



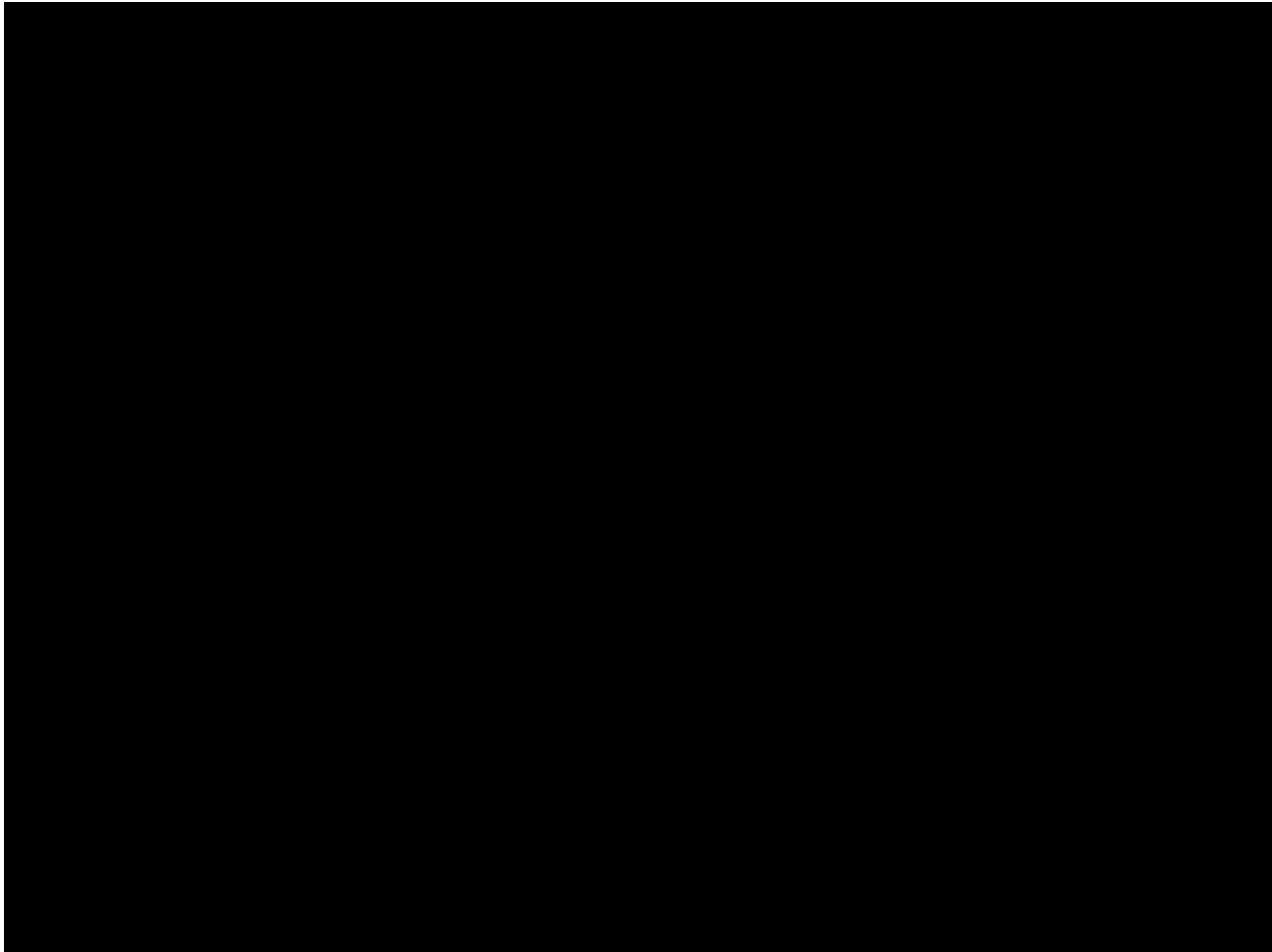
# Crisis & Emergency Risk Communication

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# Communicating in a crisis is different

- In a serious crisis, all affected people . . .
  - Take in information differently
  - Process information differently
  - Act on information differently
- In a catastrophic event: communication is different
- Be first, be right, be credible



# 5 communication failures that kill operational success

1. Mixed messages from multiple experts
2. Information released late
3. Paternalistic attitudes
4. Not countering rumors and myths in real-time
5. Public power struggles and confusion

# 5 communication steps that boost operational success

1. Execute a solid communication plan
2. Be the first source for information
3. Express empathy early
4. Show competence and expertise
5. Remain honest and open



# Psychology of a Crisis

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# What Do People Feel Inside When a Disaster Looms or Occurs?

Psychological barriers:

1. Fear, anxiety, confusion, dread
2. Hopelessness or helplessness
3. Seldom panic
4. Fight or flight
5. Vicarious rehearsal

# Communicating in a Crisis Is Different

- Uncertainty is greatest concern for most
- Reduce anxiety-Give people things to do
- Public seeks restored self-control
- Public must feel empowered – reduce fear and victimization

# Decisionmaking in a Crisis Is Different

- People simplify
- Cling to current beliefs
- We remember what we see or previously experience (first messages carry more weight)
- People limit intake of new information (3-7 bits)

# How Do We Communicate About Risk in an Emergency?

## All risks are not accepted equally

- Voluntary vs. involuntary
- Controlled personally vs. controlled by others
- Familiar vs. exotic
- Natural vs. manmade
- Reversible vs. permanent
- Statistical vs. anecdotal
- Fairly vs. unfairly distributed
- Affecting adults vs. affecting children

# Be Careful With Risk Comparisons

- Are they similarly accepted based on
  - high/low hazard (property/people measure)
  - high/low outrage (emotional measure)

A. High hazard	B. High outrage
C. Low hazard	D. Low outrage

# Risk Acceptance Examples

- Dying by falling coconut or dying by shark
  - Natural vs. manmade
  - Fairly vs. unfairly distributed
  - Familiar vs. exotic
  - Controlled by self vs. outside control of self

# Risk Communication Principles for Emergencies

## Allow people the right to feel fear

- Don't pretend they're not afraid, and don't tell them they shouldn't be.
- Acknowledge the fear, and give contextual information.





# Messages and Audiences

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# What the Public Will Ask First

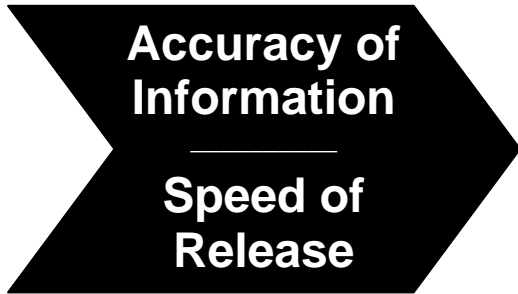
- Are my family and I safe?
- What have you found that may affect me?
- What can I do to protect myself and my family?
- Who caused this?
- Can you fix it?

# What the Media Will Ask First

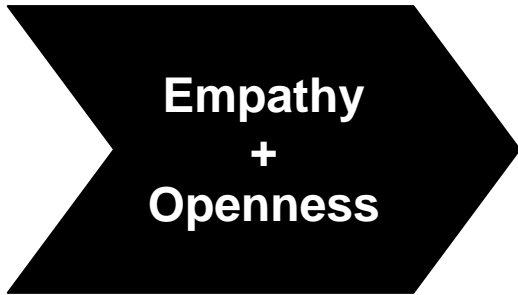
- What happened?
- Who is in charge?
- Has this been contained?
- Are victims being helped?
- What can we expect?
- What should we do?
- Why did this happen?
- Did you have forewarning?

# 5 Key Elements To Build Trust

1. Expressed empathy
2. Competence
3. Honesty
4. Commitment
5. Accountability



**CREDIBILITY**



+  
**TRUST**

=  
**Successful  
Communication**

# Initial Message

## Must

- Be short
- Be relevant
- Give positive action steps
- Be repeated

# Initial Message

## **Must *Not***

- Use jargon
- Be judgmental
- Make promises that can't be kept
- Include humor



# Working With the Media

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# Information sought by media

- Casualty numbers, condition, treatment
- Property damage
- Response and relief activities
- Resulting effects (anxiety, stress)
- Questions are predictable

# Media and Crisis Coverage

- Evidence strongly suggests that coverage is more factual when reporters have more information. They become more interpretative when they have less information.
- What should we conclude?

# Role of a Spokesperson in an Emergency

- Take your organization from an “it” to a “we”
- Build trust and credibility for the organization
- Remove the psychological barriers within the audience
- Gain support for the public health response
- Ultimately, reduce the incidence of illness, injury, and death by getting it right

# Emergency Risk Communication Principles

- Don't overreassure
- Acknowledge that there is a process in place
- Express wishes
- Give people things to do
- Ask more of people

# Pitfalls for Spokespersons

- Use of jargon
- Humor
- Repeating the negative
- Expressing personal opinions
- Showing off your vocabulary

# Spokesperson Qualities

- Be your organization; then be yourself.
- What's your organization's identity?

# Great Spokesperson Step 1

- It's more than “acting natural.” Every organization has an identity. Try to embody that identity.
- Example: CDC has a history of going into harm's way to help people. We humbly go where we are asked. We value our partners and won't steal the show. Therefore, a spokesperson would express a desire to help, show courage, and express the value of partners. “Committed but not showy.”

# Great Spokesperson Step 2

- Know your audience
- Your audience is NOT the reporter interviewing you

# Two press conference killers

- Have “hangers on” from your organization circling the room
- Being visible to the media/public while waiting to begin the press conference



# Stakeholder/ Partner Communication

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# Stakeholder/Partner Communication

- **Stakeholders** have a special connection to you and your involvement in the emergency.
- They are interested in how the incident will impact them.
- **Partners** have a working relationship to you and collaborate in an official capacity on the emergency issue or other issues.
- They are interested in fulfilling their role in the incident and staying informed.

# Dealing With Angry People

## Anger arises when people. . .

- Have been hurt
- Feel threatened by risks out of their control
- Are not respected
- Have their fundamental beliefs challenged

## Sometimes, anger arises when . . .

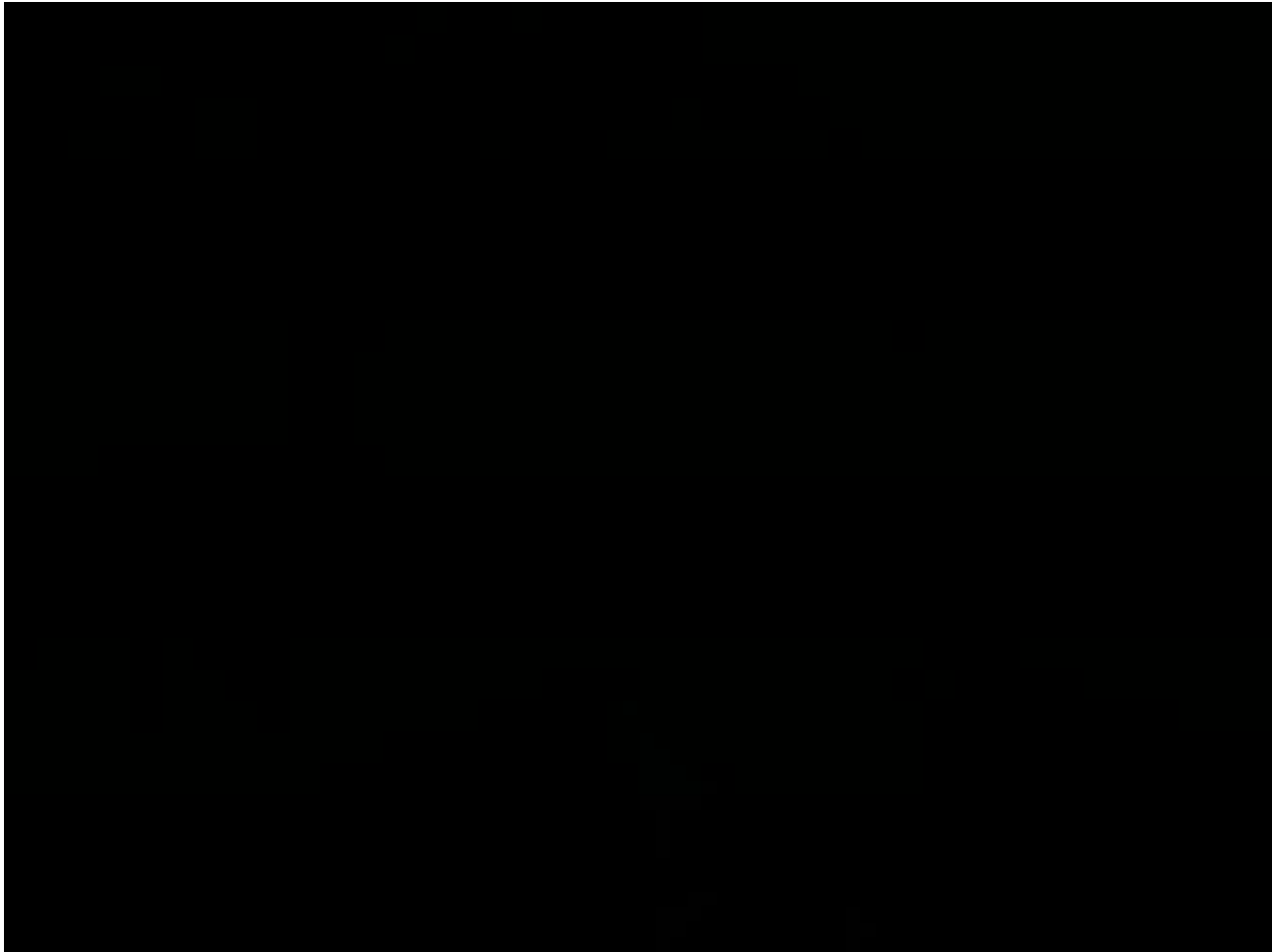
- Media arrive
- Damages may be in play

# Don't lecture at the Townhall

- Easy but not effective
- Doesn't change thoughts/behaviors
- Key: don't give a solution, rather help audience discover solution by asking questions

# 2 simple tips to gain acceptance

1. Accumulate “yesses”
2. Don’t say “yes, but”—say “yes, and”





# Crisis & Emergency Risk Communication

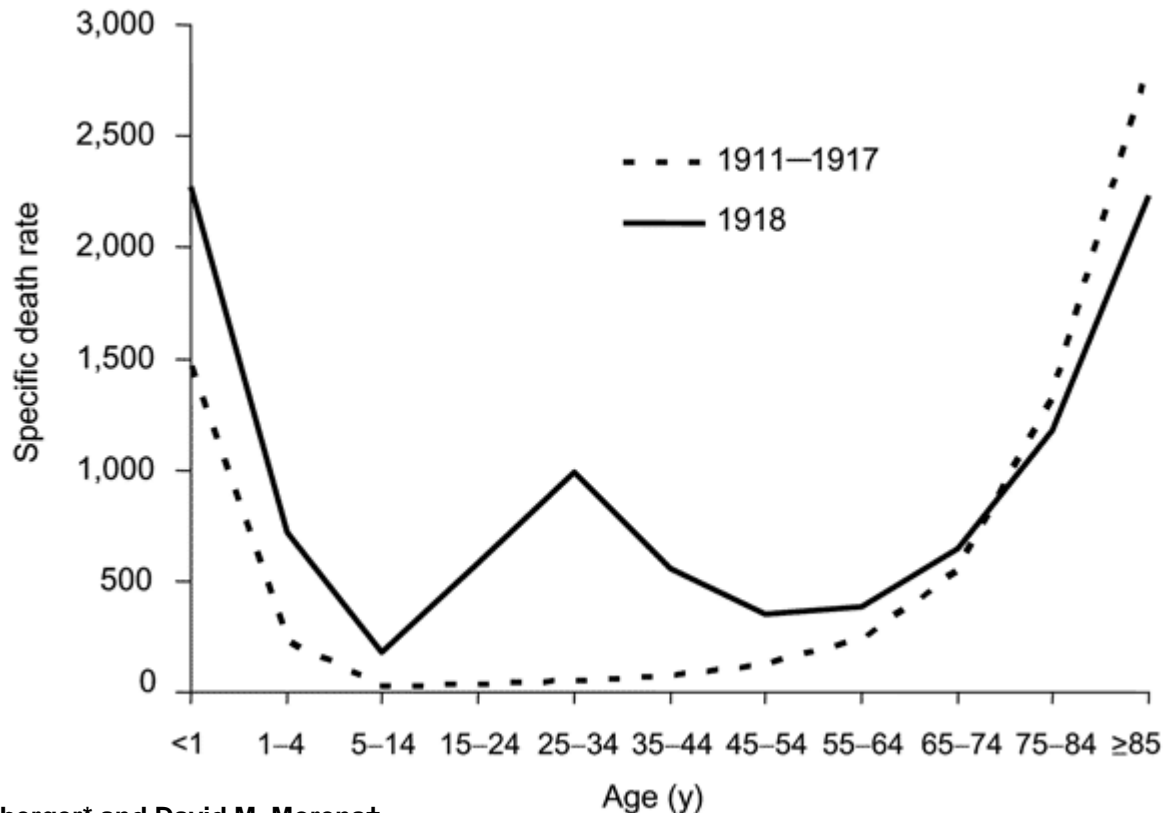
## Pandemic Influenza

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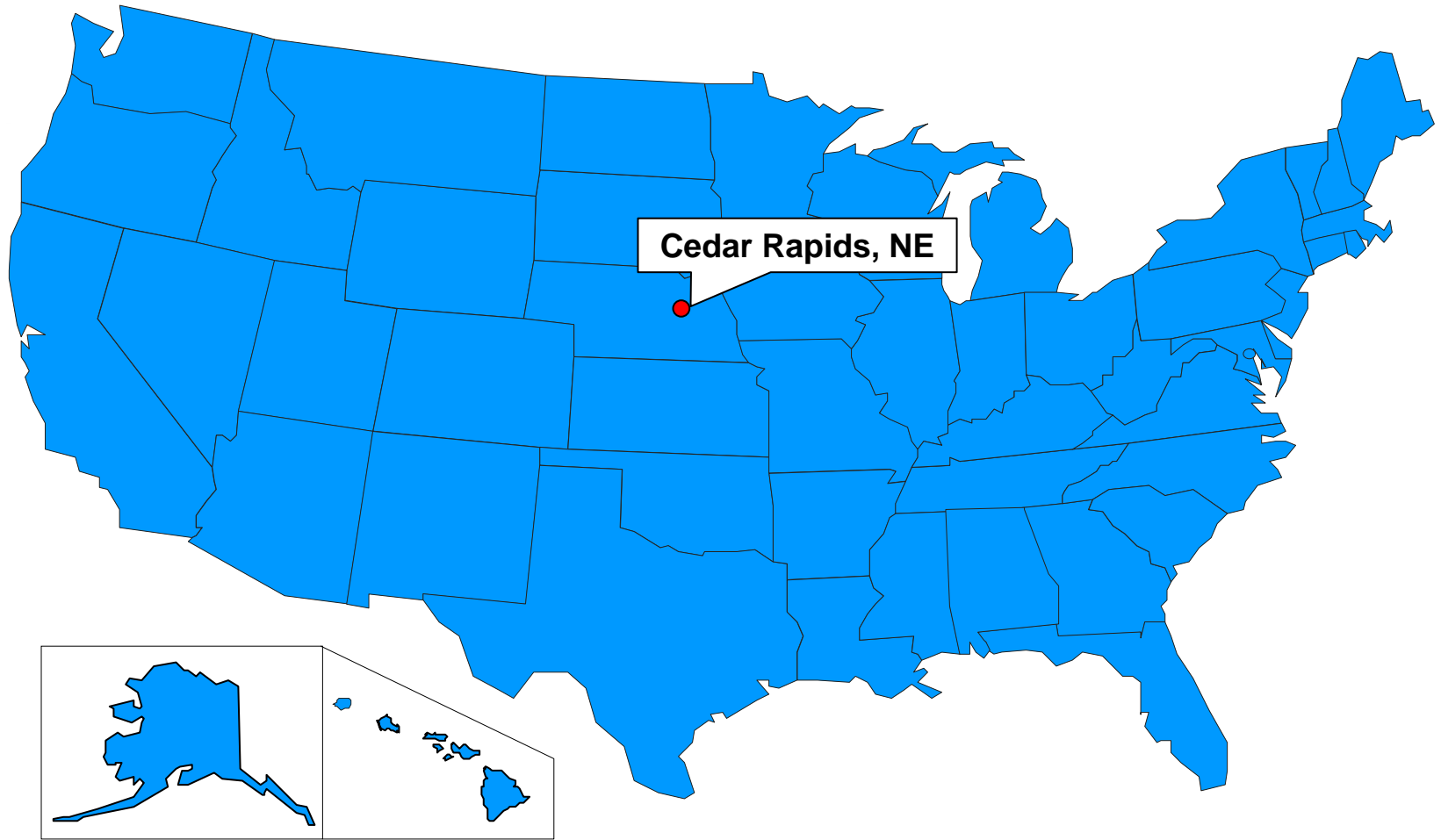
# 1918 Pandemic Deaths by Age

**Figure 2.** "U-" and "W-" shaped combined influenza and pneumonia mortality, by age at death, per 100,000 persons in each age group, United States, 1911–1918. Influenza- and pneumonia-specific death rates are plotted for the interpandemic years 1911–1917 (dashed line) and for the pandemic year 1918 (solid line)



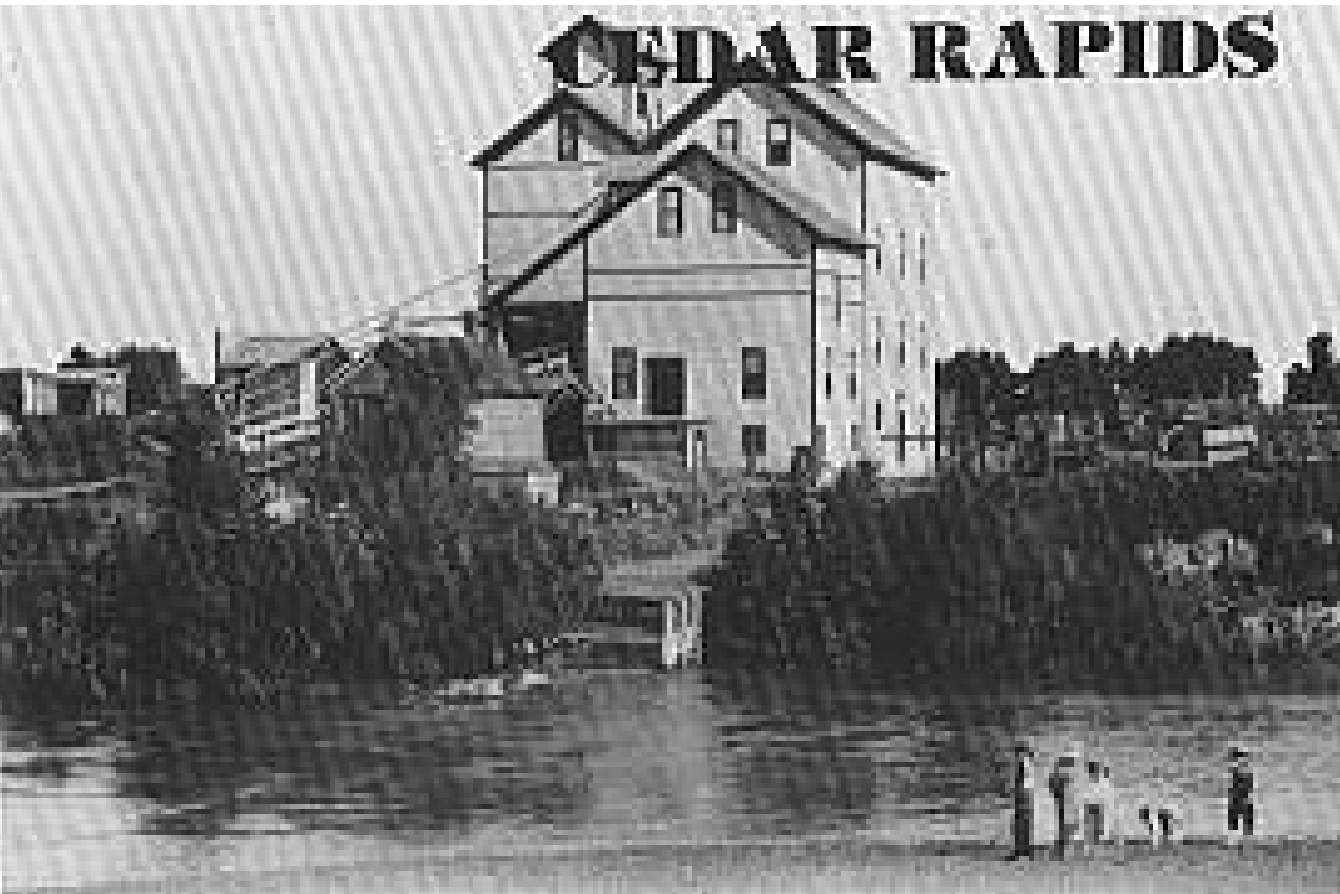
Jeffery K. Taubenberger\* and David M. Morens†

\*Armed Forces Institute of Pathology, Rockville, Maryland, USA; and †National Institutes of Health, Bethesda, Maryland, USA



Cedar Rapids, NE

# Cedar Rapids, Nebraska



Census 1910  
Town pop. 576  
1,885 in area  
6 churches  
Flour mill

# The Langan Boys-1918

Thomas Langan, 25 years old

William Langan, 22 years old

Edward Langan, 20 years old

David Langan, 16 years old

Thomas and Carrie Langan were married in 1909  
and had 5 children

William, Edward, and David lived at home

**Thomas &  
Carrie Langan  
(seated)  
On their 1909  
wedding day**



# H1N1 Comes to Cedar Rapids

- Dec. 1918 all four boys became ill with influenza
- Thomas fell ill and William dropped off a home remedy

# December 16: Edward (20) died



# December 19: William (22) died



# December 20: David (16) died



**Thomas, still ill,  
attends the funerals  
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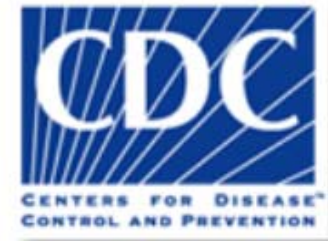


# Thomas & Carrie Langan 1941



# Thomas & Carrie, 1955





# Crisis & Emergency Risk Communication

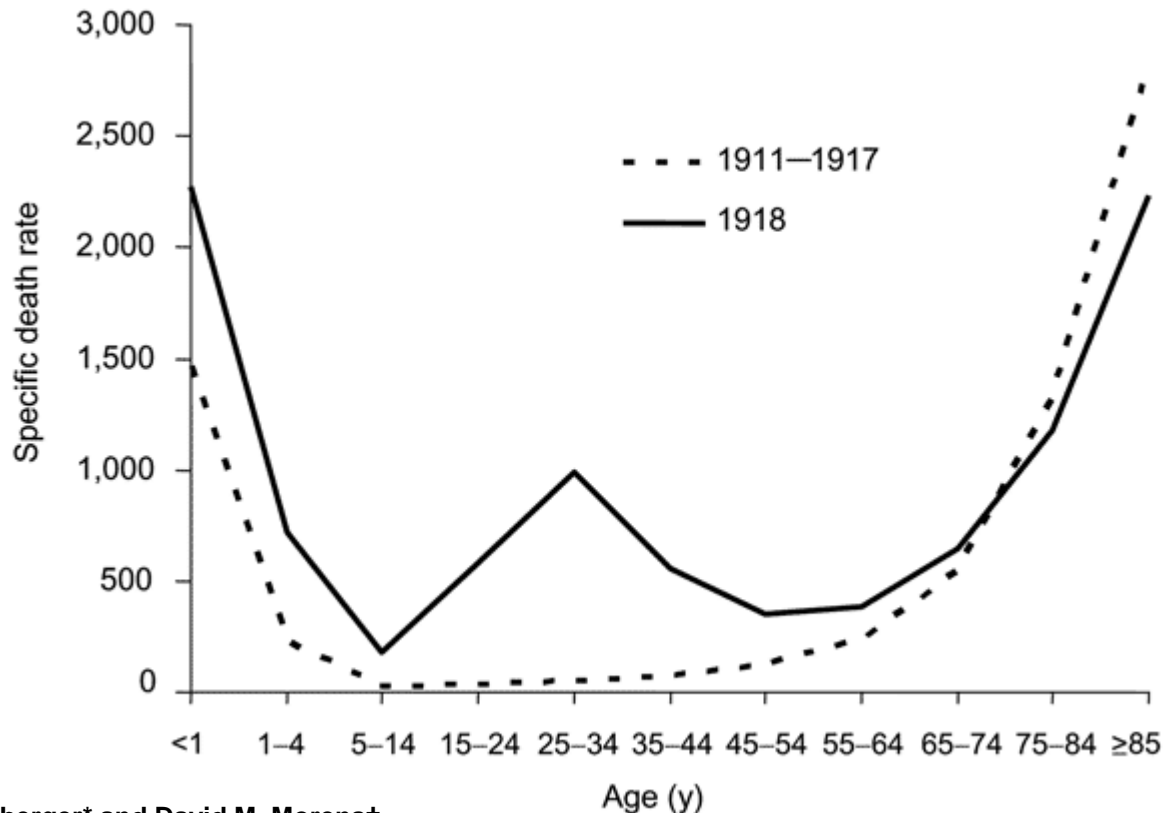
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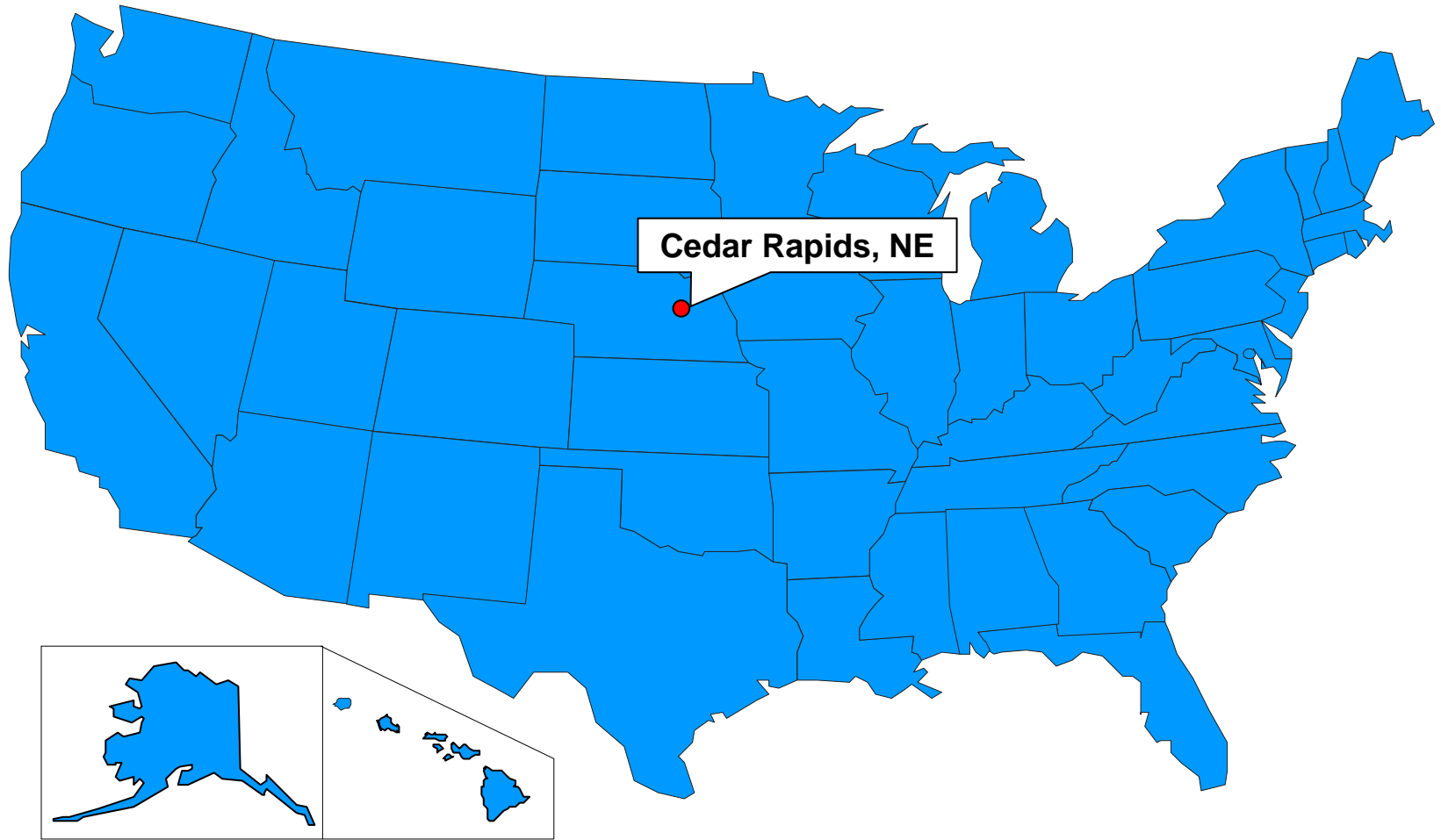
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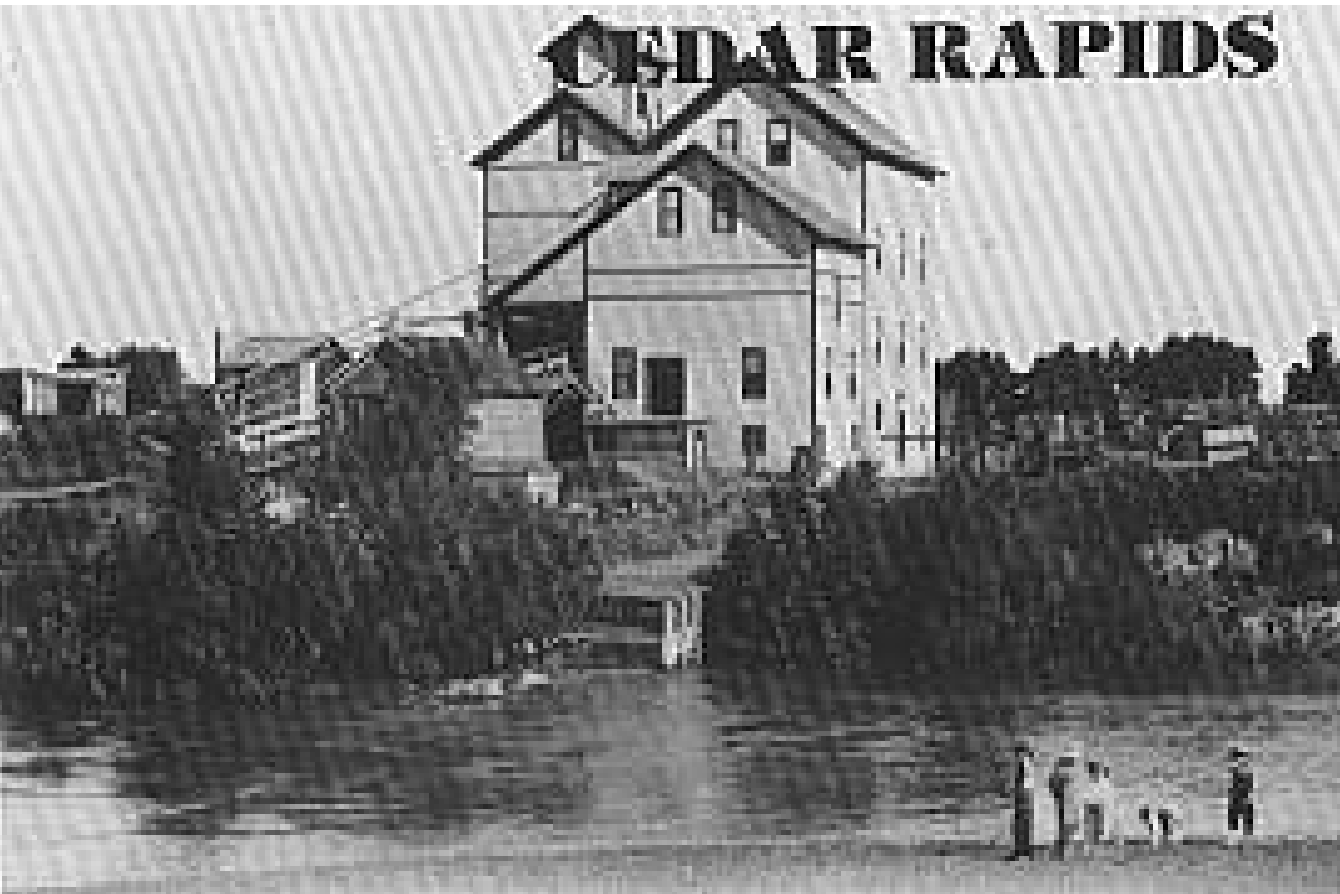
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# Community Hardiness

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# Community hardiness: Defined

- Existing protective qualities and vulnerabilities that will determine the community's ability to take deliberate, meaningful, and collective action against a public health threat
  - Protective qualities: **robustness, redundancy, resourcefulness, & rapidity**
  - Vulnerabilities: **susceptibility related to sense of community, shelter, sustenance, security, and growth from adversity**

# Community hardiness: Factors

- Socioeconomic status
- Community-based organizations
- Health care capacity
- Social stressors (racial, economic, political strife)
- Political and civic perspectives
- Community cohesion and group self-efficacy

# Community hardiness

- Overcome helplessness: strengthen group-efficacy
- Overcome fear of risk by promoting protective actions
- Overcome dread and uncertainty by sharing honest information early
- Overcome despair by engaging people in the response
- Overcome isolation by reconnecting people

# Personal resilience: Factors

- Mental toughness more important than physical strength
- A purpose for going on: “help my family”
- Self-efficacy: “I think I can”
- Prior experience
- Good coping strategies (repress negative and take action)

# Communication strategies

- Focus less on “we need your commitment” and more on “you can do it and here’s how”
- Stress self-efficacy “you can do it”
- Remind people that they make a difference
- Give them things to do in steps to master the skills

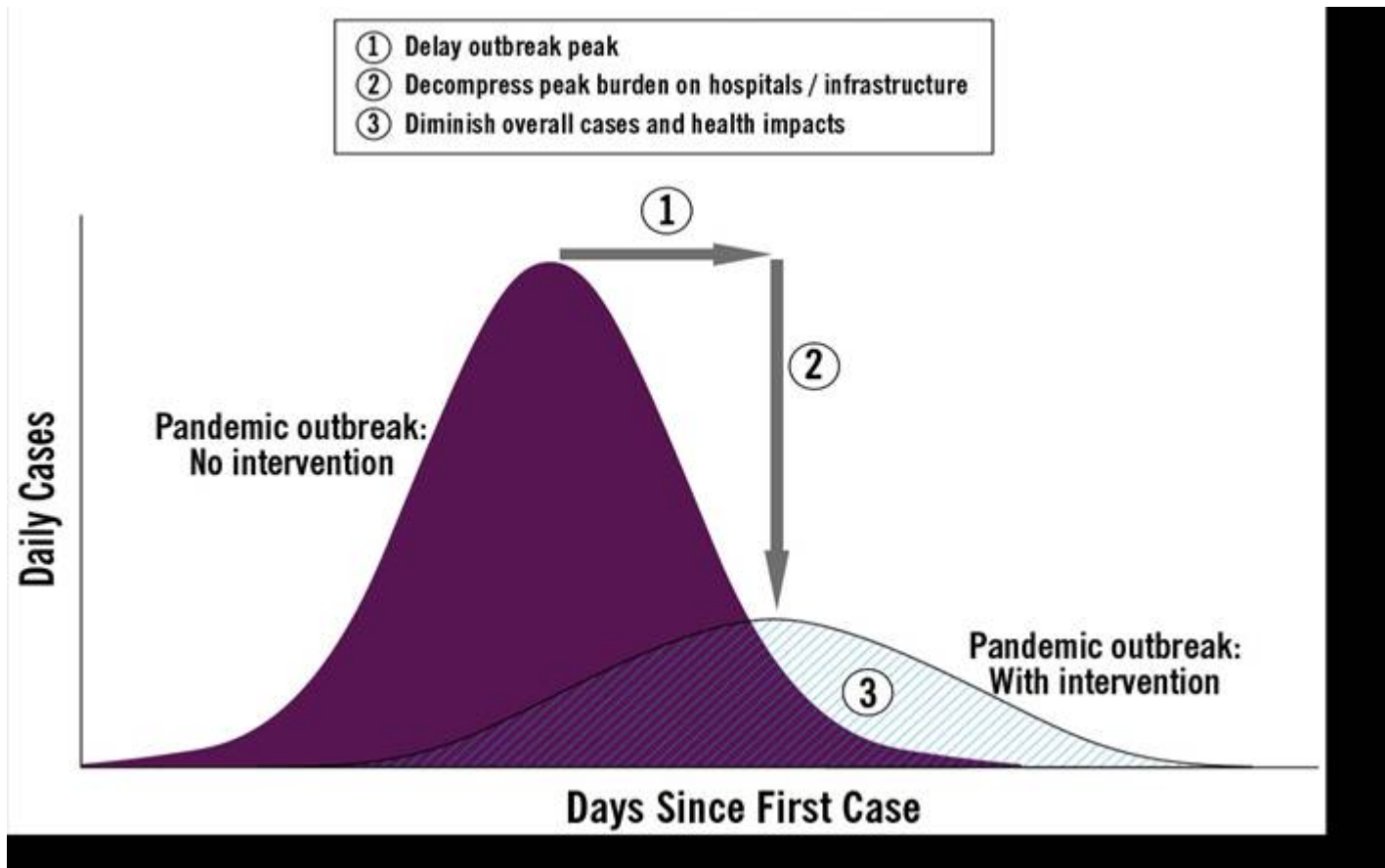
# Leader's role

- Becomes a symbol of order among chaos
- Authoritative/charismatic leader style in crisis
- Help people reduce fear, anxiety, despondency
- May become “mourner-in-chief”

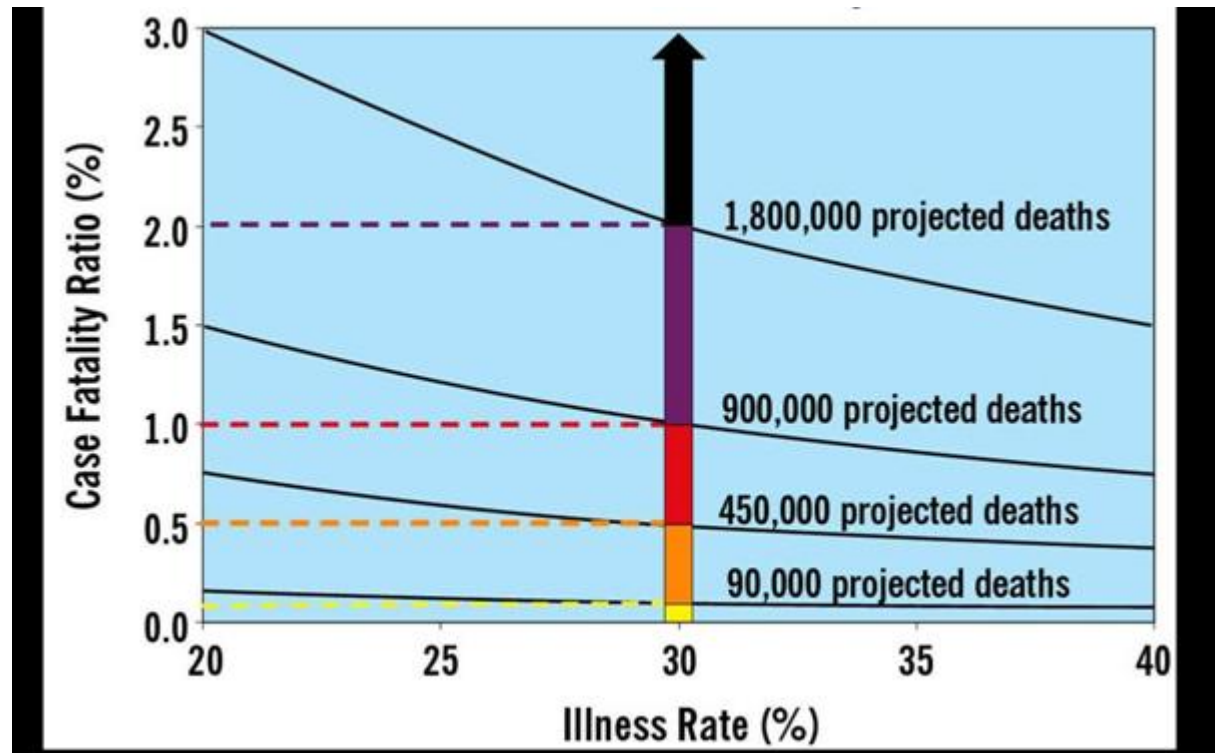
# Community Mitigation

- **Early, targeted, layered application of multiple partially effective nonpharmaceutical measures:**
  - **Isolation and treatment** with antiviral medications for confirmed or probable pandemic influenza
  - **Voluntary home quarantine** of household members with confirmed or probable influenza (possible prophylactic use of antiviral medications)
  - **Dismissal of students** from school and activities. Closure of childcare programs. Protect children and teenagers through social distancing in the community
  - **Use of social distancing** measures to reduce contact between adults in the community and workplace

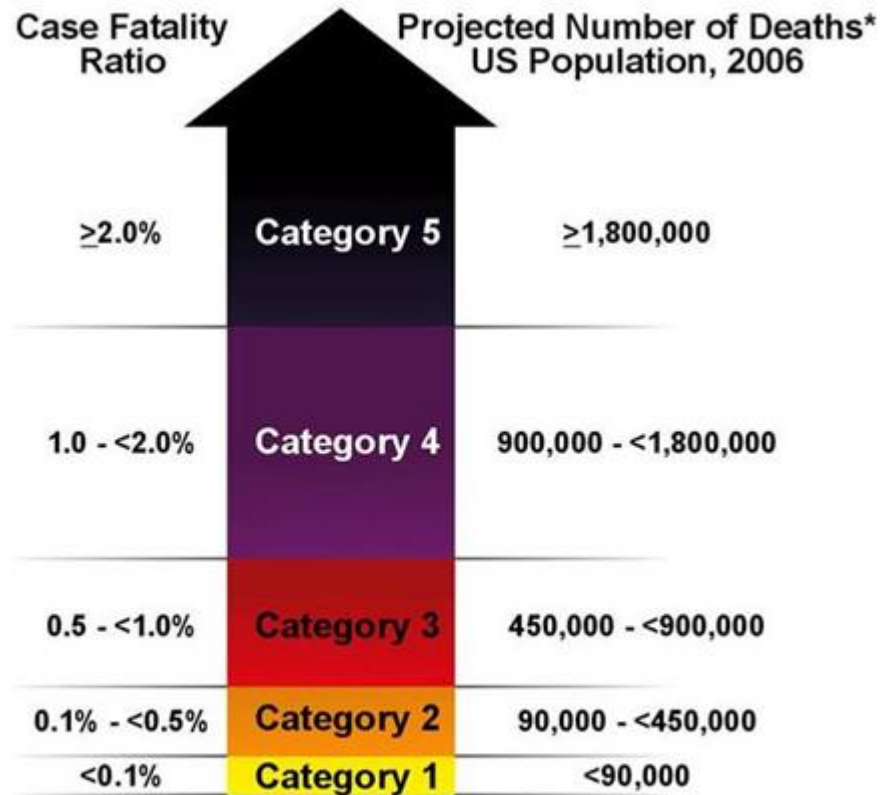
# Goals of Community Mitigation



# Pandemic Severity Categories As Determined by Differences in Case Fatality Ratio



# Pandemic Severity Index



\*Assumes 30% illness rate  
and unmitigated pandemic  
without interventions

# Table 1. Pandemic Severity Index by Epidemiologic Characteristics

Characteristics	Pandemic Severity Index				
	Category 1	Category 2	Category 3	Category 4	Category 5
Case Fatality Ratio (percentage)	<0.1	0.1 - <0.5	0.5 - <1.0	1.0 - <2.0	≥ 2.0
Excess Death Rate (per 100,000)	<30	30 - <150	150 - <300	300 - <600	≥600
Illness Rate (percentage of the population)	20 - 40	20 - 40	20 - 40	20 - 40	20 - 40
Potential Number of Deaths (based on 2006 U.S. population)	<90,000	90,000- <450,000	450,000- <900,000	900,000- <1.8 million	≥1.8 million
20 <sup>th</sup> Century U.S. Experience	Seasonal Influenza (Illness rate 5-20%)	1957, 1968 Pandemic	None	None	1918 Pandemic

# Table 2. Summary of the Community Mitigation Strategy by Pandemic Severity

Interventions* by Setting	Pandemic Severity Index		
	1	2 and 3	4 and 5
<b>Home</b>			
<b>Voluntary isolation</b> of ill at home (adults and children), combine with use of antiviral treatment as available and indicated	Recommend †§	Recommend †§	Recommend †§
<b>Voluntary quarantine</b> of household members in homes with ill persons †‡ (adults and children); consider combining with antiviral prophylaxis if effective, feasible, and quantities sufficient	Generally not recommended	Consider **	Recommend **
<b>School</b>			
<b>Child social distancing</b>			
-dismissal of students from schools and school based activities, and closure of child care programs	Generally not recommended	Consider: ≤4 weeks ††	Recommend: ≤12 weeks §§
-reduce out-of school social contacts and community mixing	Generally not recommended	Consider: ≤4 weeks ††	Recommend: ≤12 weeks §§
<b>Workplace / Community</b>			
<b>Adult social distancing</b>			
-decrease number of social contacts (e.g., encourage teleconferences, alternatives to face-to-face meetings)	Generally not recommended	Consider	Recommend
-increase distance between persons (e.g., reduce density in public transit, workplace)	Generally not recommended	Consider	Recommend
-modify, postpone, or cancel selected public gatherings to promote social distance (e.g., stadium events, theater performances)	Generally not recommended	Consider	Recommend
-modify work place schedules and practices (e.g., telework, staggered shifts)	Generally not recommended	Consider	Recommend



# Stigmatization

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# Stigmatization

- Can affect product, industry, animal, place, people
- Four characteristics to stigmatization
  - Problem stigmatizer believes he can control
  - Must be distinguishable
  - Stigma associated with the party
  - Reaction that distances

# Recent examples

- 1997 strawberries and hepatitis A in U.S.
- 1997 H5N1 outbreak in Hong Kong
- 1999 West Nile virus outbreak in New York
- 2003 SARS outbreak in China and Canada

# Why people stigmatize

- Shortcut when uncertainty and threat are both present to protect against physical and emotional harm
- Occurs in a social context
- Expect it early in a severe influenza pandemic unless dominant group first to become ill

# The toll of stigmatization

- Emotional pain (e.g., stress & anxiety)
- Limited access to health care, education, housing, and employment
- Physical violence
- Affects minority groups differently
- Potential for group conflict (i.e., a group-level ethnocentric worldview)

# Role for communication

- Communication must balance the real risk with needless association of an identifiable group
- Take an active role in dispelling misperceptions
- Correct faulty assumptions

# Steps before, during & after

- Avoid geographic links if not necessary (e.g., Spanish pandemic versus 1918 pandemic)
- Avoid visuals that link group to threat--watch out for subconscious links: *Avian Influenza H5N1*
- Teach response professionals about stigma
- Share with media the concern
- Scan for stigma and confront quickly
- Watch out when creating historical products



# Understanding loss and bereavement

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# People not Numbers

<b>Characteristic</b>	<b>1958/68-like</b>	<b>or (1918-like)</b>
Illness	90 million (30%)	90 million (30%)
Outpatient	45 million (50%)	45 million (50%)
Hospitalization	865,000	9,900,000
Mech. ventilation	64,875	745,500
Deaths	209,000	1,903,000

# Deaths in the U.S. vs Pandemic

- About 2.5 million annually
- Seasonal influenza 36,000 deaths/95% ->65 yrs
- In 12-18 months add 2 million
- Deaths “out of time” (healthy adults/children)

# Grief and mourning

- The circumstances of the death
- Nature of the relationship to deceased
- Prior loss experience
- Secondary losses
- Grieving is done in a cultural context

# Severe pandemic and loss

- Multiple deaths in families
- Truncated bereavement rituals
- Potential for kinship from shared misery
- Responders could feel guilt

# Compassion in communication

- People will expect demographic details of first deaths (“How do I compare?”)
- Look of official reports must be respectful (web)
- Responders may be losing members too
- People mourn financial loss too

# Theories of grief & mourning

- Dual process model (loss-oriented vs restoration-oriented)
- Integrative model—family oriented
- Death of a child (“Parents expect to see their children grow and mature”)
- Disenfranchised grief

# Cultural differences

- Acceptance versus avoidance
- U.S. dominant group culture
  - Little interaction with death/dying
  - Care ends at gravesite ceremony
  - No transition period from life to death
  - Death is failure, to be avoided

# Dominant group expectations

- Rational is more important than emotion
- Move to restoration orientation quickly
- Rituals not important

# Cultural differences?

- Have you been to a funeral outside your own culture? What is the color of mourning?
- What matters matters a lot
- Acculturation attenuates differences—don't stereotype
- Religious differences are cultural differences
- Bereavement ignored will cost in personal/community resilience