

**Risk = Hazard + Outrage**

## **Beyond Panic Prevention: Addressing Emotion in Emergency Communication**

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This is one of three articles I wrote for the CDC's CD-ROM on emergency risk communication. This one deals with the likely emotional impacts of terrorism (and other major emergencies), and how communicators can best help the public cope with these emotions. The focus is especially on denial and misery as more common emotional reactions than panic — reactions that may be mishandled if the communicator is over-worried about panic prevention instead.

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# Beyond Panic Prevention: Addressing Emotion in Emergency Communication

by Peter M. Sandman

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By far the most common reaction to risky situations is apathy. Figuring out how to combat apathy – how to get people to recognize a risk as serious, to become concerned about it, and to take action – is the mainstay of a risk communication specialist's job. It is also the mainstay of a health educator's or health communicator's job. The list of health risks to which people under-respond is a very long list indeed.

But of course sometimes people do take a risk seriously, becoming concerned, even frightened, perhaps angry as well. More often than not, the risks that generate these emotional responses have several characteristics in common, characteristics I have termed "outrage factors" (for more on these, see <http://www.psandman.com/col/part1.htm#head1>). High-outrage risks tend to be coerced rather than voluntary; unfair rather than fair; dreaded rather than not dreaded; controlled by others rather than controlled by the individual; imposed or managed by organizations that are mistrusted rather than trusted, and unresponsive rather than responsive; etc. People usually take high-outrage risks seriously whether the technical risk is serious or not, and people are usually apathetic about low -outrage risks, again whether the technical risk is serious or not.

One of the outrage factors is the distinction between chronic and catastrophic risk. In general, the same level of technical risk will generate much more outrage if it comes concentrated in space and time than if it is spread out in space and time. Tobacco, for example, kills hundreds of thousands of Americans every year. If they all had to die on November 13 in Chicago, on November 14 we would outlaw smoking. In at least this one way, all emergencies are highoutrage. Many emergencies exhibit a number of other outrage components as well. Some, such as bioterrorist attacks, exhibit essentially all of them.

In ordinary times, the range of possible reactions to a risk runs from apathy at one extreme to outrage at the other extreme. If people are inappropriately apathetic, the communication goal is to get them more outraged. If people are inappropriately fearful or angry, the communication goal is to reduce their outrage.

But sometimes – and a bioterrorist attack is surely one of those times – the level of emotional response moves beyond normal outrage. One possible version of this "extreme beyond the extreme" is panic. A more common version (because panic is relatively rare) is denial. Risk communicators don't usually need to think too much about how to address panic and denial; apathy and outrage are our daily adversaries. But for some of the health emergencies now being planned for, panic and denial, especially denial, are additional possibilities. And so are some other extreme emotional responses: rage, depression, etc.

I am a risk communication consultant, not a psychotherapist. Individuals with powerful emotional reactions to a health emergency may need the help of a mental health professional. Clinical depression and post-traumatic stress disorder, for example, are medical conditions that benefit from medical interventions. My goal in this chapter is not to urge that communicators try to preempt the psychotherapeutic role – only that communicators try to understand what sorts of emotions may be in play and what sorts of communication approaches are likely to exacerbate or ameliorate people’s emotional responses to the emergency. My own understanding of these phenomena owes even more than usual to the counsel of my wife, psychiatrist Jody Lanard.

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## 1 . Fear, Panic, and Denial

The most straightforward emotional response to risk, of course, is fear – especially fear for oneself and one’s family.

Let’s organize this “fear” family of emotions. Consider the range:

Apathy  
Concern  
Fear  
Terror  
Panic  
Denial

These are, I think, largely in order, although panic and denial may be alternative branches at the high-fear end of the scale. And in the sense that denial looks a lot like apathy, perhaps the scale could be reorganized as a circle.

Ordinary risk communication never gets beyond the first three reactions on the list. So if people are too apathetic, we try to get them more concerned – sometimes by arousing fear, other times by arousing other sorts of outrage. And if people are too frightened, we try to diminish their concern – yes, get them more apathetic – sometimes directly by diminishing their fear, other times by diminishing other sorts of outrage. Notice that what you do depends on two things: How concerned people are (or you think they’re likely to become), and how concerned you want them to be. Organizations with different views on either of those two questions naturally pursue different risk communication strategies.

When the topic is a bioterrorist attack, or any health emergency, apathy probably isn’t your goal. In the pre-event phase – that is, when you’re talking about a possible future emergency – you want concern. In fact, you want pretty high concern, maybe even fear. Why? You want the public to be cautious, vigilant, willing to help, willing to be inconvenienced, willing to pay for preparedness. During an actual emergency, even concern isn’t enough. Fear is appropriate, even high levels of fear. Terror goes too far.

## *Panic*

Panic, of course, goes much too far. Panic prevention is a crucial goal of emergency management, because panic is highly contagious and highly destructive. But in another sense, panic prevention is the wrong goal – because panic is relatively rare. In moments of great danger, most people become preternaturally calm, not panicky. In the face of awful events, we become simultaneously resourceful and responsive. If told what to do by those in authority, we tend to do it; if no one is in authority, we figure it out for ourselves. When the crisis is over, we may feel anxiety, fear, even delayed “panic attacks” now that the need to stay calm has passed. It is true that the public often chooses self-protective responses to an emergency that go beyond those recommended by the authorities. The authorities may see this as panic ... but it isn't. After the first plane hit the World Trade Center on September 11, many people evacuated the twin towers, even though the authorities said the danger was past. But survivors tell us the evacuation was orderly and cooperative, not panicky. During the anthrax attacks that followed, many people secured their own personal stockpiles of antibiotics. This turned out to be unnecessary, but it was hardly a sign of panic – even though it was often referred to as such by commentators who have never seen real panic. If anything, it was a sign of *hedging*. Panic, in short, is rare.

Preparing to cope with panic, or with incipient panic, is like preparing for any other worst case scenario; it's part of your job. But it is important not to neglect planning for more likely scenarios in the process.

Even when panic is a real possibility, moreover, the goal of panic prevention does not justify false reassurance. In fact, false reassurance is likelier than anything else to precipitate a panic. People are likeliest to panic – though still not very likely – when they sense that they are at urgent and imminent risk but they can't tell for sure; when it is not clear what actions they can take to learn more or protect themselves; when the authorities are telling them not to be frightened even though there is more than ample reason to be frightened. So if you're worried about panic, tell people the truth, gently but clearly; tell them it's okay to be frightened; and tell them what they can do.

## *Denial*

But the real worry is usually denial. You can see denial as an alternative to panic, or as a defense against panic, or as an even more extreme response than panic. However you see it, denial is much more common than panic. But you're likely to miss it, because it looks a lot like apathy. Like apathetic people, people in denial are reluctant to pay attention to the issue; if pushed to talk about it, they do so without emotion. But denial is actually the opposite of apathy. It is repressed emotion – in this case, repressed fear, fear so high it trips a psychological circuit breaker.

The difference between apathy and denial is clearest when you try to warn people, to scare them into attention and action. Apathetic people don't have much initial interest in your warnings, but once you get through to them they become more concerned. But people in denial have a very different response: The scarier your message, the deeper into denial it

pushes them. During the cold war, activists against nuclear weapons often tried to arouse public concern with terrifying speeches about what it would be like if a nuclear weapon were to explode right here, right now. Those in the audience who were apathetic about nuclear weapons (not a large group, generally) got concerned; those who were already concerned and active in the movement (a larger group) got more concerned; those who were in denial (often the largest group) went further into denial.

Pre-9/11, some people were apathetic about terrorism and weapons of mass destruction. Some were concerned, even frightened. Some, I think, were already in denial. Since 9/11, the movement has been from apathy to concern, from concern to fear, from fear to terror and denial, from denial to deeper denial.

Does it follow that people in denial, or in danger of going into denial, need to be reassured? It does and it doesn't. Certainly people in denial don't need to be frightened more. They're too frightened already! But denial is defensive. People in denial tend toward paranoia. They're lying to themselves, and they project that into a generalized suspiciousness: "You're lying to me." So false reassurance may well backfire as badly as excessive warning. They'll sniff out the dishonesty and it will push them deeper into denial.

What then are the key strategies for dealing with denial? If saying scary things is likely to backfire, and saying reassuring things is also likely to backfire, what do you say?

- Legitimate the fear, so it can be acknowledged and accepted. Model tolerating fear, not being fearless.
- Provide action opportunities. People are less in need of denial if they have things to do; efficacy is an antidote to denial.
- Focus on victims who need to be helped and potential victims who need to be protected. Love, too, is an antidote to denial.
- If appropriate, focus also on malefactors who need to be caught and punished. Unless it escalates into out-of-control rage, or is itself denied, anger is also an antidote to denial.
- Be candid – but gently candid.

### *Over-reassurance*

Notice that for every level of fear we have discussed, over-reassurance is the wrong answer. And yet over-reassurance is probably the most common communication error in emergency situations. Even the mass media tend to be over-reassuring in an emergency. Before the crisis, reporters will often resort to hype. After the crisis, they'll gleefully tell people how close we came to disaster and whose fault it was. But in mid-crisis the media are surprisingly (even dangerously) committed to the same goal and the same misunderstanding as the authorities: They try to prevent panic by

suppressing bad news. One interesting though comparatively trivial example from the 2001 anthrax story: Virtually no mainstream media used the readily available photos of cutaneous anthrax. (I did see one TV clip with a closeup of a skin lesion.) Arguably, it would have been useful for the public to know what cutaneous anthrax looks like. But desperate as they were for good art to accompany the anthrax story, editors nonetheless decided that the photos were too gruesome, too likely to frighten readers and viewers.

For more on why and how to avoid over-reassuring people, see “4. Being alarming versus being reassuring” in [“Dilemmas in Emergency Communication Policy.”](#)

### *Legitimizing fear*

The opposite of over-reassurance, and the best way to deal with fear, panic, and denial, is to legitimate people’s fear. The goal, in a sentence, is to help your public bear its fear, rather than to try to persuade your public not to be afraid. I have worked on a wide range of risks of unknown seriousness, some of which later turned out serious and some of which did not: mad cow disease, Three Mile Island, global warming, silicone breast implants, AIDS. None of the concerns on this list benefited from the pretense that people weren’t afraid, or that they shouldn’t be.

For more on why and how to legitimate people’s fear, see “9. Acknowledge and legitimate people’s fears” in “Anthrax, Bioterrorism, and Risk Communication: Guidelines for Action” (<http://www.psandman.com/col/part2.htm#9>).

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## 2 . Vigilance, Hypervigilance, and Paranoia

Though not strictly speaking an emotion, vigilance is the essence of taking a risk seriously. When we want people to take a risk seriously, we tell them to be vigilant: “Watch out!”

### *Hypervigilance*

When faced with an emergency, or even a possible emergency, some people’s vigilance may escalate into hypervigilance. Watching for danger begins to take precedence over the ordinary activities of life. Though unpleasant, hypervigilance is appropriate when the danger is imminent. And even when hypervigilance isn’t appropriate, it can’t be switched off at will. Instead of trying to “allay” people’s hypervigilance, therefore, the wiser course is to harness it: Tell them what to watch for. When hypervigilance is legitimated and harnessed, not disparaged, it settles back more quickly into routine, tolerable, ordinary vigilance. Of course the level of vigilance may end up higher than it started – which may well be appropriate for the new level of danger.

One useful way to harness hypervigilance about anthrax was teaching people how to

distinguish inhalation anthrax from influenza. This had a medical purpose as well, of course; it's better if people with flu don't rush to the hospital fearing anthrax. But harnessing hypervigilance about anthrax was useful in risk communication terms as well. The fact that anthrax in its early stages is hard to distinguish from flu is part of what makes it so dreaded. If it turned your nose purple, people would know what to look for, and would calmly make periodic nose color checks.

## *Paranoia*

Hypervigilance is not itself a problem. The problem is that hypervigilance is often intertwined with paranoia. This is especially likely when the emergency at hand is intentional, as with terrorism.

One of the most lasting effects of September 11 may turn out to be an emerging American paranoia – a pervasive new awareness that “they” want to kill us. Prior to the 9/11 attacks, most Americans luxuriated in the assumption that we were largely immune to terrorism. Maybe we felt too powerful to attack; maybe we felt too lovable to attack. Mostly we were in denial. On September 11 we learned we were wrong. “They want to kill me. ME! Someone really wants to kill ME!” No data about comparative risk can mitigate this newly discovered truth. It isn't about the odds. It's about the fact.

Any therapist will quickly add that paranoia includes not just a sense that others mean you harm (leading to some mix of fear and injured self-esteem), but also a projection of the suppressed desire to harm them back, or first. This, too, applies to 9/11 and terrorism. Our paranoia is the reality that others want to kill us, plus our projected desire for revenge, our own suppressed homicidal rage toward them. It does no good to accuse people of these feelings, of course; that only pushes them further beneath the surface. But it is helpful to acknowledge them indirectly: “Some people are so scared and angry they can hardly bear it.” The hypervigilance is rational and useful, at least for a while till it relaxes into a sustainable though higher-than-before vigilance. The paranoia isn't rational or useful at all. The only way to disentangle them is to legitimate and harness the hypervigilance. If I am told my hypervigilance is foolish and inappropriate, if I don't have anything to do, anything to watch for, any way to protect myself, then the paranoia can reign supreme.

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## 3 . Empathy, Misery, and Depression

When bad things happen to other people, empathy is a healthy, normal reaction. We imagine what it must have been like for them, what it must be like now for their families, and we feel sad. This isn't just normal; it's functional. Empathy motivates us to help.

The sadness may or may not be augmented by survivor guilt. That, too, is normal. We feel relieved that the accident or the terrorists got them and not us; the relief strikes us as selfish and unworthy; we feel guilty about it; we repress both the relief and the guilt, and they

emerge as increased sadness.

### *Misery*

The bigger the catastrophe that missed us, the more empathy and survivor guilt are likely to escalate. “Sadness” doesn’t capture it any more. “Misery” comes closer. One of the principal reactions to September 11, for example, was a sense of shared misery. This continues to be true. I think some people who say they are frightened are actually more miserable than frightened; so are some people who say they are relatively unaffected. In the months after 9/11, Americans spent more time with their families; ate more comfort foods; experienced an approach/avoidance relationship with the news (afraid to turn it on, afraid not to). Survey research commissioned by the CDC shows that most people think they’re relatively safe from bioterrorism, at least for now, even though they do expect future attacks. In other words, people expect to survive a series of bioterrorist attacks. They expect to have to watch them on television, and they want to stay near their loved ones so they can help each other get through those attacks.

Misery is survivable; we’re surviving it. But it is nonetheless worth addressing. The first step is recognizing, acknowledging, and legitimating it. Many medical professionals find it surprisingly difficult to legitimate misery, grief, or even sadness. In a 1995 speech, Stanford psychiatrist David Spiegel wrote: “I sometimes think doctors are trained to treat crying as if it were bleeding: apply direct pressure until it stops” (the speech is brilliant; you can read it at <http://www.med.stanford.edu/school/Psychiatry/PSTreatLab/speech.html>). The next step is to share the misery, calmly, modeling that it can be borne. When you share our misery, you earn the right to help shape it ... which you cannot do unless you visibly do share it. Finally, provide opportunities for empathic action. It’s not just that we sympathize with the victims and want to help. We empathize with the victims and *need* to help – so we will feel less sad, less guilty, less miserable. Tell us what we can do.

### *Depression*

Misery is by no means as bad as “sad” can get, but it’s the strongest level that is healthy and that most people can come back from on their own – especially if it’s acknowledged, legitimated, and shared, and if there are opportunities to help. Responses more powerful than misery include depression, hopelessness, and post-traumatic stress disorder. These conditions require the intervention of a mental health professional.

Like fear, empathic misery can sometimes flip into denial if it is too powerful to be borne. So along with watching for depressed people, watch for people who seem not to care. Sometimes they don’t. Sometimes they can’t bear to.

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## 4. Anger and Hurt



Fear and empathy are common to all emergencies – accidents and natural disasters as much as terrorism. Anger and hurt, while they may be present in other sorts of emergencies, are especially prominent when the disaster was intentional.

## *Anger*

Anger is of course an entirely appropriate reaction to September 11, and to the threat of future terrorism. It is entirely functional as well. It fuels resolve, vigilance, precaution-taking. And it fuels fighting back. Honorable people can disagree about what sorts of reprisals, preemptive attacks, and the like are appropriate American responses to terrorism. Not every action motivated by anger is appropriate. But surely the anger itself is appropriate.

When anger escalates into rage, it is less functional. Rage can fuel seriously inappropriate actions, including “striking back” at innocents. Rage can also be incapacitating. Many Americans are enraged at terrorists right now. They need permission to feel the anger, and they need socially acceptable ways to channel and express the anger. The best way to defuse rage is to legitimate its more moderate, controllable cousin, anger.

Notice that one of the inappropriate directions in which anger may spill is in your direction. Expect that people who are enraged at the perpetrators of terrorism may deflect their rage into anger at you for letting it happen or mishandling it. (Of course there may also be justified anger at you.) The same is true in the other direction: Your stifled rage at the terrorists may get projected onto your publics, your stakeholders, your partners, or your boss.

Like any emotion, anger that is unbearable can be repressed or denied. There is a link here back to fear, hypervigilance, and especially paranoia. Repressed anger is often at the root of paranoia. People who feel more endangered than the facts justify may be more angry/murderous than they dare to realize.

## *Hurt*

Injured self-esteem – that is, hurt – was greatly underestimated as an emotional response to the September 11 attacks. It was most clearly visible in the bewildered question: “Why do they hate us?” This is of course an appropriate question to ask. But many of those asking it in the days after 9/11 didn’t want to hear the answers. They just wanted to express their hurt feelings.

Perhaps more than anything else, this may be what separates the United States from the rest of the world. Most of the world’s populations take it as a given that they have enemies, that their values and interests are in opposition to the values and interests of others. In the United States, by contrast, we tend to assume that our values and interests *are* – or at least should be – the world’s values and interests. It’s not mostly that we feel (or felt) too powerful to be attacked. We feel (or felt) too good to be attacked. Among other things, this explains why “jealousy” and “evil” are our favorite explanations for anti-Americanism; they preserve our sense of goodness. Hurt feelings are a common response to all intentional harm, not just to

terrorism. I see it often in my corporate clients' reactions to activist attacks, even to activist criticisms. The relationship between hurt and anger is extremely complex. Some people (most of them men) are profoundly uncomfortable feeling hurt – injured, victimized. These seem like unacceptably weak emotions, and so we deny them ... and they emerge as anger. Other people (most of them women) feel uncomfortable with anger, and convert it into hurt. Like anger and other emotions that are strong and potentially unacceptable, hurt needs to be acknowledged and legitimated, so that it won't turn into denial.

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## 5. Guilt

Guilt, like hurt, is a form of injured self-esteem. The September 11 attacks may have provoked terrorism-specific sorts of guilt – guilt that we Americans know so little about the Muslim world, perhaps, or guilt that we have it so good. But guilt is part of the emotional experience of every emergency. Consider these three sources of guilt:

- Caretaker guilt. I can't protect my children, my family, my community. I feel powerless to prevent or alleviate this emergency. Among those most vulnerable to caretaker guilt are emergency managers themselves. But we all feel it.
- Survivor guilt. We discussed this earlier as a potential contributor to misery. Relief that I have been spared generates guilt that I am so selfish; then both may be denied, and show up as increased sadness.
- Routine guilt. It's an emergency, and here I am still worrying about everyday things: my job, my bills, my chores. What's wrong with me! People who are taking the emergency in stride, experiencing less fear or empathy than their neighbors, are bound to feel guilty ... unless of course their guilt is in denial.

Helping people cope with guilt is tricky. You can't just acknowledge and legitimate the guilty feelings, because that amounts to accusing people of what they feel guilty about. "You feel guilty that you couldn't protect your children" sounds like "You failed to protect your children!" "You feel guilty because it seems selfish to you to be relieved" gets translated into "You're selfish!" This only worsens the guilt and thus increases the likelihood of denial. So you have to be indirect. "Sometimes people feel guilty about surviving when others died" is better than "You feel...." or even "It's okay to feel...."

Rather than legitimating the guilt itself, try legitimating the feeling that is provoking the guilt. A midwestern state conference on community health that I attended recently was opened by a county commissioner who is also a florist. He talked about all the weddings he had scheduled for the days after September 11, 2001. Air shipment of flowers was disrupted, and his customers were worried about the flowers for their weddings ... and felt terribly guilty about such ordinary concerns in the face of other people's tragedies. (This is survivor guilt and routine guilt combined.) It wasn't enough to assure his customers that he'd manage to get them flowers. He had to assure them that they were perfectly right to want their weddings to

be beautiful, terrorism or no terrorism. Only then could they acknowledge that they felt guilty, and feel less guilty.

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## 6 . Resilience

Fear, vigilance, empathy, anger, hurt, guilt – these are all normal responses to emergencies of various sorts. Even the more extreme versions of some of these responses – denial, hypervigilance, misery, etc. – are normal as well.

More importantly, they are bearable. And in time they pass.

Perhaps the most vital thing to do about all of these emotions is to expect the public to bear them and get beyond them – perhaps not immediately, perhaps not easily, but to do it. Resilience is also a normal response to an emergency. Call it “post-traumatic growth.”

Sadly, there will be those who cannot bear their emotional responses to the emergency, and who cannot recover without professional help. But notice who these people usually are. Those who experience intense emotion will generally do fine, especially if you’re actively legitimating and channeling the emotion. It is those who are feeling little or nothing, who are denying what they’re feeling, that have the worst prognosis.

Psychiatrist Elvin Semrad wrote that the goal of psychotherapy is to help the patient “acknowledge, bear, and put into perspective” whatever is causing the patient’s pain. Emergency managers and emergency communicators are not psychotherapists. But Semrad’s goal is our goal. People cannot put the emergency and how it makes them feel into perspective until they have borne it; they cannot bear it until they have acknowledged it. That’s why it is so important to accept the public’s emotional responses as appropriate, bearable, and temporary – to encourage those responses and not to suppress them.

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## 7 . You Too

My clients like the thought that their stakeholders’ risk responses are distorted by outrage, fear, denial, misery, whatever. But they prefer to imagine that their own responses are purely science-based.

It would be very surprising indeed if this were the case. My typical corporate clients are understandably outraged at the activists who are attacking their competence and integrity, and undermining their profits – and at the public that gives the activists more credence than my clients believe is deserved. The parallelism here is perfect. The public is too outraged at the

company to respond rationally to the data that the hazard is low, even when it is. The company is too outraged at the activists and the public to respond rationally to the data that they are unwittingly exacerbating the public's outrage.

It's a little different for a public health expert or a scientist in a health emergency ... but only a little. Odds are you have no profit to protect, and people aren't questioning your competence and integrity with anything like the vigor with which, say, a corporate polluter is attacked. You're the good guys. But you're so used to being the good guys that even a mild rebuke stings ... and provokes outrage. That outrage is typically denied, suppressed as unprofessional. But unacknowledged and unattended to, it can motivate a lot of inept risk communication: impatience, defensiveness, passive aggression, lack of empathy, etc.

Nor is outrage at your critics likely to be your only strong emotional reaction to the emergency. You are likely to feel – or deny – several strong emotions about the emergency itself. You may be frightened, even panicked; you may be vigilant or hypervigilant; you may be miserable or depressed; you may feel angry, hurt, or guilty.

Technical people, in my experience, tend to be profoundly uncomfortable with emotion and human complexity; that's partly why they become technical people. It's worse for engineers – my most common clients – but health professionals are by no means immune. I think most technical people have a deep commitment to keeping emotion from influencing their work. This is, paradoxically, an emotional commitment. And it gets worse, of course, in the stress and high emotion of an emergency.

In every emergency, therefore, your organization faces two painful emotional tasks: To notice and cope with the emotions your public is feeling (or denying), and to notice and cope with the emotions your organization is feeling (or denying). And if you are a health communication specialist, you have three levels of emotional arousal (and emotional denial) to manage: the public's, your scientists', and your own. It won't be easy, but it is part of the job. It may feel unbearable, but you can bear it.