication that mirrors the theoretical point made throughout this article: because the same underlying mechanism recurs across technical accidents and ethical scandals, the tools available to detect and interrupt it should also be shared across domains that currently treat each other as unrelated. Safety science has developed extensive infrastructure for capturing near-miss data specifically because Perrow's (1984) and Vaughan's (1996) work established that repeated non-catastrophic anomalies are diagnostic rather than reassuring; corporate governance and compliance functions, by contrast, have been slower to treat repeated near-miss ethical violations — the small, unpunished exaggeration, the quietly overruled objection — with the same diagnostic seriousness, despite Greve et al. (2010) and Edwards et al. (2019) evidence that the pattern is structurally identical. Organizational silence (Morrison & Milliken, 2000) is, on this model, not a separate cultural problem to be addressed through generic engagement initiatives, but the specific mechanism that determines whether a normalizing deviation gets caught in stage two or allowed to progress to stage four; interventions aimed at making dissent genuinely low-cost — protected reporting channels, rotating oversight roles, board members with no financial stake in the organization's continued growth narrative, and the deliberate cultivation of the psychological safety that Edmondson (2018) shows is a precondition for employees to raise concerns without fear of punishment — target the actual point in the sequence where the process can still be reversed.

A final qualification matters here. This model describes a pattern documented across a specific set of well-studied cases; it is not a universal law of organizational behavior, and plenty of organizations experience serious internal problems without collapsing, just as some collapses are better explained by singular external shocks than by this five-stage internal sequence. The value of the model is diagnostic rather than predictive: it offers a vocabulary for recognizing, in real time, which stage an organization's current internal tensions most closely resemble, rather than a formula for calculating when collapse will occur.

CONCLUSIONS

Organizational failure, across cases as different as a space shuttle disaster, a banking scandal, and a medical-technology fraud, follows a recognizable social sequence rather than arriving as an unforeseeable technical or moral accident. Confidence built on earlier success produces structural and cultural rigidity; that rigidity interacts with complex, tightly coupled systems to normalize early deviations; normalized deviation survives because organizational silence makes dissent costly; silence allows escalating commitment to convert a manageable early warning into an unmanageable later crisis; and collapse finally arrives when the organization's shared framework for interpreting events disintegrates faster than its capacity to respond. This is, in essence, a more granular account of what Dekker (2011) calls drift into failure: organizations rarely fall off a cliff; they slide down a slope so gradual that each individual step looks, from the inside, like a reasonable continuation of the step before it.

The central implication is that the information needed to prevent many organizational failures typically already exists somewhere inside the organization before the failure becomes visible to the outside world. This reframes the central task of failure prevention: not primarily the detection of external threats, but the design of internal conditions — genuinely low-cost channels for dissent, structural checks on escalating commitment, and a willingness to treat repeated near-misses as diagnostic rather than reassuring — under which the organization's own early warnings can still be heard while there is time to act on them.

None of this makes organizational collapse fully predictable or fully preventable. It does suggest that the recurring social architecture identified across disaster sociology and corporate-

misconduct research deserves to be treated as a single, shared field of study rather than as two separate literatures describing unrelated phenomena.

LIMITATIONS AND FUTURE RESEARCH

As a reflection article, this work synthesizes and interprets existing scholarship and documented case evidence rather than presenting new primary data, and the five-stage model proposed here is a theoretical proposition rather than a tested causal sequence. The case evidence draws on secondary sources — published organizational-sociology research, investigative journalism, and prior case analyses — rather than on original archival or interview data, and the selection of cases (NASA, Boeing, Enron, Wells Fargo, Theranos) inevitably reflects which organizational failures have received the most extensive public documentation, which may bias the model toward large, high-visibility, English-language, and predominantly American cases. Future research could test the model's stages more directly, for instance through comparative case analysis of organizations that displayed early symptoms of normalized deviance or organizational silence but did not collapse, in order to identify which interventions actually interrupt the sequence rather than merely correlating with cases where collapse happened not to occur.

Conflict of Interest Statement

The author declares that there are no conflicts of interest regarding the publication of this manuscript.

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