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# JOURNAL OF INTERNATIONAL CRISIS AND RISK COMMUNICATION RESEARCH

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# Crisis and Risk Communication Scholarship of the Future: Reflections on Research Gaps

Brooke Fisher Liu<sup>1</sup>  and Jeannette Viens<sup>1</sup> 

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## ABSTRACT

Risk and crisis communication is a vibrant and growing area of research and practice. As we head into the third year of publishing the first journal dedicated to crisis and risk communication, the editor and editorial assistant pose some especially promising areas for future research. In this essay, we also introduce the articles published in this journal, including how they meet promising research gaps to fill.

**KEYWORDS:** risk, crisis, communication, research gaps

Risk and crisis communication is a vibrant and growing area of research and practice. As we head into the third year of publishing the first journal dedicated to crisis and risk communication, we pose some especially promising areas for future research. The journal continues to accept all research related to risk and crisis communication, but we should think about how we can best advance theory and practice through generating valuable, new knowledge. As noted in the last editorial essay, reviewers for this journal often criticize manuscripts for not advancing new knowledge (Liu & Stanley, 2019). The purpose of this essay is to start a conversation about promising future research directions, rather than generate a definitive list of research gaps. As you read, consider what you think the future of risk and crisis communication

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scholarship should be and submit that work to the Journal. We conclude the essay with introducing the articles in this issue of the Journal.

### **More Public-Driven Research**

We first pose that we need more public-driven risk and crisis communication research. From situational crisis communication theory (Coombs, 2019) to image repair discourse (Benoit, 2018) to typologies (Coombs, 2010; Lerbinger, 1997; Seeger et al., 2003), crisis and risk communication research has advanced in a manner that prioritized understanding how organizations should manage adverse events. The scholarship that emerged, while prominent and important, created an imbalance in understanding more about how organizations manage crises instead of how members of the public or communities manage crises.

Crisis exist beyond the realm of corporations, governments, and nonprofits, affecting real people, properties, and livelihoods. Risks are integral to community members' daily routines with continued gun violence and climate change disasters, among other risks. Scholars should extend their research beyond issues of reputation and repair, and find solutions for publics (Liu & Fraustino, 2014). The field needs stakeholder perspectives, not just descriptions of the nature of crisis responses. By shifting to a public-driven approach, a plethora of significant questions emerge for the discipline to consider. For example, research has highly emphasized cognitive variables and responses. Therefore, poignantly, the role of emotion and affect in crisis and risk communication needs further exploration and confirmation (c.f., Jin et al., 2012). What is the relationship among emotions, risk perception, and, furthermore, the important information-seeking and protective-actions that the discipline strives to identify? As another example question for future research, how do publics communicate about crises independent of organizations? How does this public-to-public communication affect outcomes like protective-action taking?

### **Interpersonal Risk and Crisis Communication**

The field additionally needs to supplement intrapersonal communication knowledge with a more robust understanding of

interpersonal communication in the case of risks and crises. Understanding who communicates to who, when, and with what messages has important implications. When it comes to risks and crises, communication is not limited to organization-to-public, but also includes public-to-public, as noted above. There is a need to understand what is being transmitted beyond the formal channels, at what frequency, and to what extent. This may be especially prominent in the era of social media where the plethora of online platforms and personas have an influential stake in the communication of (mis)information.

### **Current Challenges**

A third notable research gap is scholarship that addresses current risk and crisis communication challenges. At the inaugural meeting of our editorial board in March 2019, members noted that it is important to publish research that advances practice, and not just theory. We have already published research in this journal on some of the most noteworthy risks and crises of our time, including the refugee crisis in Europe (Johansson, 2018), the Ebola pandemic (Dillard & Yang, 2019; Sellnow-Richmond et al., 2018), sexual misconduct on college campuses (Woods & Veil, 2020), and the Fukushima Daiichi nuclear disaster (Kwesell & Jung, 2019). We call for more research on such contemporary crises, advancing theory and practice for 21st century risk and crisis communication challenges.

### **Inclusive Scholarship**

Shifting to a public-driven perspective emphasizes the important question of who is being included versus excluded in studies. Crises affect publics differently, especially publics who already are vulnerable. Waymer and Heath (2007) explored this distinction in relation to Hurricane Katrina, but it must be an essential consideration for additional crisis and risk communication research. How are warning systems being used, updated, or critiqued on behalf of disabled communities or language learners? How are protective actions being communicated to immigrants and refugees? What do these communities witness, experience, and need when it comes to crises and risks? Ultimately, there is a promising need

for crisis and risk communication theories to be more encompassing and inclusive.

As scholarship considers a diversity of publics who face a variety of crises, the role of culture also becomes more prominent. Intercultural communication is a vital part of understanding crisis communication. Further developing the field may include using culture as a variable in new and established models as well as conducting cross-cultural studies. Diers-Lawson (2017) called for scholars to broaden the voices heard in crisis research, to contextualize American research, and to promote more meaningful cross-cultural work. Crisis and risk communication research needs to expand its horizons with a more global perspective that better recognizes the work, theories, and differences around the world. Such work includes crises that span boundaries, including public health outbreaks.

### **Multiphase Scholarship**

We also pose that research needs to expand its timeline focus as the discipline continues to develop. Crises do not occur as isolated incidents in a vacuum, soon to be forgotten by those who experienced them. Risk perception is not always the result of carefully considered logic specific to each unique situation. These events are not necessarily linear, so there is a gap in understanding as to how crises proceed and take shape. In turn, future scholarship can highlight various phases, whether the preparation or recovery stage, and contribute to a stronger understanding of the nature of crises. How do our existing theories work in different stages of a crisis? Along those lines, scholarship needs to include the long-term impact of crises and further explore the influence of repeated instances. How do memory and recall of a crisis affect communication, especially surrounding protective actions, in other events? How are publics influenced in the case of frequent repeated instances, such as areas with monsoon, hurricane, or tornado seasons?

### **The Current Issue**

With these promising research gaps in mind, we now introduce the current issue of the Journal. All five articles advance one of the

research gaps noted above: advancing 21st century risk and crisis communication challenges. First, Andrade et al. (2020) offer one of the first published articles on the government's failed response to Hurricane María in Puerto Rico, focusing on the understudied area of rumor generation. Brown-Devlin and Brown (2020) extend theory to understand how to manage sports-related crises, an understudied area that frequently challenges sports organizations and their multiple publics. Brunson et al. (2020) introduce a futuristic scenario to facilitate medical countermeasure communication. By taking on a contemporary crisis communication challenge, this article illustrates how research-based simulations can advance practice. Woods and Veil (2020) examine a legal public relations case study related to sexual misconduct, thereby providing novel insights about one of the enduring risk and crisis communication challenges of our time. We hope that you enjoy reading the articles in this issue, and that they inspire you to submit your own research to the Journal.

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# Mortality Reporting and Rumor Generation: An Assessment of Crisis and Emergency Risk Communication Following Hurricane Maria in Puerto Rico

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## ABSTRACT

This study assessed the Government of Puerto Rico's crisis and emergency risk communications following Hurricane Maria and the post-disaster information environment to identify factors that may have contributed to negative public perceptions of mortality reports. Data included Government of Puerto Rico press releases, press conference audio recordings and Facebook Live transmissions, digital media news and social media commentary, and interviews with Government of Puerto Rico personnel and community stakeholders. Study findings indicate that inadequate crisis communication planning and training, coupled with information gaps and inconsistencies, contributed to rumors around the issue of mortality. As a consequence, the Government of Puerto Rico lost the ability to effectively manage messaging, thus decreasing

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their credibility, perceived transparency, and public trust. Recommendations regarding future preparedness activities and research are offered.

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**KEYWORDS:** crisis communication, disasters, mortality, rumor generation

Hurricane Maria made landfall in Puerto Rico on September 20, 2017, as a Category 4 storm, causing widespread devastation and becoming the costliest tropical cyclone in Puerto Rican history (Scott, 2018). Numerous challenges to disaster response and recovery were exacerbated by multiple cascading failures in critical infrastructure and key resource sectors. Maria left millions of residents without electricity for weeks to months, and entire communities were isolated due to disrupted telecommunications, blocked roadways, and flooding (Federal Emergency Management Administration [FEMA], 2018). In this context, Government of Puerto Rico officials experienced difficulty providing timely and accurate information about hurricane-related deaths. Soon after the hurricane, the official death toll was widely questioned given the storm's severity, anecdotal evidence, and studies by outside groups estimating mortality of up to 72 times the official count of 64 deaths (Acosta & Irizarry, 2018; Kishore et al., 2018; Pascual Sosa, 2017; Rivera & Rolke, 2019; Robles et al., 2017; Santos-Lozada & Howard, 2018). As evidence for a higher death toll mounted, so did the public's request for this issue to be addressed.

The George Washington University Milken Institute School of Public Health (GW SPH) was commissioned by the Government of Puerto Rico to conduct an independent study that included: (1) an epidemiological assessment of excess mortality; (2) a process evaluation of disaster context death certification; and (3) an assessment of the Government of Puerto Rico's crisis and emergency risk communication (CERC), with an emphasis on mortality reporting to the public. Here, we discuss the third component, with an overarching goal of identifying factors that may have contributed to controversy surrounding the death toll. To this end, we assessed the application of CERC guidelines by the Puerto Rican Government, in particular for public communication about mortality; examined the information environment in which mortality was conveyed; and explored Puerto Rican stakeholder perceptions regarding these communications.

## Literature Review

### Crisis and Emergency Risk Communication

Communication with the public is a critical component of effective disaster preparedness, mitigation, response, and recovery (Centers for Disease Control [CDC], 2014; World Health Organization [WHO], 2005). Effective communication in disasters requires extensive planning and active management, and includes elements to establish public trust through information source credibility and transparency (Covello, 2003; Reynolds, 2006, 2011; Seeger, 2006; Steelman & McCaffrey, 2013; S. Veil et al., 2008). *Effective Media Communication during Public Health Emergencies* lays out six recommended steps for effective media communication, and includes capacity assessment tools, such as the *Internal Media Relations Assessment Tool* and an *Effective Media Communication Plan* checklist (WHO, 2005). Further, there are guidelines in the *Crisis and Emergency Risk Communication* (CERC) manual (CDC, 2014), which outline principles of risk communication in crisis, and details other considerations, such as planning and the communication lifecycle; crisis stages; audiences, messages, and channels; spokespersons; human resources; and working with the media. However, the experiences of Hurricane Maria underscored the limitations of these guidelines when communicating about mortality after a catastrophic natural disaster.

### Information Vacuums and Public Perception in Disasters

Regardless of established best practices and guidelines for communication, disasters present unique challenges given their inherent uncertainty, particularly in the case of catastrophic natural disasters (Seeger et al., 2018; Tinker & Vaughan, 2010). In rapidly evolving disaster contexts, facts can be elusive. Communicators must have the capacity to adapt, especially when faced with limited availability of credible information, or an unmet “information sufficiency threshold” (Griffin et al., 2009; Seeger et al., 2018, p. 197). In disasters, these *information vacuums* create opportunities for the public to speculate, make inferences to explain gaps, question motives, generate rumors, or propagate unverified/false information, in an attempt to reconcile perceived incongruences (Hagar, 2013).

In the absence of sufficient information, people tend to rely on their perceptions (Reynolds, 2011; Seeger, 2006; Seeger et al., 2018), as well as information sources they already trust and familiar channels (Savoia et al., 2013; Wray et al., 2008). Given the importance of public perception in disasters and the potential risks introduced by information vacuums, CERC planning and delivery should incorporate mitigation of any gaps between public perceptions and facts (Peters et al., 1997; Pornpitakpan, 2004; Ruggiero & Vos, 2015). Nevertheless, while CERC guidelines address the correction of misinformation and misperceptions in the media, they do not adequately address how information vacuums, a phenomenon that is likely to occur following catastrophic events, should be handled by communicators after disasters.

### **Navigating the Disaster Information Environment**

Inevitably, disaster communication exists within a larger disaster information environment, compelling communicators to monitor and interact with this environment (Savoia et al., 2017). An increasing number of studies highlight the impact that news media can have on public perceptions and behaviors in crises (Eckert et al., 2018; Parmer et al., 2016; Westerman et al., 2014), demonstrating its potential to be leveraged for its broad public reach and familiarity (Littlefield & Quenette, 2007; Reynolds & Seeger, 2005). Social media networks have, in many cases, eclipsed traditional mass media as critical disaster information sources. As a rapid, two-way channel, social media has the potential to create disaster response transparency, enhance situational awareness, facilitate aid delivery, and crowd-verify or eliminate rumors (Hughes & Palen, 2012; Yates & Paquette, 2011). At the same time, not all disaster response agencies have established capacities to monitor public reactions and engage with stakeholders in real time through social media platforms. Consequently, these information-sharing networks can produce unprecedented challenges, such as the rapid propagation of misinformation, contributing to an information environment that can swiftly spin out of control (Liu et al., 2014). In these cases, organizations leading disaster response risk losing their ability to manage crisis messaging, potentially compromising response efforts (Reynolds, 2011; Seeger, 2006).

## Communication of Disaster Mortality to the Public

A key issue of public interest following disasters is mortality, especially since it is crucial to informing response and recovery efforts, policymaking, providing insight into population health status, and creating a broader understanding of the disaster's magnitude and impact (Checchi & Roberts, 2005; Rickard et al., 2013; Salama et al., 2004; Santos-Burgoa et al., 2018). Notably, mortality also has the potential to become highly politicized following disasters (Checchi & Roberts, 2008). Despite the importance of communicating to the public about disaster mortality, there is a scarcity of research in this area, and currently no consensus, on best practices for disaster mortality communication—it is here where the experiences of Hurricane Maria offer important lessons.

While disaster psychology and risk communication are established fields, efforts in the scientific and emergency management communities to systematically examine how the public processes and interprets disaster death counts or estimates are minimal. It is reasonable to think that lay audiences and media outlets may experience difficulty understanding methods used to determine disaster mortality (Lagassé et al., 2011; Reynolds, 2011; Seeger et al., 2003), which can be statistically complex and vary from one study to another. Nevertheless, these methods influence how mortality estimates can be interpreted given the assumptions and limitations of each approach (Hammer, 2018; Sandberg et al., 2019). This very scenario unfolded following Hurricane Maria, when the information environment became saturated with media coverage comparing the official death toll to numerous unofficial estimates, all using distinct methods, time periods, and populations at risk to produce mortality estimates (Sandberg et al., 2019). Yet, these death figures were compared without considering these important differences.

Following Hurricane Maria, journalists and the general public demanded that every lost life be counted, viewing this method as the most valid method of truly knowing how many died (Checchi & Roberts, 2008). While it is appropriate to mourn every lost life following such a tragedy, this information can be difficult to obtain and verify in the immediate post-disaster period. This expectation of having timely and accurate hurricane-related death counts immediately following a catastrophic disaster represents a

failure among scientists and communicators to convey the inherent superiority of excess mortality estimation over “body counts” in complex disaster scenarios where surveillance systems and death certification processes are disrupted (Checchi & Roberts, 2008). Currently, there is little to guide communicators in making this distinction apparent to public audiences; while there is scientific literature related to mortality surveillance (Choudhary, 2012; Farag et al., 2013; Kim et al., 2017; Rocha et al., 2017; Seil et al., 2016) and documenting cause of death (Centre for Research on the Epidemiology of Disasters [CRED], 2016; Lakkireddy et al., 2004; Phillips et al., 2014; Wexelman et al., 2013), there is a paucity of studies exploring the specific concept of communicating disaster mortality to the public. There is no literature base that examines how death counts from a disaster should be communicated to the media, how to best explain information gaps that are common following disasters, how death counts may evolve post-disaster, or how to explain the science behind excess death estimates and what we can or cannot infer from these estimates. This research gap increases the likelihood that efforts in this area of communication will continue to be fraught with challenges if not addressed.

## Methods

To understand factors that may have contributed to the death toll controversy, we used a multisource post-disaster CERC rapid assessment protocol to examine Government of Puerto Rico communications and spokesperson media interactions, how these interactions influenced the evolution of media coverage, and stakeholder perceptions of mortality reports. CERC and WHO guidelines informed the analytical framework described below (CDC, 2014; WHO, 2005).

### Data Collection and Analysis

We collected data from five sources. We systematically reviewed 17 Government of Puerto Rico press releases and 20 press conferences (10 Facebook Live transmissions, 10 audio recordings) for the study period, September 20, 2017–February 28, 2018, to identify key messages and spokesperson delivery of mortality information (see Table 1).

**TABLE 1 Press Releases and Press Conferences**

Data Source	Analytical Framework Source Assessment Criteria
Press Releases (n=20)	<p>WHO <i>Effective Media Communication During Public Health Emergencies</i> handbook:  <a href="https://www.who.int/csr/resources/publications/WHO_CDS_2005_31/en/">https://www.who.int/csr/resources/publications/WHO_CDS_2005_31/en/</a></p>
	<p><b>Press Release Content Included:</b></p> <p>(1) Key messages to the public; (2) Actions currently being taken; (3) Actions that will be taken next; (4) How the public can help; (5) Where to look for more information</p> <p>CDC CERC manual guidelines: <a href="https://emergency.cdc.gov/cerc/manual/index.asp">https://emergency.cdc.gov/cerc/manual/index.asp</a> adapted criteria, <i>9 Elements for Establishing Trust and Credibility through Communications</i>, p. 158; adapted criteria, <i>Spokesperson Pitfalls During an Emergency</i>, p. 160  <i>WHO Effective Media Communication During Public Health Emergencies handbook, Steps of Communication in Crisis</i></p>
Press Conferences (n=17)	<p><b>Content and Spokesperson Delivery included:</b></p> <ol style="list-style-type: none"> <li><b>Expression of empathy (<i>trust</i>)</b>        [Demonstrates empathy, caring, commitment—verbally and in body language]       <ul style="list-style-type: none"> <li>When responding to a question or comment about loss of any kind (death/injury) first expressed compassion, empathy, caring?</li> <li>Acknowledged the validity of people’s emotions?</li> </ul> </li> <li><b>Clarifying facts/call for action (<i>credibility</i>)</b>        [What you know—in clear, key messages; Information is accessible to all educational levels; Avoid professional jargon; Information source expertise (education, role); Accuracy: Accurate facts that have been confirmed; Consistency: Consistent information]       <ul style="list-style-type: none"> <li>Delivered information in a clear manner?</li> <li>Used language appropriate for target audiences?</li> <li>Avoided the use of undefined jargon, acronyms and technical language?</li> <li>Provided supporting facts for key messages?</li> <li>Used numbers, statistics and data effectively?</li> <li>Acted in partnership with credible third parties?</li> <li>Avoided going beyond the bounds of expertise?</li> <li>Made corrections quickly if errors were made?</li> <li>Provided consistent, coordinated information?</li> </ul> </li> </ol>

<b>Press Conferences (n=17)</b>	<p><b>3. What is not known (<i>trust/transparency</i>)</b>  <b>[Acknowledgement of Uncertainty: What you don't know—in clear key messages; Explain why information isn't available for release]</b></p> <ul style="list-style-type: none"> <li>• Acknowledged uncertainty?</li> <li>• Discussed data and information uncertainties, strengths and weaknesses—including those identified by other credible sources?</li> <li>• Clarified unknown information in a way that established transparency (“I don't know” instead of “I cannot answer that”)?</li> <li>• Avoided guessing/speculating?</li> <li>• Provided a valid reason for not answering the question?</li> </ul> <p><b>4. Process to obtain answers (<i>trust/transparency</i>)</b>  <b>[What process you are using to get answers: explain steps/required information]</b></p> <ul style="list-style-type: none"> <li>• Described the process required to obtain requested information?</li> <li>• Explained what processes you are waiting for, circumstances contributing to delays?</li> <li>• Supported and reinforced your message with visual aids such as timelines or flowcharts?</li> </ul> <p><b>5. Statements of commitment (<i>accountability</i>)</b></p> <ul style="list-style-type: none"> <li>• Stated commitment to acquiring and providing additional information as soon as possible?</li> </ul> <p><b>6. Information referrals/scheduled updates (<i>transparency</i>)</b></p> <ul style="list-style-type: none"> <li>• Provided guidance on where to obtain additional information that expanded on key messages?</li> </ul>
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We conducted qualitative content analysis of press releases based on the extent to which they included information on hurricane mortality in five areas (Maxwell, 2009) (see Table 1): inclusion of mortality as a key message (and consistency of provided details); what was being done to assess mortality; what will be done to assess mortality; actions the public could take to assist; and where to look for more information. We also reviewed press conference proceedings based on criteria drawn from WHO and CDC guidelines (see Table 1). We assessed spokesperson delivery and content to determine the extent to which these criteria were met, thus contributing to the conceptual domains of *trust*, *credibility*, *transparency*, and *accountability*. For example, if spokespersons fail to describe steps being taken to determine mortality and

provide vague responses about information they have about the death count, this may compromise perceptions of trust and transparency among public audiences.

To assess potential information environment influence on stakeholder perceptions of Government of Puerto Rico mortality reports, we systematically collected and reviewed 172 English- and Spanish-language digital media news reports and related social media commentary. We collected primary sources of information or stories from major U.S. mainland and Puerto Rican news outlets (e.g., CNN, *Washington Post*, *New York Times*, *El Nuevo Día*, *LatinoUSA*, among others). News articles (n=53) and social media posts were identified through web-based search engines (Google, Yahoo) and social media platforms (YouTube, n=36; Facebook, n=37; and Twitter, n=46) by systematically searching for predetermined keywords and hashtags (see Table 2).

**TABLE 2 Digital Media News Reports & Social Media Commentary**

Data Source	Analytical Framework Source Assessment Criteria
<b>Digital Media News Reports &amp; Social Media Commentary (n=172)</b>	CDC CERC manual guidelines, <i>Working with Social Media Before &amp; During a Crisis</i> , p. 268 WHO <i>Effective Media Communication During Public Health Emergencies</i> handbook
	(1) Reasons and timing of mortality reports; (2) Appropriate use of statistics; (3) Contradictory mortality data from official spokespeople and unofficial sources; (4) Information used to classify death as hurricane-related; (5) Explanations and illustrations given for complex topics/processes; (6) Information gaps filled by unofficial information; (7) Perceptions of the accuracy and transparency of Government of Puerto Rico messages regarding death figures  <u>Keywords/Phrases:</u> Death toll Hurricane Maria; Deaths Hurricane Maria Puerto Rico; Rosello death toll; Controversy death toll Hurricane Maria; Deaths Hurricane Maria Puerto Rico; Muertos Huracan Maria; Muertes Maria Puerto Rico  <u>Hashtags:</u> #PuertoRico #HurricaneMaria #puertoricohurricane Maria #PuertoRicoRelief #PuertoRicoDeathToll #Hurricane MariaDeathToll #HurricaneMariaDeaths

Digital media data collection captured mortality information destined for the public as it was introduced or changed to understand the chronology and information sharing dynamics. We conducted qualitative content analysis of digital media news and social media commentary to identify content in seven areas, related to domains of *trust*, *credibility*, *transparency*, and *accountability* (Maxwell, 2009) (see Table 2). For example, if in response to a news article suggesting that the official death toll was an undercount, the predominant commentary expressed the perception that the Puerto Rican Government was hiding information that would discredit their disaster response, we assessed that line of commentary to express perceptions of (non-) transparency and a lack of accountability.

Interviews were also conducted with 33 key informants, including 11 Puerto Rican Government personnel and 22 leaders representing stakeholder groups, during a 2-week period in April of 2018. Interviews helped characterize actions and events related to preparation and dissemination of mortality data, as well as stakeholder perceptions of the Government’s mortality communications. Government personnel participants held key positions

**TABLE 3 In-Depth Interviews**

Data Source	Analytical Framework Source Assessment Criteria
Community Stakeholder Interviews (n=22)	CDC CERC manual guidelines, <i>Stakeholder and Partner Communication</i> , p. 241 WHO <i>Effective Media Communication During Public Health Emergencies</i> handbook
	Qualitative thematic analysis, Perceptions of mortality reports—in the domains of trust, transparency, accountability, credibility (subdomains: expertise, accuracy, consistency)
Government Personnel Interviews (n=11)	CDC CERC manual guidelines, <i>9-step crisis communication plan and process</i> , p. 98; <i>Working with Social Media Before and During a Crisis</i> , p. 268 WHO <i>Effective Media Communication During Public Health Emergencies</i> handbook
	Qualitative thematic analysis, Accounts of mortality reporting communication processes

including heads of agencies or departments and communication leadership or staff. Community stakeholder participants included municipal mayors, community leaders, emergency responders, police, faith leaders, health care providers, non-profit organization staff, and funeral home directors, which were selected to represent all regions of Puerto Rico and exemplify a range of experiences given municipal diversity in socioeconomic status, political affiliation, demographics, and proximity to hospitals/clinics. We conducted interviews that lasted approximately 1 hour using a semi-structured protocol in Spanish. Interviews were audio-recorded and transcribed. Participants provided informed consent and protocols were IRB-approved. Shown in Table 3, we deductively and inductively coded transcripts using a procedure similar to the qualitative content analysis described above, and analyzed coded text to identify major themes representing participant response patterns. Coding was accomplished using NVivo version 11 software. As such, common and unique views and experiences among stakeholder and government personnel participants were elucidated (Bernard, 2005; Maxwell, 2009).

## **Results**

Results are presented below, and organized into the following thematic areas: (1) CERC planning and coordination undertaken by the Government of Puerto Rico; (2) handling of mortality information gaps by the Government of Puerto Rico; (3) unofficial mortality reports in the information environment; and (4) Government of Puerto Rico CERC capacity, including spokesperson performance. Perceptions of Puerto Rico stakeholders are discussed throughout.

### **CERC Planning and Coordination**

According to Government of Puerto Rico personnel participants, a number of factors created difficult circumstances for the teams responsible for CERC, mortality surveillance, and communication of mortality to the public. These circumstances stemmed from the devastation caused by Hurricane Maria, and also because a foundation for effective disaster communication was not in place. The

Government of Puerto Rico did not have formal, written CERC plans at the time of the hurricane. As noted in our interviews:

. . . there was nothing [for CERC plans]. We were preparing—we had a couple of months saying this is what we need, these are the work groups. We had everything set up, and then boom [the hurricane hit].—Government of Puerto Rico Agency Leadership

Was there a written emergency communication plan before the hurricane? Not that I was aware of.—Government of Puerto Rico Agency Communication Leadership

According to agency leadership, Puerto Rico's emergency plan, and municipal emergency plans, was appropriate for a Category 1 hurricane, but not a catastrophic event. According to one member of the Government of Puerto Rico Agency Leadership:

. . . the plans in Puerto Rico were not prepared for a Category 5 hurricane. The plans in Puerto Rico are prepared for a Category 1 hurricane, which is really what we are used to having in Puerto Rico. So, now they have learned that the plan created many difficulties because neither the people were prepared for this [hurricane], nor the agencies either.

As a result, emergency plans did not include scenarios such as multiple cascading failures in critical infrastructure and key resource sectors, as specified in the Department of Homeland Security's National Planning Scenario (NPS) #10, "Category 3 or Higher Hurricane." Mass media channels were largely unavailable, and Government personnel had not strategically planned to use alternative channels, such as radio or interpersonal communication, to coordinate public health or disaster response efforts. As various participants in our interviews noted:

We were almost completely incomunicado. There was only one radio station.—Community Leader

There was one [radio] station that worked during the hurricane . . . it was the only media that there was, no cellular, no television, no electricity, and in terms of health information, on that station it was very general.—Non-profit Organization Personnel

. . . let's talk about leptospirosis. Well, I presented this issue directly to the Department of Health. There was no response to prevent cases. That never occurred. —Municipal Mayor

Finally, communication contingencies that were implemented were inconsistent or ineffective. As one Municipal Mayor noted:

Communications? Bad . . . satellite phones didn't work at all. I even remember when the personnel came to our municipality to demonstrate how the satellite phone worked, and they said to me, "Mayor, there's no way. What you will have to do is use it after midnight." And I said, "What do I need it for after midnight?" I think that for almost all of the mayors the satellite phone didn't work.

The lack of communication capabilities post-hurricane detracted from community members' perceived credibility of preparedness and response efforts. According to one community leader:

For me it was surprising to see people from emergency management that didn't have radio communication. I could not believe that in the middle of a hurricane, the most important people in Puerto Rico for managing disasters weren't prepared. So, the worst part of everything was the question of preparedness . . . really, for us it showed complete ineptitude in this day and age . . .

These factors related to planning and infrastructure collapse limited the Puerto Rican Government's ability to coordinate with municipalities and provide timely, reliable mortality information to the public. On one hand, Government personnel who were operating from the Center for Operations in Emergencies (COE) described a highly centralized process for preparing information destined for the public. This was reflected, for example, in the consistency between death counts given by spokespersons and press releases. However, communication personnel also noted challenges and delays in coordinating mortality data with municipalities, again related to infrastructure collapse and inadequate plans for effective contingencies. According to a member of the Government of Puerto Rico Agency Communication Leadership:

The problem with communication between municipalities and the central government was that there was no way to communicate efficiently. At first, the governor had [someone] going to all the municipalities each day to communicate. A lot of information was delayed. We were at the COE 24 hours and communication among us was

continual. But, information wasn't flowing from municipalities. There should have been a designated liaison at each municipality to communicate with the central government instead of one person trying to reach all 78 municipalities.

Further complicating the communication of hurricane-related mortality to the public was the establishment of the Department of Public Safety (DPS) only months prior to hurricane season. This was the new umbrella for seven agencies related to emergency management, public safety, and forensic sciences. There are two agencies responsible for handling mortality data in Puerto Rico: (1) the Demographic Registry under the Department of Health (DOH), which is the final destination for all death records, and (2) the Bureau of Forensic Sciences, which is responsible for investigating any deaths suspected to be from unnatural causes, and had been recently shifted under the DPS umbrella. According to study participants, at the time of the hurricane, the transition to fully integrate this newly formed agency umbrella had not yet occurred, and this contributed to confusion about the delegation of responsibilities and processes underlying disaster mortality reporting. At the time of the hurricane, there was no updated, written protocol in place to coordinate release of information to the public between the two agencies. Upon creation of the DPS, decision-making changed for the timing and clearance of mortality data for the public, and one respondent perceived that the formal vetting process had been compromised.

Emergency plans for events with mass mortality always have a unified command, where there should be periodic meetings between the Department of Health, Bureau of Forensic Sciences, Department of Justice, Demographic Registry. Once the event happens, these meetings take place to make the decision about what information was going to be shared with the public. When the Department of Public Safety was created, an office which still hadn't been well-formed, the hurricane came. There was confusion because it wasn't Health that disseminated information on mass mortality, but instead DPS . . . I think that information . . . it didn't pass formally through the Executive Committee because the process was disrupted, and there's another person requesting information, even though it wasn't through the official source.—Puerto Rico Government Agency Leadership

Stakeholder respondents perceived this lack of coordination and protocol in mortality reporting as a DOH failure because shifts in agency responsibilities between the DPS and DOH were still not well-understood by community stakeholders. As noted by some of our participants:

It seems to me there wasn't a coordination protocol [for mortality surveillance] with the Department of Health.—Municipal Emergency Management Director

I went back to the Convention Center and intercepted the Secretary of Health, and I say to him, "Secretary, we have a situation with death certificates." I don't believe the Department of Health was as proactive as I expected . . . what he said was: "Go to the Center of Operations and raise the issue." We went there and we raised the issue, went back two days later to search for a solution, but there still wasn't a solution.—Municipal Mayor

### **Handling of Information Gaps**

Due to the devastation caused by Hurricane Maria and significant challenges to mortality surveillance, Government officials did not always have sufficient information to provide the public. Additionally, measures were not taken to explain these gaps or to monitor and counteract the spread of misinformation. The hurricane-related death count was typically not a key message in press conferences, and the Governor did not talk about the death toll unless asked specifically, after which he confirmed the official count in concordance with press releases or deferred to the Secretary of Public Safety. According to a review of press releases, beginning with the first official figure of six deaths on September 22, authorities clarified that more deaths were likely, but only those confirmed as hurricane-related would be reported, vaguely citing "safety personnel" as responsible for making this determination.

Based on a review of press materials, media coverage, and participant interviews, there was no overview given to the public to outline mortality surveillance or death certification processes. Spokespersons did not provide details or illustrations to facilitate an understanding of how these processes had been interrupted, and clarify reasons for delays or information gaps. As a member

of the Government of Puerto Rico Agency Communication Leadership noted:

The public doesn't understand the process for certifying deaths. There should be a public awareness and education effort, and media should help convey this.

Government communications provided minimal information about the next steps they would take to ascertain hurricane-related deaths, and only two press releases on November 17 and 20 informed the public about what they could do to help.

Inconsistencies occurred in the provision of details for deaths and unexplained increases in deaths. In press releases on September 24 and 25, October 11, 12, 14, 20, and November 1, 2017, the Government provided specifics about causes and locations of deaths. However, press releases from October 5, 10, and 29 did not follow this format, and little to no detail was provided. After almost a week post-hurricane, in which the death toll remained unchanged at 16, the controversy over mortality count transparency intensified when, after the U.S. President visited on October 3, the Governor of Puerto Rico announced that the death toll had risen from 16 to 34. This coincided with President Trump's comments about the hurricane's limited impact, and also the abrupt change in the level of detail provided about deaths in press releases. Very little explanation was given to fill information gaps regarding this abrupt increase. When asked about the doubling death count on October 4, the Governor answered that the information they had before was insufficient, and that they are making sure to only count deaths certified as hurricane-related. There was no description of how mortality surveillance functions had been compromised, and as they began to be restored, that the public should anticipate a spike in mortality, a phenomenon known as the "Burkle Effect" (Burkle & Greenough, 2008). It was not explained that this is an expected occurrence following complex and catastrophic disasters. The unexplained abrupt increase in deaths contributed to perceptions that the Government was manipulating death counts to avoid discrediting their disaster response, or evade blame. In one community leader's perception:

The government made an error in not giving the correct number of deaths. I think they felt threatened that people would know that because of their negligence so many people died . . . one of the things that you could tell from the media, when we finally had access, was the criticism was strong.

According to stakeholder respondents, this affected perceptions of transparency and credibility. According to two participants:

In giving that [death] report they weren't transparent, they weren't sincere with the public. Many of us understand that there's no reason to hide it. They probably wanted to clean their image . . . I can't give a reason as to why they did it because I don't understand, but they weren't transparent.—Health Center Personnel

That is what made the public so uncomfortable—they are not telling the truth, lying. I saw this and was saying, but my God, what's happening? What do they want to hide?—Former Department of Health Personnel

The lack of clarity about the death certification process also persisted in media coverage, signaling a major impediment to an accurate count. Doctors and funeral home directors responding to media indicated that they did not have clear guidelines for death certification in disasters. Funeral directors noted that they had been authorized to proceed with cremations and burials if a death had been certified as unrelated to the hurricane. From September 20 to October 18, there was a seemingly higher than usual authorization of cremations. According to DPS personnel, these cremations were misunderstood to represent hurricane-related deaths:

. . . the body would stay in the hospital if they died there. If they died at home and there was no electricity, they had to bury them. In order to bury someone, you had to request a permit and the Bureau of Forensic Sciences has to provide it. So, people opted to cremate because there wasn't time. That's why cremations during that time period increased. Also, it was cheaper. It had to be done . . . the increase in cremations created the perception that all people who were cremated died from the hurricane, but one thing has nothing to do with the other.

Explanation of shifting trends in cremations were not provided to the public, opening space for misinterpretations, lingering suspicions, and questions about death reporting transparency. This potentially influenced public perceptions regarding the credibility of official death counts.

### **Unofficial Mortality Reports in the Information Environment**

Numerous attempts were undertaken to employ alternative processes for identifying hurricane-related deaths. These investigative reports, scientific studies, and media interviews with mayors, health care professionals, and first responders, together with reporting of available figures from the Demographic Registry, created a confusing post-disaster information environment. Uncertainty regarding the official death count was echoed by stakeholder respondents, who perceived that the count should have been higher given their experiences. As one Municipal Police Commissioner and Emergency Management Director noted:

My town is small. Here we all know each other. Here there were weeks when I was saying, "My God, what is happening . . . every day someone dies!" I am sure mortality increased . . . I assure you that the information being provided wasn't correct because I know my town. I can tell you that . . . it was after the hurricane that it increased. It elevated to a very alarming figure.

The perception of an undercount led these stakeholders to conclude that government leadership was disconnected from the realities that communities throughout Puerto Rico were experiencing. For example, a Municipal Emergency Medical Director stated:

I believe that the impression they gave wasn't correct because I've always said that the number given was way below the reality . . . the reality that I lived. My colleagues working with me and police that were in the street lived it. This reality wasn't lived by people who were tucked away in the Command Center there in San Juan. . . . they didn't live the community's reality . . . you had to suffer that need . . .

Similarly, a Municipal Mayor noted, "I know, I have the numbers for my town, I don't know about the country, but I know that

here, deaths almost doubled. I bury them. I open the gates of the cemetery.” Some community leaders compared official mortality reports to media reports and calls on the radio about missing persons, which they perceived as credible firsthand sources of information. For example, in one community leader’s perception:

That they hid information because you see the news and how people called the radio program saying that so-and-so is missing. Those people that went missing maybe died and were never found. It is understood that they died and that information the government doesn’t offer as real.

### **Crisis and Emergency Risk Communication Capacity**

In addition to the Government’s lack of CERC plans, there had been insufficient pre-hurricane CERC training of communication personnel and official spokespersons, further limiting the likelihood that CERC best practices would be utilized. This lack of CERC training was apparent in spokesperson performance and study respondent indication of a lack of formal training for communication in disasters. As one government communications employee noted:

When they told me to report to the Center for Operations in Emergencies . . . I had no idea what we were going to face. I had to face a phenomenon of great proportions, but didn’t know what I was going to do there. I’m talking about even at the most basic, personal level of what to bring.

Following Hurricane Maria, there were few official spokespersons providing information to the public. The Governor initially conducted daily press conferences as the main spokesperson, although he was sometimes accompanied by others. He appeared to be prepared with relevant talking points, which aligned with press releases. He seemed to listen carefully to questions and responded without using overly technical language. To some extent, he managed uncertainty by saying what was known, identifying what was still being reviewed, and indicating willingness to provide information when available. However, when asked about deaths, he often deferred to the Secretary of Public Safety instead of a subject matter expert.

The Secretary of Public Safety was also a prominent spokesperson. In his interactions with the media, he delivered concise information, conveyed authority, acknowledged uncertainty in the mortality count, and also indicated a willingness to provide more information when available. However, he provided very limited responses to media questions, and in some cases, contradictory information. When asked about mortality, his responses tended to be relatively limited, such as “We are still reviewing” or “as soon as we get more data,” with no specifics provided about what was still being reviewed, who was reviewing it, what type of data they were waiting for, or why there were delays. Further, while maintaining on numerous occasions that the government would not be influenced by anecdotes or assumptions, he stated in a press appearance on November 8 that there could be an increase of 30% in the average daily deaths. No details were provided to validate this statistic, which conflicted with previous statements, including one on October 1, when he speculated that deaths could increase “exponentially.” The ineffective use of statistics and suppositions may have influenced perceived credibility.

Both the Governor and the Secretary of Public Safety failed to defer to subject matter experts early in the post-disaster period to answer questions about mortality surveillance and death certification. It was not until November 8 that the Secretary of Public Safety called upon representatives from the Bureau of Forensic Sciences and the Demographic Registry to discuss these processes and respond to public inquiry. This coordination with subject matter experts occurred too late. By that time, there were already inconsistencies and rumors circulating in the information environment, as well as growing stakeholder frustration.

The credibility of official messages was also called into question with reports of contradictory or unconfirmed statements by other public officials. One example was the Mayor of San Juan’s response to the Secretary of Homeland Security, stating that the death count could be 10 times higher than official data. The Secretary of Public Safety characterized this statement as “irresponsible,” but did not offer corrections. In a media interview on September 28, the Puerto Rican Secretary of Health acknowledged that some

hospital morgues were full. According to one funeral home director respondent, this contributed to misconceptions since deaths occur daily regardless of disasters:

We are more or less the same right now [in April, 2018]—there has not been an increase [in deaths]. People have the perception that many more people died . . . because in a hospital there are 10 deaths a day, and funeral homes claim those bodies immediately . . . but if funeral homes cannot go . . . tomorrow they have 20 and the next day they have 30 . . . there is a perception that there are more deceased than there are.

However, the Secretary of Health gave no explanation to contextualize morgue capacity. This information vacuum opened an opportunity for misconceptions about hurricane-related deaths.

The Secretary of Health also provided mortality data that had not yet been formally incorporated into the official death count. For example, in the interview on September 28, he indicated that there were seven additional deaths at hospitals, but the cause of death was pending; yet the official death toll was 16. The release of such unconfirmed, contradictory information may have influenced public perceptions of credibility and transparency.

## **Limitations**

Several limitations should be considered when interpreting study findings. Data was collected 7 months post-hurricane, introducing potential recall bias in respondent accounts. Additionally, we undertook a rapid assessment with a condensed study timeline, limiting the digital media that could be reviewed and the interview sample size. We did, however, focus our digital media review on pivotal points in the availability of information, and interviewed a number of key actors within the Government who were involved in mortality data management or communication. Furthermore, we recruited interview respondents with diversity in a number of criteria that were likely to affect a community's experiences with the hurricane. Regardless of the sample size, we reached saturation.

## Discussion

The days and weeks following Hurricane Maria were characterized by widespread criticism of the Government of Puerto Rico's handling of mortality reporting. In addition to the hurricane's aftermath, there was also a crisis of death toll uncertainty. Not only did this issue dominate discourse, detracting from other important issues post-hurricane, it also raised key questions about planning for similar complex disasters. The experiences of Hurricane Maria highlighted areas of prospective research and practice that should be prioritized by scientific and disaster communities, and signaled areas related to disaster *impact communication* that should be expanded upon in CERC guidelines—mortality communication and communicating in catastrophic disaster contexts.

### CERC Guidelines and Information Vacuums

One goal of communication in disasters is to provide accurate, timely information to the public. According to CERC and WHO guidelines (CDC, 2014; WHO, 2005), government administrations and disaster response organizations can build public confidence by having coordinated, transparent information sharing, and trained spokespersons and subject matter experts to provide consistent information and explanations. The Government faced difficulties communicating about mortality, stemming from a lack of CERC plans and the timing of recent government restructuring that complicated coordination. These challenges were exacerbated by not anticipating widespread infrastructure failures and a lack of communicator CERC training.

Another goal of communication in disasters is to minimize misinformation, which includes monitoring the information environment and counteracting rumors (Liu et al., 2014; Savoia et al., 2017; Seeger, 2006). Following Hurricane Maria, the politicization of the death count resulted in part from information gaps coupled with insufficient monitoring and rumor control. Major interruptions to mortality surveillance resulted in delayed reporting and a substantial information vacuum. Official and unofficial mortality reports proliferated in the media to fill this void, contributing to stakeholder perceptions that questioned credibility and

transparency of the Government of Puerto Rico. In the context of waning public trust, overall disaster response capabilities can become greatly diminished.

Additionally, Government of Puerto Rico personnel did not recount efforts to engage with stakeholders on social media or systematically monitor this digital information environment as part of an overarching communication strategy. Official press conferences were streamed on the Governor's Facebook Live account, but there were no coordinated efforts taken to monitor and respond to misinformation or rumors. Given the potential of social media for disseminating verified information and minimizing the spread of rumors, this was a missed opportunity. Practitioners engaged in disaster preparedness planning should integrate social media use into daily operations, dedicating personnel to facilitating stakeholder relationships, and monitoring and responding to public reactions during crisis.

Situations also arose following the hurricane that were inadequately explained by spokespersons. These information gaps created opportunities for the public to question the Government's motives and speculate as to why the information was unavailable, when it was not necessarily a question of motive. Even in the absence of timely mortality data, the processes of mortality surveillance and death certification could have been described and barriers to these processes detailed. These occurrences following Hurricane Maria raise the question about how governments and disaster response organizations can adequately prepare to communicate in catastrophic disasters, where the likelihood of information vacuums is high, mortality surveillance is at risk for disruption, and high levels of public interest and media coverage can be anticipated. An important consideration is how information vacuums should be handled; however, while CERC guidelines address the correction of misinformation and misperceptions in the media, they do not elaborate on how information vacuums should be handled by disaster communicators. Furthermore, CERC guidelines delineating communication plan design and implementation do not address catastrophic disaster situations, when the communication landscape drastically changes and contingencies are required to maintain communication functions.

Drawing from lessons learned following Hurricane Maria, current CERC guidelines should be expanded to address these important areas. With guidelines for communicating following catastrophic disasters, planning can be undertaken to anticipate factors such as elevated mortality yet disrupted mortality surveillance systems, information vacuums accompanied by intense media interest, and toppled communication infrastructure necessitating contingencies. With catastrophic CERC guidelines, communicators following Hurricane Maria would have been better positioned to prepare for substantial information vacuums and address them more effectively through messaging and responding to the rapidly evolving information environment; have communication plans and contingencies in place to enable information sharing and message coordination, including with local stakeholders throughout Puerto Rico; and anticipate mortality as a key point of public interest and vital piece of information for disaster responders and policymakers.

### **Communicating Post-Disaster Mortality**

Risks to credibility, trust, and transparency can be mitigated in part by having spokespersons who are highly trained in the subject matter, and who place as much importance on the message itself as the manner in which the message is communicated. CERC and WHO recommendations detail considerations of spokesperson selection, characteristics, and training. CERC and WHO guidelines also highlight the importance of delivering early messaging from information sources that build credibility through illustrative descriptions for complex topics, background information, supporting facts, third-party validations, and explanations of situations that may be questioned by the public. While Government of Puerto Rico spokespersons were experienced in public speaking, the lack of CERC media training was notable. This was evidenced by spokesperson performance during press conferences and media interviews, as well as accounts from study participants who indicated that they had not been trained in disaster communication. Spokesperson missteps, including vague responses when asked about disaster mortality, the use of inconsistent statistics,

speculation about anticipated mortality counts, late involvement of subject matter experts in press conferences, lack of supportive materials to explain death certification, communication of deaths to the media that had not yet been confirmed as hurricane-related, and inconsistent messaging between official spokespersons, created a post-disaster information environment saturated with criticism and diminished credibility of the Government of Puerto Rico's efforts.

Future disaster preparedness efforts should emphasize spokesperson and communication personnel training related to mortality surveillance processes and communicating with the public about mortality, especially following catastrophic events. This raises the questions: What is the best way to communicate with the public about disaster mortality, and what do we know about how public audiences understand and interpret mortality estimates? The current CERC and WHO guidelines do not include a nuanced discussion of communicating disaster mortality to the public. Future research should explore these areas in order to inform best practices.

## **Conclusion**

The response and recovery period following Hurricane Maria was punctuated by significant controversy surrounding mortality reporting. Puerto Rican Government officials provided information they had available to them at the time and made attempts to be open and transparent. Given the level of destruction experienced in Puerto Rico, it is likely that delays in mortality surveillance and temporary information gaps were inevitable. However, given these circumstances, not applying CERC best practices and inadequate CERC training led to unexplained information gaps and inconsistencies that contributed to rumors and controversy. Confusion was intensified by numerous unofficial death counts in the information environment. Ultimately, the Government of Puerto Rico lost the ability to effectively manage messaging, thus decreasing their source credibility, perceived transparency, and public trust. While an essential role of government in disasters is to protect the

public from risk, the mortality count controversy drained political capital and detracted from efforts to meet population health and safety needs.

These experiences highlight the importance of CERC planning and training, which should be expanded to include guidelines for disasters of catastrophic scale where key resources and infrastructure are impacted, communication channels are similarly degraded, and information vacuums are likely to occur. Future research should examine the role of a robust CERC response in disaster communications, as well as examine application of the CERC model across diverse disasters and contexts, including those with considerable resource constraints (Avery, 2019). These occurrences also emphasize the need for more *impact communication* research, or communicating to the public about a disaster's impact, including mortality. Little is known about how audiences process disaster mortality information. Consensus in this area will inform development of anticipatory educational materials, spokesperson training and key messages, guidelines for inter-sectoral and stakeholder collaboration, and recommendations for navigating the post-disaster information environment.

### Archived links from Table 1

CDC *CERC* manual guidelines. Retrieved from web archive:

<https://web.archive.org/web/20190614141121/https://emergency.cdc.gov/cerc/manual/index.asp>

WHO *Effective Media Communication During Public Health Emergencies* handbook. Retrieved from web archive:

[https://web.archive.org/web/20190418231742/https://www.who.int/csr/resources/publications/WHO\\_CDS\\_2005\\_31/en/](https://web.archive.org/web/20190418231742/https://www.who.int/csr/resources/publications/WHO_CDS_2005_31/en/)

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# When Crises Change the Game: Establishing a Typology of Sports-Related Crises

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## ABSTRACT

In order to properly evaluate crises that occur in sports, scholars have previously called for a sports-specific crisis communication typology (Wilson et al., 2010). Two studies were conducted to develop the resulting typology. Study 1 utilized a questionnaire to obtain a comprehensive list of sports-related crises that were later grouped into 12 crisis types and three unique clusters through the use of qualitative content analysis. Study 2 utilized a questionnaire completed by 282 college students to determine the levels of crisis responsibility attributed to each cluster of crises. The resulting typology provides the necessary foundation for crisis communication research that uses sports as a context by evaluating the level of organizational blame that exists when a crisis occurs.

**KEYWORDS:** crisis communication, situational crisis communication theory, crisis typology, sports communication

In 1919, eight Chicago Black Sox baseball players were accused of accepting bribes from gamblers and intentionally losing the World Series. The scandal rocked the sporting world and landed on the front page of all major newspapers, marking the first time the mainstream media prioritized the coverage of a sports-related scandal. Today, sports scandals continue to receive vast amounts of public scrutiny. Controversy surrounding issues of drug use, domestic violence, sexual assault, racism, sexism, gambling, bribery, concussions, and more quite literally play out on the sports

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field while concurrently dominating media coverage. Because of the large emphasis culture places on sports (Raney, 2006), such scandals impact a vast audience as they dominate sports media headlines and online trending topic lists.

Sports scandals permeate popular culture, as perhaps no other form of entertainment connects as closely to a person's self-esteem as their sports team affiliation (Wann, 2006). When a crisis strikes a sports organization or player, it often negatively affects their key stakeholders, sports fans (N. A. Brown & Billings, 2013). Specifically, crises that impact sports organizations and athletes have the ability to cause harm by tarnishing a team or athlete's reputation or impairing their in-game performance. Additionally, the negative fallout from recent sports-related crises shows their impact has progressed beyond the field, including the potential to damage a university's entire organizational brand (e.g., Michigan State/Larry Nassar scandal; Penn State scandal; Baylor University scandal).

In order to address the impact of sports-related crises, this study seeks to test a primary component of Coombs's (1999b) situational crisis communication theory (SCCT) by examining the level of crisis responsibility attributed to a sports organization in crisis. Coombs and Holladay (2002) noted that organizations can improve the overall effectiveness of their crisis responses by evaluating the level of responsibility that stakeholders attribute to them during crises. By exploring the different types of crises that sports organizations encounter, this study seeks to answer the call of Wilson et al. (2010) to establish a typology of crises that impact sports organizations, which the authors noted would be valuable for sports crisis scholars by allowing them to more effectively define and examine sports-related crises.

Thus, this manuscript features two studies to measure the level of crisis responsibility attributed to each type of sports-related crisis. Following the methodology of Mitroff, Pauchant, and Shrivastava (1988), the first study surveyed sports communication researchers to form a comprehensive list of sports-related crises, which was then clustered through the use of conventional qualitative content analysis (Hsieh & Shannon, 2005). In the second study, researchers replicated the methodology utilized by Coombs and Holladay (2002) and administered a quantitative

survey of 282 college students to evaluate the level of crisis responsibility attributed to an organization during each type of crisis. The survey also helped the researchers determine how each type of crisis impacts an organization's reputation and the amount of control stakeholders perceive an organization had over the situation.

## Literature Review

### Crisis Communication Typologies

Coombs (2012) defines a crisis as the “perception of an unpredictable event that threatens important expectancies of stakeholders related to health, safety, environment, and economic issues, and can seriously impact an organization's performance and generates negative outcomes” (p. 3). Communication scholars have long evaluated the reputational threat that results from organizational crises (Coombs, 2012; Coombs & Holladay, 1996). Coombs and Holladay (2002) noted that an organization's reputation is a valuable asset among stakeholders; and, as such, reputational threats should be avoided. When crises do befall an organization, stakeholders typically re-evaluate the favorability of an organization's reputation, prompting organizations to strategically engage in reputation repair (Coombs & Holladay, 2005).

Scholarship has long investigated how to best respond to a plethora of crises. Benson (1988) suggested a need for a theoretical approach to address the following tenets: (1) synthesize existing crisis communication literature into a typology of crisis types that might alarm an organization; (2) synthesize reputation repair strategies that can be utilized during a crisis; and (3) establish a theoretical linkage between the type of crisis an organization faces and the corresponding repair strategy that should be selected. This call was later addressed by Coombs's (1999b) SCCT.

SCCT champions the importance of beginning a crisis response by first analyzing the type of crisis that threatens an organization in order to guide the effective selection of a reputation repair strategy (Coombs, 1999b). Coombs (2012) noted that to evaluate the reputational threat a certain crisis poses, three factors must be addressed: crisis type, crisis history, and prior reputation. In order to address the first factor, Coombs and Holladay (2002) developed

a list of crisis types and the levels of crisis responsibility associated with each. Coombs and Holladay (2002) defined a crisis type as “the frame that publics use to interpret an event” (p. 167). Their list featured 10 crisis types that were placed into one of three different categories: victim crises (resulting in minimal crisis responsibility), accident crises (resulting in low crisis responsibility), and preventable crises (resulting in strong crisis responsibility). These crisis clusters are “premised on the logic of crisis portfolios: similar crises can be managed in similar fashions” (Coombs & Holladay, 2002, p. 180). While Coombs and Holladay’s (2002) typology has been widely used in crisis scholarship, its methodology has not yet been replicated by other crisis scholars to create additional crisis typologies.

This concept is meant to simplify the process of selecting optimal response strategies that are associated with similar crises. By first acknowledging the type of crisis an organization faces, crisis managers can determine the amount of blame and crisis responsibility stakeholders attribute to the organization, itself (Coombs & Holladay, 2002). SCCT states that the more crisis responsibility the public attributes to an organization, the more accommodating an organization will need to be toward the victims when selecting reputation repair strategies (Coombs, 2012). Essentially, a proper evaluation of crisis type should improve the overall effectiveness of a crisis response (Coombs & Holladay, 2002). After analyzing the crisis type, a crisis manager should adjust his/her initial assessment of attribution, which depends upon other significant factors such as the organization’s crisis history and its prior relationship with stakeholders. Only then should a crisis manager select a proper reputation repair strategy.

### **Crisis Communication and Sports**

The combination of media prominence of sports issues and an “increased activism of sports fans” led to a surge of sports crisis communication research (K. A. Brown et al., 2012, p. 155). The expansion of sports-centric programming channels such as ESPN and Fox Sports created print, broadcast, online, and mobile outlets dedicated to covering every aspect of sports, including sports

scandals. While the uncertainty of sports outcomes establishes a certain amount of inherent drama, a crisis striking the field of play can only heighten that effect. Such growth in exposure and interest can increase sports organizations' profitability. Thus, researchers wanted to determine the extent to which a sports team or athlete's reputation affected them financially by exploring the intersection of sports and crisis management (Brazeal, 2008). The resulting sports crisis communication research primarily examined sports crises through the use of image repair theory (IRT) and SCCT (Benoit & Hanczor, 1994; Brazeal, 2008; N. A. Brown & Billings, 2013; K. A. Brown et al., 2012).

### **Rationale for Sports-Specific Crisis Typology**

While previous sports crises have been evaluated using SCCT's reputation repair strategies (Brown & Billings, 2013; Richards et al., 2017; Williams & Olaniran, 2002), Brown et al. (2015) noted that SCCT's typology does not fully encompass sports-related crises and, as a result, scholars have been unable to fully test SCCT's theoretical linkages in the sports context. As such, the Coombs and Holladay (2002) typology has *not* been utilized by sports-related crisis research. Perhaps this is unsurprising given Björck's (2016) claim that "a single typology cannot capture the complexity and interdisciplinary nature of a crisis" (p. 1). Therefore, context-specific crisis typologies have been developed in areas such as tourism (Laws & Prideaux, 2008), restaurant management (Tse & Sin, 2006), governmental relations (Rosenthal & Kouzmin, 1997), and, of course, corporate contexts (Coombs, 1999a).

Björck (2016) noted that crisis scholarship should formulate typologies that reflect important "cultural and contextual dimensions" (p. 1), such as the unique nature of sports and its vital cultural significance (Raney, 2006). In order to address this need for typologies in the sports context, Wilson et al. (2010) established an initial framework for classifying sports-related crises (i.e., "unintentional/intentional" and "internal/external"), and noted that future scholars should incorporate a quantitative component to this area of research. Yet, scholarly examinations of sports-specific crises must account for the fact that crises can result from

individual or organizational actions. As noted by Sato et al. (2015), Wilson et al.'s initial framework would need to be expanded upon to incorporate "the unique characteristics of athlete reputational challenges that distinguish them from other celebrity scandals" (p. 436), and how athlete actions that violate the "nature of sport" can also impact the larger organization's reputation. Additionally, Hughes and Shank (2005) sought to define characteristics of a sports scandal in order to aid sports scholars' understanding of the impact of such issues. However, they did not formulate a crisis typology with their results. Yet, the authors did call for future research that would help scholars quantitatively understand both the short- and long-term impacts of sports scandals on stakeholders' affiliations with sports organizations.

Previous scholarship displays a clear need for a crisis communication typology in the context of sports that can aid scholars who explore sports-related crises quantitatively, and are guided by theories such as SCCT (Wilson et al., 2010). While both corporations and sports teams are often thought of as organizations driven by profits, the largest threats to each of their reputations are too unique to be placed under one conceptual umbrella. Thus, in order to further extend the work of Wilson et al., the following research question is proffered:

RQ1: What types of crises do sports organizations and athletes commonly face?

In order to establish a sports crisis communication typology, a list of crisis types provides crisis managers with some guidance in their selection of response strategies. Wilson et al. (2010) advised future scholars to draw upon tenets of SCCT, namely attribution theory, when further developing sports-related crisis communication research. Coombs and Holladay (2002) noted that crisis managers must ascertain the level of crisis responsibility the public attributes to the offending organization in order to choose a response strategy with the proper level of accommodation toward the victims. SCCT (Coombs, 2012) includes a list of 10 crisis types divided into three clusters ranging from a minimal amount of crisis responsibility to a strong amount of crisis responsibility: victim crises, accident crises, and preventable crises (Coombs, 2012). In

order to establish a sports crisis communication typology, a list of sports crises must be categorized according to the level of crisis responsibility perceived by the public. Thus, the following research question is offered:

RQ2: Based on amount of responsibility attributed, what clusters will emerge from the list of crises?

One of the central tenets of SCCT posits that “perception of crisis responsibility is directly correlated [with] reputational damage,” meaning that as crisis responsibility increases, the possibility of damage to an organization’s reputation also increases (Coombs & Holladay, 2002, p. 173). The correlation between crisis responsibility and organizational reputation is the key linkage in SCCT; therefore, this new typology must also demonstrate this linkage. Thus, the researchers posit the following hypothesis:

H1: A direct correlation will exist between crisis responsibility and organizational reputation for each of the clusters.

## **Study 1 Methods**

### **Initial Qualitative Questionnaire**

Following the methodology of Mitroff et al. (1988), researchers contacted an expert panel of sports communication scholars through member listservs of two scholarly organizations devoted to sports communication research: the Association for Education in Journalism and Mass Communication (AEJMC) Sports Communication Interest Group and the International Association of Communication and Sport (IACS). The researchers gathered responses and created a database of potential crises that plague athletes or teams, as this initial list would be synthesized into a typology of crises that ideally would be comprehensive with few potential outliers. The researchers provided members of each listserv with a link to an online survey that contained a single open-ended question requesting scholars to brainstorm a list of crises that have affected, or could have affected, sports teams and/or athletes in recent years. Scholars employed their own definition of what constituted a crisis when responding to the questionnaire

and were encouraged to list crises that affected *all* sports. The initial survey yielded responses from 23 researchers, and produced a list of 263 sports crises, which encompassed crises that have affected virtually every imaginable sport from badminton to baseball.

### **Qualitative Content Analysis and Formation of Crisis Types**

The authors then utilized conventional qualitative content analysis as described by Hsieh and Shannon (2005), where the data gathered from the open-ended survey questions were then used to generate a list of crisis types. Qualitative content analysis was utilized since it is ideal for concept development (Hsieh & Shannon, 2005; Lindkvist, 1981). Conventional qualitative content analysis provides a method for researchers to “combine or organize this larger number of subcategories into a smaller number of categories” (Hsieh & Shannon, 2005, p. 1279).

To follow the procedures as described by Hsieh and Shannon (2005), the primary author examined the qualitative survey data guided by Coombs’s (2012) definition of a crisis, and made notes on initial impressions of the crises so that labels for codes emerged. In order to follow the method used in the development of previous crisis management typologies (Mitroff et al., 1988; Wilson et al., 2010), the author began grouping each response based on traditional crisis communication variables (internal/external crisis, individual/organizational, etc.), to develop groupings based on “how different codes are related and linked” (Hsieh & Shannon, 2005). Each included crisis had to fit Coombs’s (2012) definition of a crisis, and accordingly present one of the following three threats: public safety, financial loss, or reputation loss.

Twelve crisis types resulted from this process. Hsieh and Shannon (2005) noted that, ideally, the numbers of clusters that result from conventional qualitative content analysis will be between 10 and 15. The project’s co-author examined the development of each crisis type to ensure there was agreement regarding the resulting list, as was recommended by Elo et al. (2014). In order to ensure face validity, the authors followed the recommendation by Elo et al. and presented the list during a conference panel comprised of sports scholars prior to publication in order to garner feedback. Scholars who attended the presentation agreed that a sport-specific

typology would greatly aid crisis communication scholars who conduct research in the sports context and did not recommend any changes to the presented typology. They did, however, recommend using it in additional studies to continue to validate it.

## Study 1 Results

The first research question focused on synthesizing the crises provided during the initial survey into a crisis typology. Based on the list of crises, a typology of 12 crises was formed, divided tentatively into two categories for the sake of discussion: internal crises and external crises. Appendix A provides specific examples from the questionnaire results for each crisis type.

Internal crises directly affect the field of play. There are six of these crisis types. *Internal criminal transgressions* include actions that involve a sports figure that leads directly to an arrest, legal action, and/or conviction that happened during a competition. *Logistical and operational issues* involve issues that affect the viewing of a sports event that were not caused by a natural disaster. *Amateurism transgressions* consist of issues that affect the amateur status of a sports figure (notably college or Olympic-style competitors). *Competition transgressions* contain actions involving a sports figure or team that directly compromises the fair nature of competition. *Player/coach management issues* encompass issues surrounding a sports figure that would directly affect the team's active roster or coaching staff, such as illegal or unethical firings, especially those that result in legal action. *Misleading internal information* involves statements or other information provided by a sports figure related to internal operations that causes some controversy or compromises his/her position with the team.

External crises indirectly affect the field of play. There are also six of these crisis types. *External criminal transgressions* involve actions involving a sports figure that leads directly to an arrest, legal action, and/or conviction that did not happen during the course of competition. *Personal lifestyle transgressions* result from actions involving a sports figure that affect his/her personal life, but do not lead to an arrest and/or conviction (more morally wrong than criminally wrong). *Controversial statements/actions* consist of

statements or actions made by a sports figure that are inappropriate or that caused some controversy, but did not lead directly to an arrest and/or conviction, and did not address some aspect of the team. *“Act of God” events* are actions that affect a sports figure or a team that were outside of his/her/its control. *League/conference management issues* result from issues surrounding a team affiliation or league operations that do not directly affect the course of competition.

## Study 2 Method

In order to establish a sports crisis communication typology, the list of sports crises generated in study 1 must be categorized according to the level of crisis responsibility perceived by sports audiences.

### Quantitative Survey and Measurement of Crisis Responsibility

After the qualitative survey and qualitative content analysis, researchers conducted a full administration of the crisis typology to assign levels of crisis responsibility. The researchers used a method similar to Coombs and Holladay’s (2002) method of clustering organizational crises according to its level of responsibility, which ranged from minimal crisis responsibility to strong crisis responsibility. In order to measure the level of crisis responsibility associated with each of the crisis types synthesized from the pilot study, the researchers distributed an online survey hosted by Qualtrics to participants. The authors selected articles from ESPN.com reporting on a crisis that could be classified into one of each of the 12 resulting categories. The 12 articles used in the study included an average of 550 words, which lead to approximately 1.5 double-spaced pages. Appendix A provides definitions and examples of each crisis type. Participants were given as much time as needed to read the articles and answer the questions that followed. To prevent survey fatigue, participants were randomly assigned by the Qualtrics software to evaluate only two of the crisis types. Participants were asked to read each article and answer

items to help evaluate the level of crisis responsibility associated with each crisis.

### Questionnaire

In order to measure the amount of crisis responsibility attributed to each of the 12 resulting crisis types, the researchers designed a 22-item questionnaire to measure organizational reputation, personal control, and crisis responsibility. A sample consisting of 282 college students from a large Southeastern university was utilized for this study. The sample was 25% male ( $n = 72$ ) with ages ranging from 18 to 29 ( $M = 20.4$ ,  $SD = 1.3$ ). While Coombs and Holladay (2002) noted that students are not generally the primary audience for corporate crisis response, Enoch (2011) stated that people ages 18–24 classify themselves as avid sports fans. Therefore, college students constitute a large audience for crises involving sports organizations and/or athletes and are a valuable population to examine.

*Organizational reputation.* The researchers measured organizational reputation using five 7-point Likert scales adapted from Coombs and Holladay's (1996) Organizational Reputation Scale ( $\alpha = 0.806$ ). This scale is an adaptation of McCroskey's (1966) scale used to measure credibility, and included items such as "The organization is basically DISHONEST," and "Under most circumstances, I would be likely to believe what the organization says." The items were combined to create a composite mean score. This scale was also utilized in a study that sampled the same population by K. A. Brown et al. (2015).

*Personal control.* Researchers measured personal control using four 7-point Likert scales adapted from McAuley et al.'s (1992) Causal Dimension Scale II ( $\alpha = 0.745$ ). These items measured the degree to which the event is controllable by the organization, and included items such as "The cause of the crisis is something that was manageable by the organization," and "The cause of the crisis is something over which the organization had no power."

*Crisis responsibility.* Crisis responsibility was measured using Griffin et al.'s (1992) three 7-point Likert scales for measuring blame. Coombs and Holladay (2002) noted this scale is acceptable for measuring crisis responsibility of an organization. The scale had a Cronbach's alpha of 0.72 and included items such as "Circumstances, not the organization are responsible for the crisis" and "The blame for the crisis lies with the organization." Based on previous research, Coombs and Holladay (2002) treated personal control and crisis responsibility as one common variable, and combined the two scales into one variable of "crisis responsibility." Based on a principal components factor analysis with a Varimax rotation, similar to Coombs and Holladay (2002), the items used in this study loaded under one factor as well, accounting for 47.52% of the variance with an eigenvalue of 3.327. The final scale had a Cronbach's alpha of 0.79. Thus, the two scales were combined to form a crisis responsibility composite mean score.

*Other questionnaire items.* The instrument included two questions to check comprehension. After participants read each news article, items asked "What is the name of the organization accused in the preceding article?" and "What is the crisis presented in the preceding article?" Participants that offered incorrect responses to the two questions were excluded from the sample. The questionnaire yielded a total of 562 article responses, since each participant viewed two news articles. Yet, incorrect responses to knowledge questions eliminated 57 responses, bringing the total number of responses to 505. Each participant also answered a four-item fan identification scale adapted from Wann and Branscombe (1993) Sports Spectator Identification Scale (SSIS). Finally, four items measured demographics such as age, gender, ethnicity, and educational status. SPSS version 20.0 was used to analyze all collected data.

## Study 2 Results

The second research question focused on grouping the 12 crisis types into clusters. Similar to the method used by Coombs and

Holladay (2002), a hierarchical cluster analysis was used to create homogeneous clusters of crisis types based on similar characteristics. Since crisis responsibility is central to this typology, just like in SCCT, it was the variable used to create the crisis clusters. This method creates clusters so that the members of the same cluster have a stronger degree of association among themselves, but a weaker degree of association between themselves and members of a different cluster (Coombs & Holladay, 2002).

**TABLE 1 Crisis Typology and Mean Scores for Three-Cluster Solution**

	<b>Crisis Responsibility</b>	<b>Organizational Reputation</b>
<b>Environmental/ Individual Crisis</b>	<b><i>M</i> = 3.10 (<i>SD</i> = 0.997)</b>	<b><i>M</i> = 4.96 (<i>SD</i> = 1.075)</b>
“Act of God” Event	<i>M</i> = 2.56 ( <i>SD</i> = 1.034)	<i>M</i> = 5.23 ( <i>SD</i> = 0.931)
Controversial Statement/ Action	<i>M</i> = 3.12 ( <i>SD</i> = 1.010)	<i>M</i> = 5.17 ( <i>SD</i> = 1.119)
Personal Lifestyle Transgression	<i>M</i> = 3.25 ( <i>SD</i> = 1.096)	<i>M</i> = 5.02 ( <i>SD</i> = 1.280)
External Criminal Transgression	<i>M</i> = 3.16 ( <i>SD</i> = 0.947)	<i>M</i> = 4.64 ( <i>SD</i> = 0.996)
Internal Criminal Transgression	<i>M</i> = 3.40 ( <i>SD</i> = 0.714)	<i>M</i> = 4.80 ( <i>SD</i> = 0.997)
<b>Rules and Norms Violations</b>	<b><i>M</i> = 3.71 (<i>SD</i> = 0.899)</b>	<b><i>M</i> = 4.86 (<i>SD</i> = 1.036)</b>
Fan Involvement Issue	<i>M</i> = 3.69 ( <i>SD</i> = 0.914)	<i>M</i> = 4.90 ( <i>SD</i> = 1.126)
Amateurism Transgression	<i>M</i> = 3.70 ( <i>SD</i> = 1.028)	<i>M</i> = 4.75 ( <i>SD</i> = 0.920)
Competition Transgression	<i>M</i> = 3.74 ( <i>SD</i> = 0.768)	<i>M</i> = 4.85 ( <i>SD</i> = 1.070)
<b>Organizational Mismanagement</b>	<b><i>M</i> = 4.22 (<i>SD</i> = 0.873)</b>	<b><i>M</i> = 4.47 (<i>SD</i> = 0.931)</b>
League/Conference Management Issue	<i>M</i> = 4.02 ( <i>SD</i> = 0.875)	<i>M</i> = 4.76 ( <i>SD</i> = 0.922)
Logistical/Operational Issue	<i>M</i> = 4.30 ( <i>SD</i> = 0.908)	<i>M</i> = 4.43 ( <i>SD</i> = 0.859)
Misleading Internal Information	<i>M</i> = 4.35 ( <i>SD</i> = 0.911)	<i>M</i> = 4.38 ( <i>SD</i> = 1.006)

Based on the agglomeration schedule using Ward's method, a more efficient method of measuring distance between clusters due to its analysis of variance approach (Burns & Burns, 2009), the optimal cluster grouping was a three-cluster solution. Much less distinguishing existed between cases for subsequent clustering after the three-cluster solution. A one-way ANOVA found the cluster solution was a good fit, based on the cluster's crisis responsibility and organizational reputation scores. Table 1 provides the mean scores for the three-cluster solution. Significant differences existed among the three clusters for crisis responsibility ( $F(2, 502) = 68.785; p < 0.001$ ) and organizational reputation ( $F(2, 502) = 11.409; p < 0.001$ ).

The first cluster that resulted from the study was the "environmental/individual crisis" cluster. This cluster included the following crisis types: act of God event, controversial statement/action, personal lifestyle transgression, external criminal transgression, and internal criminal transgression. The crises in this initial cluster result from the actions of a specific individual or from an environmental event that are perceived to be outside of the organization's realm of control. Thus, such crises result in the lowest level of organizational crisis responsibility.

"Rules and norms violations" was the second cluster that emerged from the study. This cluster included the following crisis types: fan involvement issues, amateurism transgressions, and competition transgressions. The crises in this cluster all involve a rule being broken by the organization and a moderate level of organizational crisis responsibility is attributed to these crises.

"Organizational mismanagement" was the final cluster that emerged from the study. This cluster included the following crisis types: league/conference management issue, logistical/operational issue, player/coach management issue, and misleading internal information. These crises all involve an issue that should be located within the organization's realm of control; yet, the organization's mismanagement of that issue led to the crisis. Therefore, the organization possesses a high level of crisis responsibility attributed to crises in this cluster.

Hypothesis 1 examined the relationship between crisis responsibility and organizational reputation—the key linkage in SCCT.

The hypothesis posited that there would be a significant correlation for each of the three clusters. Based on the analysis, there was a negative, significant correlation for each cluster, meaning that the theoretical association between responsibility and reputation was present (Cluster 1:  $r(207) = -0.584$ ;  $p < 0.001$ ; Cluster 2:  $r(128) = -0.328$ ;  $p < 0.001$ ; Cluster 3:  $r(170) = -0.286$ ;  $p < 0.001$ ). Thus, hypothesis 1 was supported.

## Discussion

### Theoretical Contribution

This study establishes an important intersection of sports scholarship and crisis communication that aids scholars who wish to empirically examine crises in the sports context. First, this research provided an important theoretical contribution for crisis communication scholarship, as it was the first to replicate the Coombs and Holladay (2002) study. The findings confirmed the relationship between crisis responsibility and organizational reputation and supplied evidence to the use of hierarchical cluster analysis to create and analyze crisis typologies. While there could be concerns that contextually-specific crisis typologies such as the one that resulted from this study could decrease the comparability of results from differing contexts, this study's results show that it is possible to both conceptualize the unique crises that impact organizations in a context-specific typology and have the principle theoretical association between responsibility and reputation persist. Thus, the theoretical linkage of SCCT that is rooted in attribution theory should still persist and protect primary theoretical applications across contexts. This notion should be further examined by future research.

Additionally, as the number of sports-related scandals grow in both number and notoriety, the need to examine them with a proper theoretical lens also grows. This study initiates an important first step toward the development of a sports-related crisis communication typology by providing a synthesized list of potential crises that impact sports organizations. Coombs (2012) noted that three factors must be considered before engaging in crisis response: crisis type, crisis history, and prior reputation. While

this study classifies crises into clusters based on similarly attributed levels of organizational responsibility, it is important to note that levels of resulting organizational blame can be heightened by an organization's crisis history and prior reputation. For instance, Coombs and Holladay (2002) noted that these factors can create a Velcro effect, where a negative reputation can lead to increased reputational damage. Conversely, a positive reputation can help an organization outlast a crisis, which is called the halo effect.

### **Crisis Typology Clusters**

The 12 crisis types that resulted from this study were classified into three distinct clusters: environmental/individual crisis, rules violation, and organizational mismanagement. First, the "environmental/individual crisis" cluster results from the actions of an individual associated with the organization or from an environmental event. This cluster's low level of crisis responsibility suggests that the audience does not hold the organization largely responsible for the actions of each individual. The low level of organizational blame associated with this cluster suggests that the organization's reputation does not face a strong threat from these crises. However, the reputational threat sometimes increases when assessing crisis history and prior reputation (Coombs, 2012). For example, despite the University of Florida's on-field successes during Head Coach Urban Meyer's tenure, a string of over 30 player arrests eventually forced some media members to question the direction and discipline record of the Florida football program (Hyde, 2010). Thus, this example shows how the acts of individual players harmed the organization's reputation by boosting this crisis to the next level of organizational responsibility.

The "rules and norms violation" cluster involves rules that sports organizations either violated or overlooked. This cluster results in a moderate level of crisis responsibility being attributed to the organization, as fans expect sports teams to protect the heralded integrity and fairness of the game (Pawlenka, 2005). The "rules and norms violation" cluster possesses a strong dependence upon the factors of crisis history and prior reputation when determining the resulting crisis responsibility level. Audiences might

forgive a first-time offender when rules are violated, as organizations can claim ignorance. However, if an organization is a repeat offender, the current crisis would present a much larger reputational threat (Coombs & Holladay, 2005). Repeat offenses are likely to increase the perceived crisis responsibility from the moderate level typically associated with this cluster to the strong level of crisis responsibility typically associated with the organizational mismanagement cluster.

The final cluster, “organizational mismanagement,” resulted in the highest amount of crisis responsibility being attributed to the sports organization. All crises classified into this cluster arose from the organization’s own mismanagement. The public is unforgiving of crises that are preventable through proper management techniques. Organizations that face crises in this cluster also face a strong reputational threat and must select crisis response strategies accordingly.

### **Crisis Communication and Fandom**

It must be noted that the mean scores that resulted from this study suggest that while participants did rank the organizational mismanagement cluster more highly, the scores were still in the “neutral” range. This finding points to the importance of team identification in sports crisis communication research (Wann & Branscombe, 1993). Given that this study utilized true crises that affected a variety of teams and athletes, participants were likely not highly identified with all the organizations/athletes involved in the offending actions. Thus, the crises did not reach a level of personal relevance to participants that would lead them to more highly ranked levels of crisis responsibility. Therefore, this typology should be used to further examine the variable of fandom in crisis communication by examining fans’ evaluations of crises that feature the specific athlete or sporting organization with which they identify. Additionally, fandom might explain why the results of this study showed that the degree of correlation decreased as the level of responsibility increased. Future research should assess whether this relationship is also observed among highly-identified fans. Also, this study analyzes the *organizational* crisis responsibility

attributed to each of the 12 crisis types. Yet, sports crises are not simply experienced on an organizational level, as some crises primarily result from and impact an individual's actions. The relationship between the crisis typology clusters and the individual/organizational nature of the crisis must be explored, especially in a sports setting.

## Limitations

This study is certainly not without its limitations. First, the researchers utilized a convenience sample of college students for the full administration of the survey. While this study still provides valuable findings, a convenience sample cannot yield generalizable results. As such, future research should examine this typology by utilizing a more generalizable sample. Furthermore, sports literature has also noted that men and women consume and enjoy sports differently (Raney, 2006). Given that this study's sample skewed heavily female ( $n = 75\%$ ), future studies should obtain samples that allow for the examination of whether men and women evaluate crises in the resulting typology differently. This is especially necessary given the findings of K. A. Brown et al. (2015) that found that "race was a more predominant factor in the image repair process than gender" (p. 499). As such, potential racial differences should also be examined. In addition, in study 1, participants were encouraged to use their own definition of what constituted a crisis. While the authors conducted the resulting qualitative content analysis guided by Coombs's (2012) definition, not providing participants with Coombs's definition in the questionnaire could present a potential limitation.

## Conclusion

This study established a foundation for a sports-specific crisis typology, simplifying the lens through which crises will be evaluated. In doing so, the number of potential crises that could impact a sporting organization was reduced from an initial list of 263 to 12, greatly reducing the burden of the "pre-crisis" phase. This study also divided the 12 crisis types into three clusters (environmental/

individual crises; rules and norms violations; and organizational mismanagement), reflecting the amount of organizational crisis responsibility that would be associated with each event. This practice will aid both scholars and practitioners in evaluating prominent crises in sports.

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# The SPARS Pandemic 2025–2028: A Futuristic Scenario to Facilitate Medical Countermeasure Communication

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## ABSTRACT

Effective communication about medical countermeasures—including drugs, devices, and biologics—is often critical in emergency situations. Such communication, however, does not just happen. It must be planned and prepared for. One mechanism to develop communication strategies is through the use of prospective scenarios, which allow readers the opportunity to rehearse responses while also weighing the implications of their actions. This article describes the development of such a scenario: The SPARS Pandemic 2025–2028. Steps in this process included deciding on a time frame, identifying likely critical uncertainties, and then using this framework to construct a storyline covering both the response and recovery phases of a fictional emergency event. Lessons learned from the scenario development and how the scenario can be used to improve communication are also discussed.

**KEYWORDS:** prospective scenario, medical countermeasures, risk communication, public health emergency, crisis communication

Medical countermeasures (MCM)—including drugs, devices, and biologics (e.g., vaccines)—often play critical roles in curtailing the impacts of natural disease outbreaks as well as chemical,

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biological, radiological, or nuclear (CBRN) incidents (Courtney & Sadove, 2015). It is not uncommon for members of the public, however, to misuse or hesitate to take recommended MCM (Liu et al., 2017; Quinn et al., 2008; Steelfisher et al., 2011). New and unfamiliar technology, an accelerated regulatory approval process, or discordant expert views may heighten perceived risks of MCM, leading to public aversion to the countermeasure and/or diminished public trust in MCM regulators or recommenders (Belongia et al., 2005; Carlsen & Glenton, 2016; Henrich & Holmes, 2011). In other cases, strong feelings of vulnerability in an emergency situation may prompt persons to demand unnecessary MCM, protest their lack of access to MCM with limited availability, and/or use an excessive amount of prescribed MCM (Dart et al., 2015; Durigon & Kosatsky, 2012; Whitcomb et al., 2015). In still other situations, certain social groups may have limited access to MCM because some institutions are still in the process of learning how culture, race, language, and citizenship status produce barriers to health information sharing (Lin et al., 2014; Uscher-Pines et al., 2011). To mitigate all of these issues and ensure proper and timely use of MCM, good communication is key.

From 2014 to 2016, the Center for Health Security undertook a research project to catalog MCM communication “dilemmas” (in the broad sense of a problem) in emergency situations and provide practical and strategic recommendations on how better to obtain desired population health outcomes through improved communication. The principal product was a casebook featuring recent health crises (e.g., 2014–2015 West Africa Ebola outbreak and 2011 Fukushima nuclear plant accident) that helped to illustrate the principles and conditions for effective MCM communication (Schoch-Spanna et al., 2016).

Much of the practice-oriented literature relies upon real crises to illustrate successful (or failed) approaches to risk and crisis communication (e.g., Centers for Disease Control and Prevention [CDC], 2018; Ulmer et al., 2017). The project team similarly used past health emergencies to advance understanding of how communication enables appropriate public use of MCMs, because case studies have compelling benefits for learning: People reason effectively through analogy and not just abstract principles,

contextualization makes broader principles meaningful and memorable, and cases promote reflective thinking and reinforce users' abilities to apply that knowledge in novel settings (Allchin, 2013; Epling et al., 2003).

Leveraging the same didactic qualities as retrospective cases (Varum & Melo, 2010), the project team subsequently developed a fictionalized prospective scenario—The SPARS Pandemic 2025–2028—to further prepare users for MCM-related risk and crisis communication dilemmas on the horizon. A scenario is an “analytically coherent” and “imaginatively engaging” story about a possible future state (Bishop et al., 2007) that spurs users to envision and exercise their role in shaping potential outcomes (Borjeson et al., 2006; Mahmoud et al., 2009; Wilkinson & Eidinow, 2008). Outlined in this paper and available in full online (Schoch-Spana et al., 2017), the SPARS scenario is intended to help authorities better anticipate MCM emergency communication dilemmas, understand the larger contexts, practice effective responses, and develop acuity and agility for addressing unforeseen problems. The SPARS Pandemic 2025–2028 features MCM communication dilemmas both of the enduring *and* emerging kind—especially those in relation to evolving information and communication technologies (ICT).

### **Benefits of Scenarios and Simulations in Preparing for Disasters and Epidemics**

The forward-looking SPARS scenario is a tool meant to prompt readers to imagine the dynamic and oftentimes conflicted circumstances in which MCM emergency communication takes place. By engaging readers with a rigorous, simulated health emergency the scenario provides opportunities for readers to mentally “rehearse” responses while also weighing the implications of their actions (Borjeson et al., 2006). Apart from testing out responses to foreseeable events, the scenario also provides readers opportunities to consider potential measures in today's environment that might avert comparable problems or classes of problems in the future; that is, consider how to create a preferred future (Bishop et al., 2007; Borjeson et al., 2006; Mahmoud et al., 2009; Wilkinson & Eidinow, 2008).

Producing coherent and imaginative narratives about the future to inform decision-making in the present is an approach to planning and risk management that businesses, think tanks, governments, and non-governmental organizations have embraced for a half century or more, and a wide range of aims, applications, and techniques have evolved (Bishop et al., 2007; Varum & Melo, 2010; Wilkinson & Eidinow, 2008). In the case of a low-probability high-consequence event like a pandemic or CBRN incident in which MCM may be deployed, scenario development provides a way—absent an actual emergency—for stakeholders to characterize specific impacts (based on the accepted science), create a shared vision of the threat, weigh alternative futures with or without risk-reducing interventions, and stimulate action (Earthquake Engineering Research Institute [EERI], 2019; Preuss & Godfrey, 2006). Earthquake and bioterrorism scenarios, for instance, have played important roles in motivating creative thinking about the need for novel policies and programs and in mobilizing new constituencies around seismic risk reduction (National Research Council [NRC], 2011) and public health emergency preparedness (Hamilton & Smith, 2006; O’Toole et al., 2002), respectively.

Scenarios that depict an unfolding crisis are valuable tools that can heighten awareness about complex hazards and also enable practical training for the management of disasters and epidemics through exercises (European Centre for Disease Prevention and Control [ECDC], 2014; Federal Emergency Management Agency [FEMA], 2019; World Health Organization [WHO], 2018). Discussion-based exercises (often called tabletop exercises) help participants, typically decision-makers, become more familiar with emergency plans and procedures, individual and organizational roles and responsibilities, and special challenges posed by a particular threat to public health and safety. By contrast, operation-based exercises (such as drills, functional exercises, and field exercises) attempt to incorporate, to a lesser or greater degree, the front-line personnel, equipment, and physical spaces expected to be in play during an actual emergency (FEMA, 2019; Skryabina et al., 2017). A majority of studies on the effectiveness of training in emergency risk communication, in particular, conclude

that the impacts of tabletop exercises and simulation for training include enhanced awareness, readiness, and knowledge (Miller et al., 2017).

### **Social Media Challenges/Opportunities for Health and MCM Communication**

Like the previously mentioned earthquake and bioterrorism scenarios, the SPARS scenario is meant to prepare risk and crisis communicators for future emergencies, and in particular the complex conditions that rapidly-evolving ICT, including social media, are now generating around medicine/public health generally and MCM specifically.

ICT use, including text, illustrations, photo, audio, videos, and diagrams communicated through blog posts, instant messages, video chats, and social network platforms, is now widespread and often used for health-related activities. Among members of the public, a 2010 survey by the Pew Research Center, for instance, showed that 8 in 10 internet users look online for health information, making it the third most popular online activity in the U.S. (Fox, 2011). Likewise, practitioners, public health officials, and other health experts are increasingly turning to ICT—which provides a means to reach the broadest possible population in the fastest, easiest, and least expensive manner (Hinton & Hjorth, 2013)—for a variety of purposes. Clinician-to-patient and peer-to-peer communication, investing individual patients in their own care, information exchanges among diverse healthcare and public health stakeholders, and detecting and managing disease outbreaks have been transformed through ITC (Charles-Smith et al., 2015; Grajales et al., 2014; Kreps & Neuhauser, 2010; Rice & Sara, 2018). While this situation may appear overwhelmingly positive, some aspects of ITC use and its popularity remain problematic.

First, ITC use has altered the dynamics between health experts and the patients and populations they serve (Hawn, 2009). Social media in particular has provided a mechanism for laypersons to readily share their health-related experiential knowledge with each other, thus dislodging the centrality of health professionals' authoritative knowledge in people's decision-making and behavior (Hawn, 2009; Househ et al., 2014).

Second, ITC can, and is, used to spread false information. Wolfe and associates (2002), for example, found that 32% of anti-vaccine websites surveyed included pictures of “menacing needles” and 23% had pictures of children reported to have been harmed or killed by vaccines. As parents come across these images and their associated stories this can lead parents to place greater emphasis on personal and emotional experience rather than scientific evidence. Referred to as false consensus bias in the social psychology literature, parents may then hesitate to vaccinate or reject vaccines for their children altogether.

What is particularly challenging in regard to social media is that such images and negative stories tend to have a greater impact than facts and positive messages. In their research of vaccination-related YouTube videos, for example, Keelan and associates (2007) found that while the majority (48%) of the 153 identified videos promoted vaccination and only 32% were negative toward vaccination, the most liked and viewed were the ones with negative content. The lowest rated and watched videos were pro-vaccination public service announcements.

These positive and negative aspects of ITC, in turn, influence what practitioners and the broader public understand about MCM safety and efficacy, thus presenting new challenges and opportunities for crisis and risk communicators. Medication users, for example, are increasingly sharing personal knowledge and experience of drug benefits and risks via online disease support networks, patient and drug forums, and microblogging (Matsuda, 2017; Sloane et al., 2015). Through social media, these individuals can find both practical information and a sense of community, while drug safety professionals have a new, rich data source with which to mine for potential evidence of adverse events, supplementing uneven healthcare provider reports (Edwards & Lindquist, 2011; Inch et al., 2012).

At the same time, great potential exists for the public to encounter misleading or dangerous information about pharmaceuticals, as non-expert consumers deliver their own drug product testimonials and illegal online pharmacies promote their services via social media (Tyrawski & DeAndrea, 2015). Misinformation is proving especially challenging in connection with vaccines where

social media users encounter disproportionate negative reporting and images, are more swayed by personal narratives about vaccination's adverse effects than the science, and tend to judge disparate ideas about vaccines as equally valid, regardless of expertise (Guidry et al., 2015; Kata, 2012; Poland et al., 2009; Witteman & Zikmund-Fisher, 2012). Thus, in this current ITC-rich environment, good communication, and good training for effective communication, is critical.

## Methods

To develop the SPARS scenario a project team with expertise in a variety of areas, including epidemiology, public health preparedness, risk communication, and the biological and social sciences, was assembled. Utilizing these diverse perspectives, the team used a combination of the inductive and deductive heuristics delineated by Ogilvy and Schwartz (2004) to develop the scenario premise (Figure 1). This process began with selecting the timeframe for the scenario—the years 2025–2028. These dates, which were 10–13 years in the future at the time, were chosen to provide a timeline that allowed the development of future possibilities, but was not so far in the future as to make the scenario become a work of science fiction. After the timeframe was established, the project team turned to the focal question: What emergency communication issues around MCM are most likely to exist 10 years from now?

To begin answering this question, the project team considered the key economic, environmental, political, social, and technological factors they felt were likely to emerge by 2025. Factors considered by the project team included prominent ones such as technological advances like the proliferation of tools to access the internet, increased use of the internet for things like social media and telemedicine, greater political and social polarizations, changing demographics in the United States including an aging baby boomer population, and climate change and urbanization that could result in the (re)emergence of zoonotic diseases.

After careful discussion of each of these factors, which included consideration of existing literature and theoretical approaches, the team considered which factors seemed inevitable given present

**FIGURE 1** The scenario generation process, adapted from Ogilvy and Schwartz (2004).



conditions and which were the most likely to impact the direction of the scenario. From this process, two critical uncertainties were identified: the extent of access to information technology, that the team felt was inevitable, and the degree of fragmentation among populations along social, political, religious, and cultural lines, which the team felt would lead to novel communication issues. The project team then used these uncertainties to construct a scenario matrix illustrating the four possible futures that could be shaped by these trends (Figure 2). After careful consideration, the team ultimately chose the “echo-chamber”—a world comprised of isolated and highly fragmented communities with widespread access to information technology—as the future in which the prospective scenario would take place.

**FIGURE 2** Final Scenario Framework: Four possible futures in which the SPARS pandemic unfolds.

Unbridled access and openness to information technology (including social media)			
Isolated communities, social fragmentation	“Echo-chamber”	“UN Security Council”	Diverse but integrated communities, “melting pot”
	“Solitary Confinement”	“Shangri-La”	
Erratic, unequal access to information technology (including social media)			
<p>“Echo-Chamber”—a technologically savvy, plugged in, but fragmented society in which groups that hold diverse worldviews consume information that continues to validate their own positions, allowing them to live in their own mental bubble; government agencies and citizens alike have ready access to all the latest informational tools.</p> <p>“Solitary Confinement”—a society (including general population and public sector) with an uneven access to informational technology (due to lack of net neutrality, uneven infrastructure) that isolates differently minded communities.</p> <p>“UN Security Council”—a technologically savvy, plugged in society where diversity reigns, but difference and tolerance are socially valued, and where information flows freely across different groups.</p> <p>“Singapore”—a melting pot society, with peaceful co-existence of differently minded groups, but uneven levels of access to information technology.</p>			

From this point, scenario-specific storylines were developed, drawing on the subject matter expertise of the project group, interviews with expert working group (EWG) members associated with the larger project, historical accounts of past MCM crises, contemporary media reports, and scholarly literature in sociology, emergency preparedness, health education, and risk communication. This process allowed the project team to identify expected and new communication dilemmas to include in the scenario. As one example of this, the project team considered how the internet and social media affect the social dynamics of health communication. Using the theory of false consensus bias and the findings on vaccination in social media (described previously in the literature review section), the project team identified specific communication dilemmas to include in the scenario. One of these involved responding to a particularly emotional video that was widely spread via social media and then maintained in the public view for months afterward by teenagers who enjoyed the shock value of the images. This specific case, titled “Going Viral,” is presented later in this paper.

Once different dilemmas were identified, the team considered how the different storylines could reasonably fit together and what characters were necessary in order for these events to occur. An outline for the scenario was then constructed using newspaper and other social media headlines as markers for key events; in many instances, these remained in the scenario in order to introduce the different dilemmas. Finally, the entire storyline was written in draft form as if the SPARS outbreak had occurred in the recent past, allowing some outcomes and conclusions to be drawn within the scenario.

From this point, scenario development entailed a recursive process of continued research and analysis by the project team, review and feedback from EWG members (summer 2015), and two rounds of external review by authorities on risk communication and the MCM enterprise (four individuals in fall 2015, three individuals in summer 2017). Comprising the project EWG were risk and crisis communication scholars; MCM developers, producers, and regulators; practitioners in medicine, public health,

and pharmacy science; and experienced public health emergency managers at all levels of government. Revisions were made after each review in order to increase the accuracy and usefulness of the material presented in the scenario.

The final product, referred to hereafter as the SPARS scenario, is not intended to be a crystal ball of things to come; rather, it is meant to serve as a plausible narrative that illustrates a broad range of serious and frequently encountered challenges in the realm of risk and crisis communication. To increase the usefulness of the scenario, each response- and recovery-phase dilemma is followed by food for thought questions that are meant to prompt readers, reading as individuals or in training groups, to consider how they might respond to similar situations or how they might prevent similar problems or classes of problems from occurring in the first place. Like the studies of scenario-driven exercises (Skryabina et al., 2017) show, including those featuring emergency risk communication (Miller et al., 2017), the SPARS scenario is intended to prepare users for mitigating public health emergencies and managing MCM communication dilemmas more effectively. In the following sections, we outline the scenario environment and how the fictional outbreak begins. We then provide excerpts of two dilemma sections as examples of the larger document.

## **The SPARS Scenario: An Introduction**

### **Scenario Environment**

The setting of SPARS is the world in 2025–2028. For this time period, the project team imagined a world that is simultaneously more connected and yet more divided. There is nearly universal access to wireless internet for even the poorest persons in the United States. Additionally, technological innovations and competition between technology companies have made an even wider range of information technology readily available to all. Despite the possibilities for these advancements to facilitate broad communication between individuals and communities, the project team also envisioned a future where many have chosen to self-restrict the sources they seek for information, often electing to interact

only with those whom they agree with on significant issues. This trend increasingly isolates cliques from one another, making communication across and between these groups more difficult.

In relation to MCM communication more specifically, government agencies like the CDC have increasingly adopted social media technologies, including long-existing platforms such as Facebook, Snapchat, and Twitter, as well as emerging platforms like ZapQ—an interface that enables users to aggregate and archive media content from other platforms and communicate with cloud-based social groups based on common interests and current events. Federal and state public health organizations have also developed agency-specific applications and ramped up efforts to maintain and update agency websites.

Challenging this technological grip, however, are the diversity of new platforms and the speed with which social media communities evolve. Moreover, while technologically savvy and capable, these agencies still lag in terms of their “multilingual” skills, cultural competence, and ability to be present on all forms of social media. These agencies also face budget constraints, which complicates their efforts to improve public communications efficiency and effectiveness by increasing their presence in existing and emerging social media platforms.

## **SPARS**

After much consideration of possible emergency situations that would require MCM use, the project team decided on setting the storyline around a novel coronavirus that caused a mild, flu-like disease in most instances, but pneumonia and/or hypoxia requiring hospitalization and extensive medical treatment in a small minority of cases. The project team named this fictional pathogen the St. Paul Acute Respiratory Syndrome Coronavirus, or SPARS for short, because in the scenario it is first identified in St. Paul, Minnesota.

Two features of this disease are important to note because they impact how the storyline of the scenario plays out, as well as some of the communication dilemmas that occur. First, the project team decided to make SPARS have an extended incubation period

(7 to 10 days) but a short latent period (4 to 5 days). This complicates the scenario because infected persons in the story are capable of spreading the virus for up to 6 days before showing symptoms of the disease themselves. This feature of SPARS makes isolation procedures in the scenario, like urging people to stay home if they think they might be sick, less effective than what is typically expected for airborne pathogens and thus introduces novel dilemmas in the storyline. Second, the project team decided to make the morbidity and mortality from SPARS both significantly higher in children than adults, and among pregnant women and those with chronic respiratory conditions. This parallels disease characteristics associated with past disease outbreaks, including the H1N1 pandemic, and allowed for some communication dilemmas from the past to be revisited under different future circumstances.

In all, the SPARS scenario provides 19 specific storylines, and an associated 23 communication dilemmas for readers to consider. An outline of the entire storyline is available in Table 1, and a list of the communication dilemmas provided in the scenario can be found in Table 2. The following sections provide excerpts of two dilemmas included in the scenario as well as their associated communication dilemmas and food for thought questions.

**TABLE 1** Timeline of Events in the “SPARS Pandemic 2025–2028” Scenario

2025	
October	The first US deaths occurred due to SPARS. Initially, these deaths were thought to have been caused by influenza.
November	Cases of SPARS were reported across Minnesota and in six other states.  Thanksgiving holiday travel and Black Friday shopping facilitated spread of SPARS beyond the Midwest (26 states and multiple other countries by mid-December).  The WHO declared the SPARS pandemic to be a Public Health Emergency of International Concern.
December	No treatment or vaccine for SPARS existed, but there was some evidence that the antiviral Kalocivir could be effective as a therapeutic.

A proprietary vaccine developed and manufactured by a multinational livestock conglomerate (GMI) was proposed as a potential foundation for a human vaccine. The vaccine was developed to combat an outbreak of a similar respiratory coronavirus in hooved mammal populations in Southeast Asia, but the vaccine had not been licensed by any regulatory authority or tested in humans. There were concerns over potential side effects.

## 2026

January

The US government contracted CynBio to develop and produce a human SPARS vaccine based on the GMI animal vaccine.

The HHS Secretary invoked the Public Readiness and Emergency Preparedness Act (PREP Act) to provide liability protection for the vaccine manufacturer and providers. Congress authorized and appropriated emergency funds under the PREP Act to provide compensation for potential adverse side effects from the vaccine.

Following reports of Kalocivir's limited success in treating patients with severe SPARS infections, the FDA issued an Emergency Use Authorization (EUA) for the antiviral. Kalocivir had been evaluated as a therapeutic for SARS and MERS, and several million doses were maintained in the SNS, which could be deployed as necessary while production capacity was established to meet demand.

The FDA, CDC, and NIH provided seemingly conflicting communications regarding the safety and efficacy of Kalocivir.

In the United States, public anxiety around SPARS resulted in extensive use of Kalocivir, frequent self-reporting of SPARS symptoms, and a surge in demand for medical care.

By late January SPARS was detected in 42 countries and all US states.

February

A lack of cultural competency in FDA and other governmental communication became apparent among various ethnic groups in the United States.

A video of a 3-year-old vomiting and fainting after taking a dose of Kalocivir was widely and rapidly spread via social media, strengthening opposition to the EUA.

	<p>The UK Medicines and Healthcare Products Regulatory Agency and the European Medicines Agency jointly authorized the emergency use of a new antiviral, VMax, in the United Kingdom and throughout the European Union. Some Americans attempted to gain access to VMax online or by traveling to Europe.</p>
<p>April</p>	<p>The CDC publicized an updated (and significantly lower) case fatality rate in the United States; the perception of lesser risk triggered a drop in public interest.</p>
<p>May</p>	<p>Production of Corovax, the SPARS vaccine produced by CynBio, was well underway.</p> <p>Federal agencies initiated a communications campaign using well-known public figures with mixed results. Polls indicated a 15–23% increase in SPARS and Kalocivir knowledge nationwide. Hip-hop icon BZee had success promoting public health messaging with an online video clip, but he lost credibility when he compared volunteers for Corovax trials with “volunteers” from the Tuskegee syphilis study. Similarly, former President Bennett provided a non-committal response when asked if she would want Kalocivir for her new grandson.</p>
<p>June</p>	<p>Public health agencies discovered that a relatively new social media platform, UNEQL, was being used as a primary means of communication in college-aged populations.</p> <p>Corovax entered the final stage of its expedited review, and production capacity was increased. Ten million doses were expected to be available by July with fifty million more in August.</p> <p>The CDC Advisory Committee on Immunization Practice (ACIP) announced vaccine priority groups. Healthcare providers were not included as a priority, inciting protests by doctors and nurses across the country.</p> <p>In order to prioritize distribution of limited Corovax supply, the federal government requested that states report summary information for patient electronic health records (EHRs) to estimate the number of individuals in high-risk populations. This effort was met with resistance from the public, who protested the federal government accessing their private medical information.</p>

<p>July</p>	<p>A week prior to initiating the nationwide vaccination program, damage to a power grid in the Pacific Northwest resulted in a widespread power outage that lasted two weeks. State and local public health agencies initiated communications programs using posters and flyers to promote the vaccination program in the absence of electronic media.</p> <p>Social media efforts across the country promoted the vaccination campaign, and crowdsourced data helped to increase efficiency in distributing the vaccine.</p>
<p>August</p>	<p>The Corovax vaccination program met resistance from several groups: alternative medicine proponents, Muslims, African Americans, and anti-vaccination activists. Initially operating independently, these groups banded together via social media to increase their influence.</p>
<p>September</p>	<p>Japan announced that it would not approve Corovax for use in Japan in favor of developing and producing its own vaccine.</p>
<p>October</p>	<p>College students predominantly on the East and West coasts staged protests against the unequal global availability of Corovax. Vaccination rates among these students were below average for college students in other areas of the country.</p>
<p>November</p>	<p>The anti-anti-vaccine movement, formed in the wake of the 2015 measles outbreak in the United States, reignited their efforts to combat the anti-vaccination super-group. The FDA, CDC, and other federal agencies also redoubled their communications efforts to promote the Corovax campaign.</p> <p>An increasing number of post-SPARS pneumonia cases were reported across the country.</p>
<p>December</p>	<p>The nationwide vaccination program was expanded beyond the initial priority populations to include the rest of the country.</p> <p>Federal agencies initiated a vaccination communication program involving targeted online advertisements.</p>
<p><b>2027</b></p>	
<p>February</p>	<p>Post-SPARS pneumonia cases stressed inventories of antibiotics across the country. The HHS Secretary authorized distribution of the oldest lots of antibiotics from the SNS to supplement the antibiotic supply nationwide.</p> <p>Tests of antibiotics in the SNS inventory determined that 94% of the remaining antibiotics in the oldest lots maintained</p>

<p>March</p>	<p>sufficient potency. Tests conducted in August 2026 provided the basis for extending the expiration of these lots from 2027 to 2029.</p> <p>Rumors spread via traditional and social media that the government was dispensing expired antibiotics.</p> <p>Alyssa Karpowitz, a leader in the natural medicine movement, sought medical care at an emergency department after natural remedies failed to resolve her son’s bacterial pneumonia. After successful treatment with proper antibiotics from the SNS supply, she touted the benefits of “expired” antibiotics in her social media circles.</p>
<p>April</p>	<p>Crowd-sourced and independent epidemiology analysis of Corovax side effects conflicted with official federal reports. The independent analyses gained popularity in traditional and social media due to visual presentation and interactive content. Government attempts to respond with data and press releases largely failed.</p>
<p>May</p>	<p>Reports of Corovax side effects began to gain traction. Several parents of children who experienced neurological symptoms after receiving the vaccination sued the federal government and CynBio. The lawsuit was dropped when they learned of compensation funds available through the PREP Act and the National Vaccine Injury Compensation Trust Fund.</p>
<p>November</p>	<p>Initial reports of long-term side effects of the Corovax vaccine emerged. These reports arose primarily from those in the initial priority (high-risk) populations and were few in number. With little available data and numerous pre-existing conditions, initial studies were unable to identify a statistically significant association with any long-term effects. Claims for compensation were placed on indefinite hold until further data could be gathered and analysis completed.</p> <p>In response to public demand for long-term side effect compensation, the HHS Secretary invited Congress to conduct an independent investigation of the federal compensation process to alleviate concerns of impropriety.</p> <p>The public and media pressured Congress to increase the funds authorized for compensation under the PREP Act.</p>
<p><b>2028</b></p>	
<p>August</p>	<p>The SPARS pandemic was officially declared to be over; however, experts remain concerned about domestic animal reservoirs and the potential for future outbreaks.</p>

**TABLE 2** Emergency Communication Dilemmas Featured in the “SPARS Pandemic 2025–2028” Scenario

Response Phase
<ul style="list-style-type: none"> <li>▶ Engendering public trust and a sense of self-efficacy when a crisis is still evolving and critical health information is incomplete</li> <li>▶ Responding to public and political pressure to share information about potential MCMs in the development pipeline even though information may be incomplete or proprietary</li> <li>▶ Maintaining trust in government processes for ensuring the timely development of safe and effective vaccines when novel threats arise</li> <li>▶ Harmonizing inconsistent messaging across health agencies</li> <li>▶ Appropriately tailoring public health messages to address the concerns and culture of specific communities</li> <li>▶ Responding to the power of graphic images of a child in distress: one story that is elevated to a population-level problem</li> <li>▶ Responding to demand for an alternative antiviral drug not available in the United States</li> <li>▶ Responding to misinformation or doubt about an MCM generated by a prominent public figure</li> <li>▶ Overlooking communication platforms used by specific groups; quickly gaining fluency and effectively engaging the public using a new media platform</li> <li>▶ Responding to public criticism about potential unequal access to MCMs like Kalocivir</li> <li>▶ Maintaining public support after changing positions on MCM safety and efficacy</li> <li>▶ Communicating the need for and reasoning behind the prioritization of scarce resources</li> <li>▶ Publicizing MCM programs and availability to promote uptake and efficient distribution</li> <li>▶ Providing real-time data on vaccine availability to align MCM supply with public demand</li> <li>▶ Maintaining consistent messaging across electronic and non-electronic media and implementing a secondary communications plan if electronic media are not available</li> <li>▶ Addressing multiple independent MCM concerns simultaneously</li> <li>▶ Meeting the information needs of citizens who come from diverse cultural, social, and demographic backgrounds and who may have varying degrees of trust in health authorities</li> <li>▶ Supporting the current MCM product in the face of opposition from a foreign regulatory agency</li> </ul>

- ▶ Responding to complex ethical issues that are beyond the United States government's control
- ▶ Responding to questions regarding safety and efficacy of drugs that have extended shelf lives

### Recovery Phase

- ▶ Communicating with the public about trustworthy sources of data and options for legal recourse in a climate of mistrust
- ▶ Bringing a sense of resolution to a period of crisis while striking a balance between the need to affirm collective grief/loss and the need to move forward
- ▶ Institutionalizing communications lessons from the 2025–2028 SPARS pandemic

## Response Scenario Excerpt

The following excerpt from the scenario takes place early on in the pandemic. One month previously the Food and Drug Administration (FDA) had issued an Emergency Use Authorization (EUA) for the antiviral Kalocivir. The drug had been evaluated as a therapeutic for other coronavirus-caused diseases and several million doses were maintained by the Strategic National Stockpile (SNS), which meant the drug could be deployed as necessary while production capacity was established to meet demand. The FDA and CDC provided information on the drug, but some differences in their messaging caused concern among certain groups including parents of young children. The specific communication dilemma this excerpt considers is how to confront the power of a single graphic image of a child in distress when one story is elevated to a population-level problem.

### “Going Viral”

Reports of negative side effects associated with Kalocivir began gaining traction in February 2026. Despite the negative response, public health agencies continued to make forward progress until February 22, when a video of a 3-year-old boy in North Carolina projectile vomiting immediately after taking a dose of Kalocivir went viral. In the video clip, the boy swallows a pediatric dose of liquid Kalocivir, vomits profusely, chokes, and then faints in the pool of his own vomit while his mother shrieks in the background.

This clip was widely shared across the United States with a variety of captions including #AntiviralsDontWork, #DontTakeTheDrugs, and #NaturalCuresAreBetterThanThis. The hashtags, in turn, provided a way for people sharing these views to find one another and band together on social media. They formed ZapQ and other online discussion groups, which allowed them to receive any messages from group members via smartphones and internet accessing technology (IAT) instantaneously as they were posted. Some members of these ZapQ groups even began to use full-sized (12"×12") IAT screens on the backs of their jackets, coats, and backpacks to loop the vomiting video for all in their immediate vicinity to see.

The social media groundswell quickly overwhelmed the capacity of local, state, and federal agencies to respond, and compliance with public health and medical recommendations dropped considerably. The FDA and other government agencies quickly attempted to remind the public that correlation does not equate to causation, and that vomiting was not a known side effect of Kalocivir. This message, while scientifically accurate, lacked appropriate empathy and failed to assuage the public's mounting fears. As a result, it was largely ignored, and public concern continued to grow.

In the following weeks, officials from the FDA, CDC, and other government organizations attempted to promote positive, accurate information about Kalocivir on several traditional and social media platforms in order to quell public fear. This messaging, however, was less than optimal both in terms of timing and dissemination. While the government took several days to provide an emotionally appropriate message, the spread of the viral video on social media was exponentially faster. By the time the government responded, most people across the country had already seen the vomiting video and formed their own conclusions. Additionally, in their responses, governmental organizations were not able to effectively access all social media platforms. ZapQ groups, for example, had closed memberships and typically could only be accessed via invitations from group members.

Both of these issues prompted government organizations to improve the timing and impact of their social media responses. While most government agencies, including the CDC and HHS,

had long-established offices that were directed to coordinate social media and other communication efforts, the protocols of individual agencies and different agency cultures led to delayed and sometimes uncoordinated messages.

Despite the many outreach efforts by various government officials and entities, the government was ultimately unable to develop a suitable replacement for the initial vomiting video. By early June 2026, the video had become the most shared Zap clip among junior high and high school students across the country who appreciated the shock factor of the video. As a result, the public was continually re-exposed to the anti-Kalocivir message for several months after the initial incident and subsequent responses.

### **Food for Thought Questions:**

1. Why might communicating the science around MCM adverse effects alone not be enough to address people's fears and concerns about an MCM like Kalocivir? Why is it also important to communicate with compassion, concern, and empathy?
2. To what extent is having sufficiently skilled staff and organizational capacity to communicate via traditional media and social media platforms critical to influencing public debates and awareness about an MCM like Kalocivir?
3. What MCM communication challenges are likely to emerge among up-and-coming youth audiences who are avid consumers of interactive and visual forms of information?

### **Recovery Scenario Excerpt**

The following excerpt from the scenario considers issues related with recovery, and how to communicate with the public about trustworthy sources of data and options for legal recourse in a climate of mistrust. At this point in the storyline, Corovax, the FDA-approved vaccine for SPARS, has been released for more than 9 months and the United States is solidly in the recovery phase of the pandemic. SPARS is now uncommon in the US and public focus has shifted from the disease to the potential side effects of SPARS treatments including the Corovax vaccine.

## **“Vaccine Injury”**

As time passed and more people across the United States were vaccinated, claims of adverse side effects began to emerge. Several parents claimed that their children were experiencing neurological symptoms similar to those seen among livestock exposed to the GMI vaccine. By May 2027, parental anxiety around this claim had intensified to the point of lawsuits. That month, a group of parents whose children developed mental retardation as a result of encephalitis in the wake of Corovax vaccination sued the federal government, demanding removal of the liability shield protecting the pharmaceutical companies responsible for developing and manufacturing Corovax.

The growing plaintiff cohort quickly withdrew their suit upon learning that the National Vaccine Injury Compensation Trust Fund (NVICTF) and an emergency appropriation of funds authorized by Congress under the PREP Act existed to provide financial reimbursement to those who were adversely affected by the Corovax vaccine in order to cover healthcare costs and other related expenses. Given the positive reaction to the federal government’s response and the fact that the majority of US citizens willing to be vaccinated had already been immunized, the negative publicity surrounding adverse reactions had little effect on nationwide vaccination rates. The focus on adverse side effects, however, resulted in a considerable increase in the number of compensation claims filed, and many grew concerned about the long-term effects that Corovax could have on their health. This concern was particularly high among some African American parents who continued to question the government’s motives regarding the Corovax vaccination campaign.

While the FDA, CDC, and other agencies were busy researching possible connections between Corovax and the reported neurological side effects, their efforts were continually undermined by epidemiological analyses produced by various non-governmental individuals and groups. The popular science blogger EpiGirl, for example, began posting interactive maps of the incidence of Corovax side effects in April 2027. To create the maps, EpiGirl collected anecdotes of adverse Corovax side effects using Facebook, Twitter, and YouTube and combined them with data downloaded

from the HHS Vaccine Adverse Event Reporting System (VAERS), a national vaccine safety surveillance program maintained by the CDC and FDA. EpiGirl also encouraged those among her subscribers who were Apple product users to share health data with her via Apple’s ResearchKit and HealthKit applications. EpiGirl’s maps were consequently shared widely in social media circles and even included in local and national news reports.

The federal government became concerned about the validity of EpiGirl’s anecdotal data and the widespread sharing of patient information via the internet. EpiGirl’s data showed a significantly higher incidence rate of nearly every reported side effect; however, federal officials believed that this was largely due to duplicate entries resulting from compiling data from multiple sources. Additionally, EpiGirl’s data did not seek to address the cause of the reported side effects, only the incidence rate. Publication of similar results from organizations such as Patients-Like-Me, a group closely associated with the natural medicine movement, further legitimized these independent reports. The government attempted to respond to these claims through formal press releases, but these were neither as visually appealing nor as interactive as EpiGirl’s maps and were, therefore, largely ignored.

### **Food for Thought Questions:**

1. How might advance development and testing of recovery messages that specifically address the topics of adverse side effects and the NVICTF help improve health authorities’ ability to respond to public distress about medical issues emerging after an MCM campaign? What are some messages that would warrant such testing?
2. Despite the uncertain science about the link between Coravax and the reported neurological symptoms, why should health officials still communicate with compassion and genuine sympathy toward those in the vaccinated population who experience medical issues subsequent to being vaccinated?
3. Given growing interest in open data systems and the application of “crowd sourcing” to solve complex problems, how

might public health officials take greater advantage of two-way communication with an interested public in the aftermath of the SPARS outbreak? For instance, how might input and analysis from members of the public help improve adverse event monitoring or assess the strengths and weaknesses of a specific MCM campaign?

## **Crafting Scenarios: Lessons Learned**

Creating the scenario described above was a months-long process that involved many iterative steps. While the basic process of scenario development is both described above and detailed by others including Ogilvy and Schwartz (2004), the following are offered as lessons learned in order to assist in the development and design of scenarios in the future:

- ▶ Having a project team with different academic backgrounds (i.e., medicine, public health, and the social sciences) provided a solid foundation for developing the premise of the future in which the scenario would take place. Different perspectives, disagreements, and even lively debates were essential to developing a premise that was both realistic and meaningful. This process also provided forward momentum for the development of specific storylines.
- ▶ Storyboarding the timeline of events was important to maintaining coherency in the project. In the development of the SPARS scenario, storyboarding was not a one-time process but rather an ongoing exercise that occurred throughout scenario development.
- ▶ As storyboarding was occurring, it was essential to keep in mind the audiences for the project. In several cases, lessons specific audiences needed to walk away with were the starting point; the project team used these to work backward to make sure those lessons were fully incorporated into the storyline.
- ▶ A focus on small details, including using supporting illustrations like newspaper and social media headlines, was necessary to make the scenario as realistic as possible. This process

of “sweating the small stuff” also provided a mechanism for the project team to check and recheck the accuracy of the overall product.

- ▶ Vetting the scenario with a group of subject matter experts was critical. In the SPARS scenario, this process helped identify dilemmas that were of particular relevance to specific target audiences as well as detect plot holes and inaccuracies that were necessary to fix in order for the storyline to be both believable and useful.
- ▶ Finally, developing facilitator guides along with the scenario was a way to increase the facility of the scenario as a teaching tool.

## Conclusion

Effective communication about medical countermeasures—including drugs, devices, and biologics (e.g., vaccines)—is often critical in emergency situations. Such communication, however, does not just happen. It must be planned and prepared for. Prospective scenarios, like the SPARS scenario described in this paper, offer important opportunities for communication planning and preparation by enabling readers, both individually and in discussion with others, to rehearse responses to communication dilemmas; encouraging readers to envision what the next generation of best practices in MCM emergency communication may entail, given technological and social trends such as the growing influence of social media and increasing levels of social isolation; and prompting readers to consider and prepare for other future communication dilemma possibilities. In today’s world of rapidly-evolving ICT, such preparation is especially crucial.

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# Balancing Transparency and Privacy in a University Sexual Misconduct Case: A Legal Public Relations Case Study

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## ABSTRACT

In 2016, the University of Kentucky became embroiled in an open records debate with its student newspaper, *The Kentucky Kernel*. Following a professor's resignation amid a sexual misconduct investigation, the *Kernel* asked for records pertaining to the case. The University refused, claiming the information would violate survivors' privacy. The decision sparked public backlash, forcing the University to combat accusations that it was prioritizing reputation over student safety. This case study provides insight into the crisis management process by exploring how key actors in the case made decisions. Drawing from theoretical perspectives including stakeholder theory and the ethics of care and justice, this study explores the complexities of addressing incongruent stakeholder perspectives and balancing stakeholder interests, along with offering implications for public relations practitioners.

**KEYWORDS:** legal crisis, public relations, crisis communication, stakeholder theory, ethics

In 2016, the University of Kentucky made national headlines amid a public legal battle with its student newspaper, *The Kentucky Kernel*. The *Kernel* filed an open records request with the University to obtain documents detailing a sexual misconduct investigation of a tenured associate professor. The University refused, claiming that releasing the information would violate

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the Family Education Rights and Privacy Act (FERPA) because it would allow for the identification of the graduate student complainants. The Kentucky Attorney General sided with the *Kernel* and ordered the release of the name-redacted records. To appeal the ruling, the University sued the paper. In the announcement of the lawsuit, University President Eli Capilouto acknowledged the tension of “safeguarding” survivors’ privacy while recognizing “the need for transparency” (Capilouto, 2016a, para. 1). The *Kernel* staff claimed the University was more concerned with protecting its reputation than its students (Editorial Board, 2016a, 2016b).

Like any organization, institutions of higher education are susceptible to crises, and “higher education leaders face the added challenge of addressing potential gaps that a crisis may reveal relative to the core values of an institution” (Fortunato et al., 2018, p. 510). University communicators must protect reputations and stakeholder relationships (Varma, 2011). Many institutions, such as the University of Kentucky, are also public entities. Thus, the crisis can also affect relationships with government agencies and create an expectation that because it is a public institution, it must be held to a higher standard (Len-Ríos, 2010).

Despite the recent emergence of crisis communication studies in sexual misconduct cases on college campuses, Madden (2018) proclaimed that little research offers guidance for how communicators “can most effectively deal with the gendered and emotional dimensions” of these issues (p. 596). Survivors cite privacy and confidentiality concerns as reasons why they choose not to report incidents (Trades Union Congress [TUC], 2016). The calls for confidentiality in sexual misconduct cases, which often include a male perpetrator in a position of power victimizing a female, point to the notion that privacy is gendered (Higgins, 1999; Roth, 1999). Researchers have found that “certain issues important to women,” such as sexual misconduct, “have traditionally been deemed private” (Goldfarb, 2000, p. 1), and judicial procedures involving these issues are seen more as individual issues than societal issues (MacKinnon, 1991). Gotell (2006) argued that “the discourse of privacy has served to mask violence, inequality, and subordination” (p. 747). While arguments for privacy are seemingly made to protect survivors, keeping sexual misconduct cases private

perpetuates the victimization of women by not publicly holding perpetrators accountable for their actions.

The case of *University of Kentucky vs. The Kentucky Kernel* exemplifies these challenges as critics attacked the institution over its lack of transparency and alleged that its misplaced priorities endangered students. We apply stakeholder theory and the ethics of justice and care to extend our knowledge of crisis communication in legal crises broadly and sexual misconduct cases specifically. Using a robust case study approach (Sellnow, Littlefield, et al., 2009), we draw from multiple data points, including interviews with decision-makers at the University of Kentucky and the *Kernel*, the University's official statements, and reports from the *Kernel* and other media sources. By speaking with the decision-makers, this study offers a better understanding of how individuals make decisions in legal crises (Fitzpatrick & Rubin, 1995), specifically when addressing issues such as privacy and transparency in sexual misconduct cases.

## Literature Review

### Crisis Communication in Sexual Misconduct Cases

Crisis communication scholars have identified five primary response strategies in legal crises: denial, excuse, justification, concession, and diversion (Benoit, 1995; Coombs, 2007; Huang et al., 2005). Huang et al. (2005) placed the strategies on a continuum ranging from defensive, which favors organizational interests and includes denial, to accommodative, where organizations show concern for victims and invoke concession strategies. Research suggests legal practitioners favor defensive strategies, advising clients to remain silent (Fitzpatrick & Rubin, 1995; Gibson & Padilla, 1999). Crisis communication scholars emphasize a more accommodative stance including openly and honestly communicating, along with engaging in corrective action, which could be considered a concession strategy (Seeger, 2006). The tension between legal practice and crisis research recommendations is evident in the University of Kentucky sexual misconduct case whereby the University claimed it could not be transparent and accommodating because of its concern for the legal right of survivor privacy.

Recent research has focused on legal crisis communication in sexual misconduct cases on college campuses (Madden, 2018), including the Duke University lacrosse (Fortunato, 2008; Jin et al., 2010; Len-Ríos, 2010) and Penn State football cases (Brown et al., 2015; Formentin et al., 2017). Scholars have emphasized the importance of identifying “critical stakeholders” during sexual misconduct crises, noting that how these individuals evaluate the university’s response impacts the university’s reputation (Fortunato, 2008). For example, Duke University identified key stakeholder groups and adjusted its communication strategies depending on the stakeholder group (Jin et al., 2010). However, Duke’s decision to refrain from involvement in criminal justice allegations prohibited it from satisfying all of its stakeholders, underscoring the challenge of balancing stakeholder interests during a crisis (Len-Ríos, 2010). In order to further explore the tension between legal crisis communication and balancing stakeholder interest under the circumstances of sexual misconduct and harassment cases, this study poses the following research question:

**RQ1:** What communication strategies did the University employ in response to the crisis, and how did stakeholders respond?

### **Managing Stakeholder Interests**

To understand how the University of Kentucky attempted to balance stakeholder interests in this case, we turn to stakeholder theory, which considers how organizations affect and are affected by groups including customers, employees, the media, and the government (Freeman, 1984). Crises require the organization to work with stakeholders to manage outcomes (Ulmer, 2001). Stakeholders can pressure an organization throughout the crisis by asking for information, demanding answers, and seeking resolution (van der Meer et al., 2017). Crises that produce conflicting stakeholder desires complicate the response process. Len-Ríos (2010) contended that universities in particular “must make strategic decisions regarding prioritizing publics” to meet the needs of their “broad array of constituents” (p. 269).

A prominent framework introduced to classify stakeholders is Mitchell et al.'s (1997) theory of stakeholder salience and identification, which offered a typology of stakeholders using three relational dimensions: urgency, power, and legitimacy. The theory posits that the more attributes a stakeholder holds, the more salient the stakeholder becomes from a managerial perspective. Urgency reflects "the degree to which stakeholder claims call for immediate attention" (Mitchell et al., 1997, p. 867). Power embodies the ability to convince an organization to do something that it would not do otherwise (Alpaslan et al., 2009). Finally, a stakeholder wields legitimacy if their actions or claims about the organization are "desirable, proper or appropriate" within a social system (Suchman, 1995, p. 574). As the circumstances surrounding the crisis change, so do stakeholders' needs and salience.

Other "ethical" approaches to stakeholder management during a crisis argue that "the decision to include a stakeholder in crisis preparation and response should not be based solely on that stakeholder's salience" (Alpaslan et al., 2009, p. 43; Xu & Li, 2013). Organizations often prioritize certain stakeholders during a crisis, but such action should be taken based on the extent of personal impact (Ulmer & Sellnow, 2000). To embrace this "ethical approach," organizations must attend to all affected stakeholders (Ulmer, 2001), prioritize stakeholders based on the situation and shift these priorities as the situation evolves (Xu & Li, 2013), and make decisions that fairly consider and reflect all stakeholder interests (Sandin, 2009; Ulmer & Sellnow, 2000).

This study thereby proposes the following question:

RQ2: What stakeholder group(s) did the University prioritize?

### **Ethical Approaches**

To balance competing stakeholder interests, an organization engages in a decision-making process. But "without an ethical compass to guide its decisions," an organization may employ strategies that violate stakeholder expectations (Tao & Kim, 2017, p. 698), straining its stakeholder relationships and jeopardizing its legitimacy. Two ethical approaches that outline how an organization can respond to stakeholder pressure are the ethics of justice and care.

An ethic of justice emerged from social justice theory, which argues for individuals to be held to universal laws (Rawls, 1971). An ethic of justice requires that an organization treat all stakeholders fairly by making impartial decisions that recognize the interests of all stakeholders involved in the crisis (Sandin, 2009). The organization acts objectively and embraces rationality, scientific approaches, and individual rights (Simola, 2003; Tao & Kim, 2017), drawing upon arguments grounded in logic and objectivity (Kim et al., 2016). However, scholars have also suggested that using universal rules may not account for nuances in crises, limiting an ethic of justice's applicability in crises (Simola, 2003; Tao & Kim, 2017).

An ethic of care emphasizes nurturing relationships and expressing values such as compassion and empathy (Fraustino & Kennedy, 2018; Kim et al., 2016; Tao & Kim, 2017). This approach entails "concern about how to fulfill conflicting responsibilities to different people, as opposed to questions of how to resolve claims of conflicting rights among them" (Simola, 2003, p. 354). An ethic of care approach was a critical response to the justice approach (Simola, 2003; Tao & Kim, 2017). Crafted by Gilligan (1977), an ethic of care emerged from a feminist perspective, grounded in Gilligan's research that found women valued contextual and relational factors when making moral decisions. Gilligan (1982) argued a justice-driven approach is too rigid to account for the complexity of moral dilemmas. An ethic of care "considers the contextual complexities" of crisis and prioritizes those who have been affected (Linsley & Slack, 2013; Simola, 2003, p. 354), implying an organization should be involved and remain "sensitive and responsive to the emotional feelings and needs of publics" (Tao & Kim, 2017, p. 693). Considering the different ethical approaches to balancing stakeholder interests, especially in the dynamics of a crisis, this study poses the following question:

RQ3: How did the University incorporate an ethic of justice and an ethic of care in its crisis responses?

## Methods

This study aims to understand how organizational decision-makers navigate challenging legal and ethical quandaries while

illustrating how stakeholder values can conflict with organizational obligations. We used a robust case study approach, which enables researchers to make claims about a situation using multiple sources of information (Sellnow, Littlefield, et al., 2009). Case studies are useful when the research examines a current event by allowing “investigators to retain the holistic and meaningful characteristics” (Yin, 2009, p. 4) to derive practical implications (Patton, 2002). This case examines the crisis communication challenges faced by the University of Kentucky when its handling of a sexual misconduct case generated allegations that it was acting irresponsibly.

For data triangulation, we included statements released by the University of Kentucky on [uknow.uky.edu](http://uknow.uky.edu) ( $n = 7$ ), emails from the University president to faculty, staff, and students ( $n = 3$ ), articles published by the *Kernel* ( $n = 47$ ) and local newspaper *The Herald-Leader* ( $n = 32$ ), and articles culled in a Google News search using the terms “University of Kentucky,” “Kernel,” and “sexual misconduct” ( $n = 45$ ). All documents were collected from April 6, 2016, when the *Kernel* published its first article, to May 17, 2019, when the Appeals Court ruled in favor of the *Kernel*. After receiving approval from the Institutional Review Board, we conducted face-to-face interviews with four individuals who were involved in decision-making processes. These individuals were the unnamed member of the University of Kentucky’s legal counsel, who provided legal advice during the case; Jay Blanton, the executive director of public relations and marketing, who handled media inquiries on behalf of the University; Marjorie Kirk, the former *Kernel* editor, who wrote many of the stories about the case and made decisions about what information to publish; and Chris Poore, the former *Kernel* advisor, who said he offered advice to student journalists but allowed them to make the final decisions. All participants except legal counsel consented to have their names included in the write-up of the study.

We used semi-structured interviews to compare answers across the sample, adjusted questions based on the interviewers’ affiliation (the University or the *Kernel*), and asked follow-up questions (Patton, 2002). Questions for participants from the *Kernel* focused on the staff’s concern with the University’s public response, how

it expressed these concerns to administration, and the challenges the staff faces in covering sexual misconduct cases. Questions for University decision-makers centered on the factors that influenced the University's public response to the case, the challenges the University faced when communicating about these types of cases, and how maintaining the University's reputation factored into these decisions. Interviews ranged from 41 to 98 minutes and were audio-recorded with permission from the participants.

After collecting data and transcribing the interviews, we conducted textual analysis (Creswell, 2013). First, all data were read to achieve a holistic understanding of the case while making initial notes and observations. Second, the data were re-read multiple times to form preliminary codes, which were grouped and placed into larger categories or themes, combining codes as needed to avoid duplication. Finally, a reading of the data was conducted to ensure all evidence supported its assigned theme. The resulting analysis is described next.

## Case Background

In February 2016, a University of Kentucky professor signed a resignation agreement following a sexual misconduct investigation comprising three allegations, two complainants, and five survivors. The case (Table 1) began when a spokesperson representing two female survivors approached then-*Kernel* reporter Marjorie Kirk (Kirk, personal communication). At first, the paper could only report on the settlement statement shared by the University, which refused to release the full report (legal counsel, personal communication), claiming it would "constitute an unwarranted invasion of personal privacy" (Smith, 2016, para. 5). Revoking tenure can take years. The University's push for resignation offered a quick solution, but once the accused leaves the university, the inquiry essentially ends (Kirk, 2016b). Because many settlements prohibit disclosing the incident to future employers, the "passing the trash" practice permits faculty to move without public knowledge of accusations (Rexroat, 2017). The survivors feared the professor would repeat the behavior at another institution (Kirk, personal communication).

**TABLE 1** Timeline of Events

<b>February 2016</b>	Accused professor signs an agreement with the University of Kentucky (Smith, 2016).
<b>March 2016</b>	Two survivors approach Kirk regarding their concerns with the settlement (Westerman, 2017).
<b>April 2016</b>	The <i>Kernel</i> publishes its first article on the case and asks the University for records pertaining to the case (Kirk & Wright, 2016). The University provides a letter of the investigation. The <i>Kernel</i> files an appeal with the Attorney General's office to release the documents (Smith, 2016).
<b>August 6, 2016</b>	The Attorney General rules the University should release the documents but redact the names and identifiers of the complainants and witnesses (News Staff, 2016).
<b>August 8, 2016</b>	The University announces its decision to sue the <i>Kernel</i> as part of the appeals process (Kirk & Wright, 2016).
<b>August 13, 2016</b>	The <i>Kernel</i> obtains 122 pages of records from a confidential source representing the two survivors (Kaufman, 2016). The University confirms its decision to proceed with the lawsuit.
<b>August 31, 2016</b>	The University files suit against the <i>Kernel</i> .
<b>September 10, 2016</b>	University of Kentucky President Eli Capilouto claims the <i>Kernel</i> publishes "salacious details to attract readers" (Blackford, 2016b, para. 12).
<b>September 17, 2016</b>	Journalism faculty ask Capilouto to apologize to Kirk over his "salacious" comment and drop the suit (Stripling, 2016).
<b>October 2016</b>	The <i>Kernel</i> wins The Pacemaker Award (Blackford, 2016b).
<b>November 2016</b>	Two survivors "switched their stance" and joined suit with the University (Blackford, 2016d).
<b>January 2017</b>	Circuit court judge rules in favor of the University in lawsuit, claiming the organization does not have to hand over records to the <i>Kernel</i> (Blackford, 2017).

**August 2017**

Circuit court judge upheld the previous ruling from January (Blackford, 2017).

**June 2018**

President Capilouto announces that the University finalized all changes for disciplinary processes for allegations including sexual assault (“UK updates policy,” 2018).

**May 2019**

Court of Appeals rules that the University violated the state’s Open Record Act, sides with *Kernel* (Cheves, 2019).

Early media coverage was impeded by the University’s decision to only provide the settlement statement, reportedly frustrating two survivors (Kirk, personal communication). Kirk and the then-editor of the *Kernel* filed an open records request with the Attorney General (Kirk & Wright, 2016), who ruled the University should release the documents to the *Kernel* and the Attorney General’s office but redact the names and identifiers of complainants and witnesses (News Staff, 2016). The University declined and, in accordance with state law, announced it would sue the paper to appeal the decision, leading the two survivors to give several pages of redacted records to the *Kernel* (Kirk, personal communication). Kirk warned the survivors that “this story’s probably going to take off,” anticipating the local newspaper would be interested but not that it would quickly gain national attention (personal communication).

## Findings

### RQ1: University Response and Stakeholder Reactions

Secrets “stain” the university’s image. The University applied the excuse strategy by using *provocation*, presenting its actions as the appropriate legal response (Huang et al., 2005). Following an allegation, the University must investigate. If the investigation reveals an incident did occur, the University initiates a three-step process: stop the activity, mitigate the effects, and ensure it never happens again “on our campus” (legal counsel, personal communication).

The University must provide due process and can only remove the accused (legal counsel, personal communication). According to University spokesperson Jay Blanton, settling was the fastest way to legally remove the threat, even if it “was imperfect” (personal communication). The University also sued the *Kernel* to avoid releasing the redacted documents, which it said contained enough information to identify the complainants and witnesses. Blanton recognized the courts were necessary to reconcile the competing tensions of transparency and privacy (personal communication), and University legal counsel added that “naming the *Kernel* is a quirk of Kentucky law. Our dispute is with the Attorney General” (personal communication).

The case gained national media attention (Kaufman, 2016), even though the University’s decision to sue is a common practice between journalists and public institutions according to *Kernel* advisor Chris Poore (personal communication). Some stakeholders supported the University, including on-campus survivors’ advocacy group SPARC, which argued that transparency should not jeopardize survivors’ “privacy and dignity” (Melanson, 2016, para. 22). But conveying the legalities of the situation proved problematic as the University’s proclaimed desire to protect individuals was overshadowed by claims that it “is fighting for secrecy, not for privacy. It is fighting for itself, not for victims” (Editorial Board, 2016b, para. 32).

A local journalist claimed nearly all the media attention was critical (Blackford, 2016d). The *Kernel* called the case “a stain on the University’s image” (Editorial Board, 2016a, para. 20), and external agencies deemed it “embarrassing” (Merlan, 2016, para. 2). The *Kernel* accused the University of hiding information (Editorial Board, 2016a) and safeguarding its own image (Editorial Board, 2016b). Reporters highlighted the University’s status as a public institution, contending this position made its behavior more egregious (News Staff, 2016). This veil of secrecy was fed by what Poore labeled “the Blanton funnel” (personal communication). Poore expounded that “You only have one source for a story on campus. That’s Jay Blanton,” which often produces a “washed out” rather than “accurate version of the story.” Kirk added that for

the majority of the case, only Blanton's office would speak with the *Kernel*, which she felt made it appear as though the University was "responding to a public image concern, not an administrative or a disciplinary concern" (personal communication).

**Following legal precedent or hiding behind the law?** The University attempted to act with *good intentions* by citing the Family Educational Rights and Privacy Act (FERPA). Because the University receives federal funds, it must adhere to the federal law, which "precludes us from revealing educational records without the consent of everyone involved" and broadly defines an educational record "as essentially any document maintained by the University that relates to a student" (legal counsel, personal communication). According to legal counsel, the law required the University to retain all records, even if redacted. The ability to access information online also influenced the University's decision as administration determined it was "effectively impossible" to redact all identifying details (legal counsel, personal communication) and feared the justice system could not guarantee confidentiality to prevent retaliation (Westerman, 2017). University legal counsel emphasized it acted "with guidance from the U.S. Department of Education in 2006," which stated "you cannot turn over FERPA protected documents to a State Attorney General in the context of an open records dispute" (personal communication). Legal counsel added that the University provided a description of the documents to the Attorney General.

Citing FERPA added a new tension. Critics stated the University overstepped its bounds as the decision about what documents can be released "is the job of the legal system, not the University President" (Editorial Board, 2016b, para. 23). Others argued the use of FERPA made the University the "latest example of colleges hiding behind student privacy laws to protect their image and reputation" (New, 2017, para. 3). Both Kirk and Poore claimed other universities provided documents in similar cases and were not punished (personal communication).

Blanton and the legal counsel were "disappointed" that media coverage never noted the complexity of the University's decision as "there never seemed to be an acknowledgment that the University wasn't just making this up. We were, in effect, following

well-established law” (legal counsel, personal communication). Blanton also claimed the media failed to recognize the University’s precarious situation by including “scant” mention of the legal-privacy tension and disproportionately focusing on the open records debate (personal communication). Conversely, the *Kernel* frequently questioned why administrators would not release a redacted report as a form of compromise (Editorial Board, 2016a; Kirk, 2016a). Kirk claimed names and event descriptions are unnecessary as “you would just need to know that [the professor] was found responsible by his employers for doing this, this, and this . . . That page has nothing on it that you could even argue was an education record” (personal communication).

**The university’s redaction blunder.** The survivors later changed their stance and sided with the University as the case gained national attention, believing that “the line between the laudable goal of transparency and the blatant invasion of privacy has been crossed” (Blackford, 2016d, para. 3). But this turn of events was overshadowed by a University gaffe. At its Board of Trustees meeting, the University distributed letters written by the survivors expressing their “dissatisfaction” with the media coverage, but when removing identifying information, overlooked one reference that identified a survivor (legal counsel, personal communication). Kirk, who attended the meeting, caught the mistake and brought it to the attention of Blanton (Kirk, personal communication), who swiftly collected the letters and later apologized to the survivors (Blanton, personal communication). The media capitalized on the mishap, emphasizing that “UK is the only one that has identified a victim by name” (Editorial Board, 2016b, para. 20).

**Selling salacious news.** During the same Board of Trustees meeting, President Eli Capilouto escalated criticism when he stated that “In printing salacious details to attract readers, they [the *Kernel*] have effectively identified the victim survivors” (Blackford, 2016b, para. 12). Blanton explained that Capilouto meant not all details need to be included to print the story (personal communication). Nevertheless, the damage was done, and Capilouto’s use of the *attacking the accuser* strategy backfired. Many saw his comment as a direct attack on Kirk. Even though Capilouto did not explicitly name Kirk, she was the paper’s “decision maker” (Kirk,

personal communication). For Poore, “UK was fine as they were arguing it as a policy issue. When Dr. Capilouto made it about the person, he went way too far” (personal communication).

Journalism faculty at the University penned a letter requesting an apology (Stripling, 2016). Capilouto refused, arguing that “to have a student newspaper provide so much information in an article that anybody in 15 minutes could most likely identify the victims of assault” is “a serious matter” (para. 47). Kirk said she conferred with the survivors about the details included in the articles, such as the professor’s behavior at conferences, and received their approval (personal communication). Poore explained that without those details, the survivors feared that “people wouldn’t realize the setting he had done that in” and thus, assertions that they could be readily identified “was pretty unfair treatment” of Kirk (personal communication).

**Corrective action.** The University invoked *concession* by announcing systemic changes. Early on, administrators used corrective action by declaring that it would require new faculty members to share their sexual misconduct history and offer training to graduate students and their mentors (Capilouto, 2016b). The University also introduced a process for reviewing faculty behavior following “clear examples of sexual misconduct” (para. 11). Yet, thus far, a required training session has only been offered to graduate students and not their faculty advisors. While other steps, such as the revised disciplinary process, show commitment to addressing University members’ “concerns and suggestions” (“UK updates policy,” 2018, para. 2), it must implement all of its plans to address the “passing the trash” problem at the university level.

#### RQ2: Stakeholder Priorities

The University publicly identified its salient stakeholders to be (1) the survivors, and (2) current students. The University of Kentucky maintained its decisions were to protect the survivors’ privacy while adhering to legal obligations. Legal counsel emphasized the *Kernel* provided details, such as “the fact that they were Ph.D. students,” noting that the University posts dissertations online with advisor names (personal communication). Thus, “If

you wanted to look back and see how many students got a Ph.D. in a particular field, you could do so in a matter of moments.” The University voiced that “truly honoring the value of transparency” required letting the survivors make decisions about sharing details (Manouchehri, 2016, para. 12).

First, as part of the University’s three-pronged response to sexual misconduct (stop, mitigate, prevent), it emphasized that its responsibility is to survivors, and that removing the threat to protect these stakeholders was paramount (Blanton, personal communication; legal counsel, personal communication). Second, the administration claimed that protecting survivor privacy in this case was necessary to establish a climate where other survivors would feel safe to report incidents. In an email, Capilouto (2017) asserted that “Without privacy, we know victim survivors will not come forward to report. That’s what was at stake in this case” (para. 3).

Critics maintained that the University was prioritizing itself and neglecting “other students and the public” (Kirk, 2016a, para. 1). The *Kernel’s* Editorial Board (2016a) offered that the University’s denial of the open records request “showed it cares more about its own interests than it cares about the law, accountability or the public’s right to information” (para. 13). Critics also claimed that the University’s response prioritized the accused over the survivors and other stakeholders. Early on, a spokesperson for the two survivors argued:

It feels like UK is trying to protect what went on here and to protect [the professor]. Why not have complete transparency in this? . . . UK should be interested in protecting not just the students at UK. (UK) should also be in the interest of protecting students at other universities where [the professor] may end up. (Kirk, 2016a, para. 15)

The Editorial Board (2016b) echoed this claim, asserting that “The university gives the accused privacy in matters the public has a right to know” (para. 10).

### RQ3: Ethical Approaches

Several of the University’s decisions and communications reflected an ethic of justice by underscoring fairness, protecting rights of

all involved parties, and employing legal reasoning. First, Blanton emphasized that individuals have a right to due process and recognized that the University has a responsibility to create fairness for the accuser and accused (personal communication). Second, the University relied on logical reasoning by citing laws, reflecting an attempt to objectively evaluate a conflict. Although the University cited FERPA to justify not releasing the records, legal counsel also explained that “in the sixth circuit, the constitutional right to privacy extends to the details of a sexual misconduct except where the disclosure of those details is necessary for a criminal prosecution” (personal communication). Thus, “FERPA aside, if instead of students, these were departmental secretaries or non-students who were alleging sexual misconduct, we could not as a governmental entity turn that information over.”

Although the University tried to determine what the law required, Blanton explained that legal codes are “not always 100% clear. Judgments have to be made” (personal communication). When making the judgment call, the University “landed on the side of the victims’ rights to tell their story,” including *when* and *how* (personal communication), permitting it to employ an ethic of care approach by maintaining that its response was an effort to do what was right for the survivors. Blanton emphasized that these decisions were based on the survivors’ needs, claiming the University “cannot—and should not—decide when it is appropriate to violate a victim-survivor’s privacy—and a victim-survivor’s trust—by providing information to the Office of the Attorney General, the *Kernel*, or any other entity” (Blackford, 2016a, para. 11).

President Capilouto (2016a) underscored relational aspects when he asserted that “we believe strongly in the need to protect the privacy of members of our community: our students, patients, faculty, and staff” (para. 3). During the Board of Trustees meeting, he maintained that the University was trying to remain sensitive to the needs of the survivors and support them:

It is essential that the victim survivors of sexual misconduct know that their University stands with them, embracing them when they come forward in the courageous effort at justice and at healing; and that we will do everything in our power to protect their privacy. . . . (Melanson, 2016, para. 17)

Capilouto (2016a) also claimed that the University ponders the needs of affected stakeholders. He expounded that the University annually receives hundreds of open records requests and complies with most, but makes circumstantial decisions when deciding between transparency or protecting “the privacy and dignity of individual members of our community” (para. 7).

## Discussion and Implications

Madden (2018) claimed university-led discussions about sexual misconduct “call into question who is being valued and why” and added that “it could become problematic if protecting the institution and institutional values supersedes the protection of individuals” (p. 305). This statement captures the essence of the University of Kentucky case as the administration maintained that its priorities lay with protecting the privacy of the survivors while many of its stakeholders, including the *Kernel*, argued that it was pursuing self-interest and secrecy. Using stakeholder theory and ethical approaches, we explore the theoretical applications in this case before describing the larger social implications and offering suggestions for practice.

### Theoretical Applications

**A stakeholder approach.** Power, legitimacy, and urgency were crucial to the case’s evolution (Mitchell et al., 1997). Although the two survivors reported the professor, leading to his resignation, no further action occurred at the University level. After publishing a handful of articles and filing the open records request, the *Kernel* gained a foothold. Shortly thereafter, the alliance of the *Kernel* and two survivors, followed by the newsworthy aspect of the University’s decision to sue the *Kernel*, shifted the balance of power in the favor of the *Kernel*. Further, the *Kernel* claimed its access to the documents, thanks to the survivors, meant the University’s message “of fighting for the privacy of its victims” fell apart (Editorial Board, 2016a, para. 20), lending legitimacy to the paper’s request. The amount of attention given to the case and stakeholder pressure on the University added a degree of urgency, pushing it to announce changes to minimize the risk of sexual

misconduct on campus in September 2016. Although Blanton said the adjustments were already under review (Horsley, 2016), Kirk (2016c) claimed the step came “only after the university felt pressure and criticism” (para. 16) from stakeholders.

External media narratives reflected sentiments expressed by the *Kernel*, seemingly delegitimizing the University’s stance as reporters criticized the validity of the legal arguments, portraying them as “a smokescreen” (New, 2017, para. 14). Some stakeholders doubted the legitimacy of the institution itself by raising questions about its values, arguing its actions were irresponsible and tried “to block sexual assault reporting” (Higdon, 2016, para. 1). Legal rulings throughout the case also shifted the tide of legitimacy arguments. In 2017, the University received support when the circuit court ruled in its favor, prompting a sizable decline in external media coverage. The survivors’ decision to join the University in the lawsuit after the case received substantial publicity, expressing concern that disclosing additional records would allow the media or others to uncover their identities (Blackford, 2016d), and also altered the trajectory as those who were the most directly affected by the University’s decisions now stood with it.

Although the *Kernel*’s persistence in pressuring the University to release the information made it, along with others, a salient stakeholder, the University refused to budge and relied on an ethical stakeholder argument (Xu & Li, 2013). The administration fervently maintained that its efforts were to protect those most affected by the crisis, the survivors, from the onset when the University removed the accused. The University had to operate within legal parameters that required some details to be withheld while responding to public pressure to release information. The situation created a legal-ethical tension since releasing information would place the survivors at risk and, according to the University, violate federal law. However, withholding the information could endanger other individuals and violate the Open Records Act. The University’s unwillingness to release certain documents out of a proclaimed interest to protect the survivors hindered it from taking action that reflected the interests of all stakeholders (Sandin, 2009; Ulmer & Sellnow, 2000). The University maintained that it had a legal obligation and a “moral responsibility” to protect

survivors (Kaufman, 2016, para. 20), but one reporter countered that it had “a moral and ethical obligation, presumably, to inform people when a faculty member who might be hired elsewhere has been accused of something as egregious as this” (Stripling, 2016, para. 33). By withholding the documents, the administration alienated select stakeholders, including the *Kernel*, some students and faculty, the Attorney General, external media outlets, and early on, two female survivors. Unable to shield the survivors, empower third parties to expose the alleged wrongdoing of the accused, and operate within legal confines, the University simply could not reconcile all stakeholder interests.

**Ethical approaches.** The University tried to embrace an ethic of justice in emphasizing its compliance with the legal system. By adhering to a universal standard, the University attempted to appear objective and fair. However, an ethic of justice requires impartiality (Sandin, 2009), and the University also openly claimed to prioritize the survivors and current students over other stakeholders. A key component of an ethic of justice is the ability to resolve conflicting rights (Simola, 2003), which created a double-bind for the University as the two values in question were the survivors’ right to privacy and the public’s right to know. Favoring one came at the expense of the other, and the situational constraints made it infeasible for the University to employ an ethic of justice.

The University’s announcement to prioritize those who it perceived to be most affected by the crisis, survivors and current students, reflected an ethic of care, which accounts for caveats by recognizing the “particular circumstances of individuals” (Xu & Li, 2013, p. 382) and acknowledges that organizations may not be able to resolve stakeholder conflicts (Simola, 2003). By adopting an ethic of care, the University should have been able to address each stakeholder group in accordance with its own needs, permitting it to thoughtfully explain its stance and underscore its value for all stakeholders. The University adhered to an ethic of care by noting the situational complexities and vocalizing support for survivor privacy. However, its use of legal reasoning to defend its position and the administration’s openly discordant relationship with the *Kernel* often left it appearing detached rather than “sensitive and responsive” to all stakeholders (Tao & Kim, 2017, p. 693). This

approach fostered a public perception that these stakeholders did not matter to the University (Editorial Board, 2016c), hindering it from fulfilling conflicting stakeholder responsibilities (Simola, 2003), and crippling the effectiveness of its crisis response.

### Critical Applications

A larger implication of this study reflects the University's reliance on the value of privacy to protect the survivors, ultimately illustrating the concerns advanced by feminist legal scholars who warn that a privacy approach can overshadow the greater issue at hand (Higgins, 1999; Roth, 1999). Gotell (2006) advanced that constructing a privacy argument on behalf of complainants creates a paradox as the "public/private divide" can be "deployed to shield sexual violence from public view" (p. 746). Gotell also offered that privacy appeals can nurture a systemic problem as this argument perpetuates the idea that sexual misconduct is a private matter, allowing it to "become individualized and contained in a moment" (p. 747). Although the case did bring attention to the systemic shortcoming of "passing the trash" in academia, this concern was quickly buried by an avalanche of coverage on the open records debate and lawsuit. The extensive focus on the privacy-transparency tension prohibited the University and media outlets from fully illustrating the complexities of the case and discussing the problems inherent in the justice system and higher education, which was the crux of the survivors' decision to pursue the issue in a public forum in the first place.

Additionally, this case study reflects the fluid dynamics between media coverage and victim reporting in sexual assault/misconduct cases. In October 2016, the University claimed that the number of individuals reporting sexual assault dropped from 59 reports to 38 since the beginning of the case, which it attributed to the extensive media coverage (Blackford, 2016c). While we do not know that the media coverage was the catalyst in the reduced number of reports, this case offers warnings about the effects of extensive coverage of sexual harassment and assault cases. When the complainants went to the University's Title IX office, confidentiality was their key concern, and one survivor emphasized she wanted to avoid the

courts to protect her identity because of her career (Westerman, 2017). However, the survivors' decision to side with the University as news coverage escalated out of fear that their identities would be revealed demonstrates the potential costs that survivors may encounter when they report these crimes. It also suggests that the substantial attention given to these cases could discourage others from reporting and preserve a culture of silence.

### Practical Implications

This study offers six practical implications for legal crises, and specifically, sexual misconduct and harassment crises. First, legal and public relations practitioners should establish relationships before crises. Blanton recommended practitioners be “at the table” when decisions are made or they will “be behind” (personal communication). He added that the President's office, legal counsel, and public relations team were all involved in drafting messages, underscoring the need to form an interdepartmental crisis management team and coordinate response efforts (Coombs, 2019; Seeger et al., 2003).

Second, organizations must maintain a respectful relationship with the media. The administration and the *Kernel* publicly disagreed and made scathing comments. Yet, Kirk and Blanton shared that they respected each other (personal communication). Kirk and Poore also noted that the University never attempted to influence the *Kernel's* coverage (personal communication). Poore added that the University gave the paper a “courteous heads up” before filing the lawsuit and explained that he and Blanton conversed “behind the scenes, trying to solve problems if they were solvable” (personal communication).

Third, even if organizations cannot supply all details, granting media access to relevant parties, including important actors, is essential. The University's reliance on the “Blanton funnel” supported claims in this case that the institution was not being transparent. Some crisis scholars recommend that organizations use multiple individuals to disseminate a message (Sellnow, Ulmer, et al., 2009). Issues such as sexual misconduct are complex and sensitive, and a public relations practitioner may not be the best

individual to relay messages. The University should have enabled others to discuss the case, including legal counsel, Title IX officers, members of its Violence Intervention and Prevention Center, and other administrators. A chorus of voices highlighting different components and delivering more empathetic statements, while maintaining a consistent narrative, can lend more authenticity and credibility.

Fourth, organizations must explain situational challenges of complex legal issues. Legal counsel claimed that the University attempted to share its legal position in a way that the general public “would readily understand and appreciate” (personal communication). However, Blanton admitted that the University “struggled” to share its perspective (personal communication). The University released only seven public statements compared to the *Kernel’s* 47 articles. Blanton noted the University became more proactive as the case escalated because “other people are going to tell your story . . . it’s always better to take the shot first” (personal communication).

Fifth, even though an organization may not be able to pacify all stakeholders, it should embrace an ethic of care in its responses by recognizing all concerns. The University’s heavy use of the justification and excuse strategies, along with its reliance on legal reasoning, impeded it from acknowledging stakeholders who questioned its actions. Fraustino and Kennedy (2018) proposed that organizations should “communicate with these publics from a stance of care,” particularly when dealing with “vulnerable populations” (p. 25). An organization should acknowledge and respectfully engage with all publics, but it may need to prioritize certain stakeholders, such as survivors, during these situations.

Finally, this study advocates for journalists to thoughtfully cover these cases, underscoring the importance of trauma-informed reporting (Gearing, 2019). Kirk explained sensitivity was “the hardest part” as “I had to make sure I was not going to cause harm that I could not justify” (personal communication). For the news media to play its significant role in bringing these issues to light, news agencies should cultivate a reputation that ensures survivors are comfortable approaching the outlet because they know their dignity will be maintained.

## Conclusion

The *Kernel* and its staff earned national recognition for their reporting. The *Kernel* received “The Pacemaker” award, known as the “Pulitzer Prize of collegiate journalism,” from the Associated Collegiate Press (Nederhoed, 2016) and the College Press “Freedom Award” from the Student Press Law Center (SPLC, 2017). *Glamour* magazine recognized Kirk as one of its ten “College Women of the Year” (Harder, 2017). Despite these accolades, in August 2017, the circuit court sided with the University, ruling the Attorney General does not have the authority to examine documents if they are protected under FERPA (Blackford, 2017). In May 2019, the Kentucky Court of Appeals overturned that decision. Judge Kelly Thompson, who wrote the three-judge panel’s majority opinion, stated the University “has taken the indefensible position that the records are exempt because it says they are and it must be believed” and requested the University review all documents to identify those which are not exempt under privacy rule (Associated Press [AP], 2019, para. 5). The University must then release documents that can be safely redacted, and explain why withheld documents are exempt under law (Cheves, 2019).

As stakeholders demand transparency, organizational decision-makers must identify how to balance information provision and privacy. In the University of Kentucky’s sexual misconduct case, the privacy-transparency tension placed administrators in a precarious position. By protecting survivor privacy, the University seemingly put other stakeholders at risk, provoking an outcry that the institution favored its reputation over transparency. This study describes the challenges organizations face when balancing stakeholder interests because of legal restraints or because interests are irreconcilable. Despite demands for an organization to be open, this study demonstrates how prioritizing stakeholders can limit an organization’s ability to be forthcoming, particularly when the story the public is interested in is not the organization’s story to tell.

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