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CREATING A NEW TYPOLOGY WITHIN THE CRISIS COMMUNICATION FIELD

A Master's Thesis presented to the Faculty of the

Graduate Program in Communications

Ithaca College

In partial fulfillment of the requirements for the degree

Master of Science

Alexis Rosamilia

December 2013

Roy H. Park School of Communications
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CERTIFICATE OF APPROVAL

MASTER OF SCIENCE IN COMMUNICATIONS

This is to certify that the Thesis of

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submitted in partial fulfillment of the requirements for the
degree Master of Science in the Roy H. Park School of Communications
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Abstract

This thesis examines the Australian DJ royal hoax case that provides evidence for the creation of a new typology in the crisis communication field. Three theories -- Worlds Theory, Attribution Theory, and Situational Crisis Communication Theory -- provide the framework for the analysis of the case. In addition to the theories, psychological components are integrated in the development of the psychological-shift typology to analyze a crisis that results from a suicidal death. Using a naturalistic methodology approach, this thesis concludes with the examination of themes and gaps relevant for each organization involved in the crisis.

Key Words: typology, crisis communication, suicide, psychology, crisis management.

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Creating a New Typology within the Crisis Communication Field

This thesis focuses on two Australian deejays (DJs), Michael Christian and Mel Greig, who were involved in a radio stunt that ended with the tragic suicide of Jacintha Saldanha, a nurse who worked at King Edward Hospital in the United Kingdom. The two DJs along with the parent company, Southern Cross Austereo Radio Network, received negative backlash from multiple citizens in Britain and Australia.

This case is unique because the type of crisis shifts once the death of Saldanha is discovered. The crisis is initially treated as a breach of confidentiality. The focus of the crisis emphasizes the patient confidentiality breach of Kate Middleton's medical condition. After Saldanha's suicide, the crisis shifts into something else. It deals with not only a death, but a death that occurs due to a suicide, which is believed to be linked with the hoax phone call. Although there is no sign of physical malevolence, the perception of the hoax is that two DJs play a role in a woman's death.

Rationale

Researchers working in the crisis communication field theorize several different typologies of crises. Typologies range from natural disaster, employee misconduct, technical error, human error, malevolence, to death and injury. Many of the typologies listed imply death and injury to be the result of certain actions. The typologies in existence focus on death as a result of malevolence and/or natural disaster. However, there is no typology that focuses on death as a result of suicide. Suicidal death is different from death caused by malevolence as it occurs from an individual's decision to end his/her own life. Suicidal death includes interpersonal impacts that differ from deaths that occur from malevolence and/or natural disaster. While individuals may place blame on a natural disaster, and/or a violent individual as a result of

mass loss of life, suicide deaths are tricky as the blame can only be placed on the individual who has committed suicide, whom is also seen as the victim. This, in turn, clashes with individuals' mental process in placing blame on a victim; it does not make sense, therefore individuals look for an outside agent, something that may have lead up to the suicide.

Typologies are useful in studying crisis communication as they offer practitioners and researchers an initial approach to handling and researching crises. Creating an additional typology that addresses suicide as a crisis for an organization would benefit practitioners and researchers in the crisis communication field. A new typology would synthesize interpersonal and organizational aspects of crises that are often separate when dealing with crises. Zaremba (2010) includes a typology known as employee/management misconduct, in which an employee creates a crisis because he/she deviates from standard operating procedures. At a first glance, it seems that this typology may be the best fit for the case studied throughout this thesis. However, at a closer glance, it does not make logical sense to place this case within this category as the two individuals described in the case do not deviate from standard operation procedures for DJs.

After extensive research into the crisis communication field and the psychology field, it has come to attention that there is a typology missing. A creation of an additional typology would help to assist researchers to understand a unique event that does not frequently occur in the crisis field. Suicide that results from an organizational crisis is rarely studied in the field; creating its own typology would assist organizations in understanding how to define and manage the crisis.

The additional crisis typology would integrate the theories of conventional organizational crises and theories associated with psychology that focus on interpersonal crises. With the integration of these two categories, another typology will emerge which will be known as the

psychological-shift typology. Within this typology, crisis communication theories along with psychological components will be integrated with the concept of blame. As of now, suicide does not fit neatly into any typology. It is often overlooked from the organizational perspective because it is often seen as an individual, interpersonal crisis. In order to close the gap between the organizational perspective and interpersonal perspective there is a need for the creation of an additional typology that stems from psychological ideas and theories.

This typology will add additional insight into how and why audience members (key publics) perceive unique events such as suicide because of an organization's actions. This thesis will address the following questions:

1. What are the theories that support the psychological typology?
2. What are the key psychological and blame components that will aid in the creation of the psychological crisis typology?
3. How can we better understand this typology through studying a specific case?
4. What are key distinctions that make the psychological typology different from other typologies frequently studied in the crisis field?
5. How can this typology be used by practitioners and/or scholars to help further understand the psychological components of a crisis?

General Case Description

Michael Christian and Mel Greig were two deejays (DJs) employed by Southern Cross Austereo (SCA), who hosted the radio show, Hot 30 Countdown, on 2Day FM in Sydney, Australia (CNN Staff, 2013). Once it was discovered that Kate Middleton had been hospitalized due to severe morning sickness, Christian and Greig devised a plan (the hoax) to talk to her while she was in the hospital. Radio hoaxes are a normal practice of radio DJs, and are perceived to be harmless fun.

On Tuesday, December 4th, 2012, Australian DJs, Michael Christian and Mel Greig, phoned London's King Edward VII Hospital Sister Agnes pretending to be the Queen and Prince of Wales (Jones, 2012). Due to the time difference, the phone call was received in London at 5:30 am, December 3rd, 2012. Kate Middleton had been staying at the hospital due to severe morning sickness. The nurse, Jacintha Saldanha, operating the switchboards that morning patched through the phone call to the nurse taking care of Kate Middleton (Smith-Spark, 2012). Under the impression that the nurse was speaking to the Queen and Prince of Wales, she disclosed Kate's conditions and medical updates (Jones, 2012; Smith-Spark, 2012).

All conversations that took place between the Australian DJs and nurses were recorded. Prior to the broadcast of the hoax, lawyers working within Southern Cross Austereo, and the owners of 2Day FM, concluded that the phone call did not seem to violate any type of rule, regulation, or code (Gelineau, 2012). However, it was unclear who had the overall decision to air the hoax call; it was thought to be a mix between the lawyers, higher-ups, and the DJs involved in the prank (Gelineau, 2012).

Once cleared, the hoax call was aired on Hot 30 Countdown, shortly after, sparking a dispute between Southern Cross Austereo/2Day FM and King Edward Hospital VII Sister

Agnes. John Lofthouse, Chief Executive of King Edward Hospital, deemed the prank as a breach in patient confidentiality and labeled it as “journalistic trickery” (Breaking News.ie, 2012; Jones, 2012). Once it appeared that the royal hoax broke some privacy codes and ethics, the DJs apologized for any discomfort they caused the royal family, especially Kate Middleton (Smith-Spark, 2012). The radio station, 2Day FM, also issued an apology that explained the overall light-heartedness of the hoax and wished the royal family all the best (Smith-Spark, 2012).

On December 7, 2012, three days after the hoax call was made, Jacintha Saldanha, was found dead in her living quarters (Deutsche Presse-Agentur, 2012). Christian and Greig were pulled off air and their show temporarily suspended (CNN Staff, 2013). Due to the negative backlash all parties in Australia received, Christian and Greig shut down their twitter accounts after being bombarded with abusive comments (Tedmanson, 2012). Southern Cross Austereo received death threats directed towards its staff members including Australian DJs, Christian and Greig (Australian Broadcasting Corporation, 2012). Due to these threats, Southern Cross moved its staff to secure accommodations for their own safety.

This case involved two primary organizations, Southern Cross Austereo and King Edward Hospital VII Sister Agnes. Within these organizations, the individuals directly affected by the hoax are Australian DJs, Christian and Greig, and King Edward Hospital’s nurse, Jacintha Saldanha and her family. The royal family is a secondary party involved within the hoax, however, much of the case focused on themes of privacy breach and suicidal death. Prior to the discovery that Saldanha committed suicide, the main concern for both parties were the legalities behind breaching the privacy of a hospital patient. Once it was discovered that Saldanha had committed suicide in connection to the hoax call, the crisis quickly shifted gears. To further understand how a new typology may assist in examining this specific type of crisis, each

organization and party involved within the hoax are detailed and described in the sections to follow. This includes the series of events and steps taken by each party in dealing with the crisis.

Organizations Involved

Southern Cross Austereo

Past Incidents: Prodromes

Southern Cross Austereo is the parent company of 2Day FM, the station that broadcasts the show, Hot30 Countdown, which aired the royal hoax. According to Duell, Tomlinson, and English (2012) 2Day FM has been serving two five-year license probations after serious breaches of codes and policies. The radio station itself does not seem to have a good reputation, as two separate incidents have resulted in probation. The first incident took place in 2009 when a fourteen year old girl was hooked up to a lie detector and acknowledged that she had been raped when she was twelve (Duell, Tomlinson, & English, 2012; Lister, 2012) . The Australian Communications and Media Authority (ACMA) censured the station due to lack of decency (Lister, 2012). The second incident took place in November of 2011 and occurred when Kyle Sandilands verbally assaulted a female journalist after she criticized his work (Duell, Tomlinson, & Reilly, 2012). Kyle Sandilands is the same DJ who was also involved in the rape incident, along with co-host Jackie O. In addition to these two incidents, the producer for Kyle and Jackie O's show was fired after posting jokes on Twitter regarding the Batman movie massacre in Denver, Colorado (Tedmanson, 2012).

Current Crisis – Pre-Death of Saldanha

Unlike previous incidents, 2Day FM found itself in an international crisis involving a suicidal death. The hoax was pre-recorded and examined by lawyers before broadcasted to listeners in the Sydney area (Breaking News.ie, 2012). Once the hoax aired, questions of ethics

began to rise. Following these ethical thoughts and questions, the radio station posted an apology for the call through Twitter one day after the hoax aired (Smith-Spark, 2012). It was not clear whether or not 2Day FM directly and personally apologized to King Edward Hospital, but John Lofthouse, chief executive of King Edward Hospital, acknowledged that the radio station had apologized for the hoax (Breaking News.ie, 2012).

Christian and Greig also apologized for the hoax and wished the best to Kate and the royal family. In their apology, Christian and Greig emphasized that they were surprised their call made it that far and were surprised that they had not been immediately hung up on (Jones, 2012). During these couple of days, the hoax still aired on the website and was available on YouTube (Lister, 2012). According to Jones (2012) Christian and Greig were pleased and excited that they had made international headlines.

Current Crisis – After Death of Saldanha

Up until Friday, December 7, 2012 the incident seemed controlled. Once news broke that Jacintha Saldanha, the nurse who patched through the phone call to the nurse caring for Kate Middleton, had committed suicide, the incident quickly escalated into a different type of crisis. The radio station immediately pulled Christian and Greig from the air and issued a statement that said the DJs would not return to the show until further notice due to the death of Saldanha. Their show, the Hot30 Countdown, was temporarily suspended and eventually taken off the air (CNN Staff, 2013). Southern Cross Austereo and 2Day FM made statements about the DJs being very shocked and that Christian and Greig would currently not comment about the circumstances (Deutsche Presse-Agentur, 2012). Following the initial news break of Saldanha's death, the CEO of Southern Cross Austereo, Rhys Holleran, made a public statement on behalf of the DJs and the crisis. He stated that this was not an event that could have been foreseen and the entire

organization was deeply saddened by what had occurred (Lister, 2012). Even with this immediate damage control, it took the radio station almost one hour to remove the advertisements for the hoax on the 2Day FM website. The organization was still advertising the hoax on its website up to an hour after the death of Saldanha was released (Tedmanson, 2012).

Following the news of the death, questions were raised as to whether the hoax had broken any legal laws. Although the organization claimed that the hoax was examined and deemed legal by its lawyers, there were refutes about the possibility of breaking broadcasting codes. According to Stevenson (2012) the broadcasted hoax went against commercial radio conduct of code six. This code stated that permission must be granted from all parties involved in a hoax prior to the broadcast of such conversations (Stevenson, 2012). In a defense to save face, Southern Cross Austereo and 2Day FM claimed that it made three attempts to contact King Edward Hospital prior to the broadcast (Gelineau, 2012). However, King Edward Hospital's management staff denied these claims; they stated that they had never received any sort of contact from the radio station (Gelineau, 2012). The actions that 2Day FM took prior to the broadcast of the hoax were thought to be signals that the organization understood the magnitude of the hoax.

Financial Impact

After news of the suicide, Southern Cross Austereo stopped running ads for 2Day FM and pulled advertising from all sponsors due to negative response from the public (Gelineau, 2012). Southern Cross Austereo also took a financial hit when it had to relocate a vast amount of staff to secured accommodations due to death threats made against the organization. It was estimated that relocation cost the company 75,000 AUD a week (AAP Newsfeed, 2012). In addition to funding secured accommodations for staff members, Southern Cross Austereo also

donated 500,000 AUD to a memorial that would help aid Saldanha's family during their time of grief (Gelineau, 2012).

Interpersonal Impact – DJ's

Shortly after the death of Saldanha, Greig and Christian shut down their twitter accounts due to the vast amount of threats and negative responses posted to their accounts. Such responses included, "Do the moronic callers still find themselves humorous?"; "I hope they're proud of themselves." and "Humanity, we have reached another low." (Lister, 2012; Tedmanson, 2012). Death threats were also sent to Southern Cross Austereo that specifically named Christian as the target (AAP Newsfeed, 2012). Even with the vast amount of negative backlash received by the DJs, there were several statements made online that supported the DJs and asked other individuals to not blame them for the death of Saldanha (New Zealand Herald, 2012). Such responses included, "there was no malice, no intent to harm, simply a prank call which at the time seemed pretty funny. No one could have predicted this type of tragic overreaction on the nurse's part," (New Zealand Herald, 2012) and "the two deejays are not responsible for the actions of an unbalanced woman" (Lister, 2012). However, even with the few supportive comments, it became clear that the two DJs were blamed for the suicidal death of Jacintha Saldanha.

Following Saldanha's death, Hill, Panther, and Dorman (2012) reported that the DJs were on suicide watch. Southern Cross Austereo reported that both DJs received medical assistance after their bosses raised concern over their physical and emotional well-being (Hill, Panther, & Dorman, 2012). The New Zealand Herald (2012) also reported that the DJs were undergoing intensive psychological counseling and were said to be in a fragile state of mind.

A couple of days following the death of Saldanha, Christian and Greig made an appearance on two different Australian TV shows. They were interviewed on “Today Tonight” and “A Current Affair” in which they spoke of their feelings and apologized for the tragedy that had ensued from the royal hoax (CNN Staff, 2013). In the videos, both DJs were visibly upset, their cheeks wet with tears and their eyes swollen from crying. In one statement from the interview Greig stated that “we [Christian and Greig] are people too... I am still trying to make sense of it all” (Johnson, 2013, para. 19).

Interpersonal Impact -- Current Status of DJs

Recently, it was reported that Christian had made it back on to the air, hosting the ten to noon shift on FoxFM (AAP Newsfeed, 2013). Although FoxFM left him nameless, Southern Cross Austereo was aware that he had made it back on to the air and released a statement that emphasized its happiness to see that Christian had returned back to radio and wished him all the best (AAP Newsfeed, 2013). After returning to the airwaves, Christian was awarded the “top jock” award (Leo, 2013). On the other hand, Greig was still off the air and was in the midst of filing a lawsuit against Southern Cross Austereo. Greig and her lawyers have filed paperwork with the fair work commission against Southern Cross Austereo for “failing to maintain a safe workplace” (Leo, 2013, para. 2).

King Edward VII Hospital Sister Agnes

Background

King Edward VII Hospital Sister Agnes has been the hospital of choice for the royal family in London. The royals have been clients of the hospital for many years according to the Queen’s former press secretary (Duell, Tomlinson, & English, 2012). Kate Middleton, the Duchess of Cambridge, had been staying at the hospital due to severe morning sickness that

accompanied her pregnancy. The hospital has not been the target of past hoax phone calls, however; the royal family has been. In 1995, a Canadian DJ was patched through to the Queen where he pretended to be the Canadian prime minister and had a fifteen-minute conversation with the Queen about Canada and London (Duell, Tomlinson, & English, 2012). The current crisis studied in this thesis was a result of two Australian DJs trying to get Kate Middleton on the phone while she was in the hospital.

Current Crisis – Pre-Death of Saldanha

Once the hoax call was broadcasted, it received instant international attention. Chief executive of King Edward Hospital, John Lofthouse, released a statement that addressed patient confidentiality and apologized for the breach in patient confidentiality (Duell, Tomlinson, & English, 2012). He also explained that the nurses employed at the hospital were caring individuals and were not trained to handle such "journalistic trickery" (BreakingNews.ie, 2012; Jones, 2012). Lofthouse explained that the policies and procedures that were put forth in order to prevent such hoaxes from occurring, regrettably, did not work. Lofthouse even received a tip that the broadcasters may have broken the law, but since they apologized, Lofthouse was unsure whether or not King Edward Hospital would press charges or open an investigation (Breaking News.ie, 2012). Initially, King Edward Hospital recognized this type of crisis as a breach of confidentiality and quickly turned to examine the phone protocols in place.

Some individuals placed blame on the hospital for the breach in Kate Middleton's privacy. According to Ken Wharfe, Princess Diana's ex-bodyguard, there were strict protocols to be followed when the royals went anywhere public. He described the process of isolating any switchboards, and giving strict instructions to put calls through to a detective prior to it reaching its final destination. He also emphasized that the royals never, personally, ring into the hospital

and stated that if the hospital staff were aware of these protocols then there would have been no issue (Gregory, 2012). It became clear that the staff working at the hospital might not have been properly informed on the protocols of nursing a high profile patient.

According to Leppard (2012) the telephone line that the DJs called was a public, advertised line. It was standard protocol that anyone who called that line was not to be put directly through to any specific ward. While these protocols were well understood by receptionist staff, it was unclear as to whether these protocols were understood by the nursing staff. Again, it was with this evidence that individuals blamed King Edward Hospital with not properly training its nurse staff to receive phone calls. Even with these protocols being broken, King Edward Hospital made positive statements regarding the two nurses. The hospital was reported to have not threatened job loss or suspension to the two nurses who had been on call that night (Davies, 2012; Deutsche Presse-Agentur, 2012; Leppard, 2012).

Current Crisis – After Death of Saldanha

Prior to the discovery of Saldanha in her living quarters, King Edward Hospital had been facing a crisis that involved a breach of security and privacy for the royal family. Once news emerged that one of the nurses involved in the hoax was found dead from apparent suicide, the hospital needed to shift its crisis strategies. Lofthouse released a sympathetic and thoughtful statement about the loss of Saldanha (Press Association Reporters, 2012). Many individuals who knew Saldanha and/or who worked with her praised her as a kind, and caring woman. King Edward Hospital supported the Saldanha family as the phone protocols went under review (Kirka, 2012).

However, in some reports it was reported that the family did not receive any word from the hospital regarding the hoax call. Even with all the media attention the hoax had received, the

family was unaware that the hoax took place and that it involved Saldanha (Hall, 2012). The family did not know that the prank occurred until the police notified the family that Saldanha had died due to an apparent suicide (Hall, 2012). It was reported that King Edward Hospital had not answered any of the family's questions in the immediate aftermath of the suicide due to its restriction to following certain protocols (Wood, 2013). Eventually a hospital spokesperson did announce that King Edward Hospital had worked with the family, speaking with them and comforting them throughout the aftermath of the suicide, however, it was unclear as to when this actually started (Miranda, 2012).

Interpersonal Impact – The Saldanha Family

Saldanha had been operating the switchboards when she received the hoax call and patched it through to the nurse taking care of Kate Middleton. That was when the nurse caring for Kate, began to discuss Kate's medical condition and her overall physical well-being. Once the hoax aired, Kate and William privately expressed their anger over the intrusion to King Edward Hospital (Leppard, 2012). Sources at the hospital said Saldanha felt "traumatized" when she learned she had been part of a hoax and although the hospital claimed to have supported her through the days that followed, no one seemed to realize how traumatized Saldanha had become (Leppard, 2012). Another colleague said that following the hoax call, hospital management offered her support, and considered her the victim of the hoax. The hospital management stood by her actions and in turn, made sure there were no disciplinary actions taken against her (Davies, 2012).

Saldanha's family had not been in contact with Saldanha in the aftermath of the hoax. Saldanha lived away from her family while she worked at King Edward Hospital and would return weekly to visit with her family whom lived in Bristol (Miranda, 2012). The family had

been upset in the wake of her death. The family claimed that they had not received any news from the hospital regarding the hoax or about her death. They found out about the death from local police who informed them of the suicide (Hall, 2012). The family was said to be distraught, with the daughter posting a memorial picture of her mother on Facebook and writing about how much she missed and loved her (Singh & Smith-Spark, 2012). Keith Vaz, spokesperson for the Saldanha family, made a statement that the family wanted questions answered, and they sought to know all the facts from King Edward Hospital (Hall, 2012).

In the few reports that combated the claims that the DJs were not to be blamed for the suicidal death of Saldanha focused on the facts of suicide. Catherine Johnstone, Chief Executive of the Samaritans, a UK group that helps individuals deal with suicide, stated that although there seemed to be a tipping point, suicide is never the result of a single incident (Lister, 2012). This plagues the question as to whether or not Saldanha had previous suicide attempts in the past. Many journalists and other media personnel portrayed her as a gentle, caring woman with no mention of any past suicide attempts or mental disorders. However, there are a couple of reports that speak of Saldanha's previous suicide attempts. The first occurred in December 2011, when Saldanha visited her family in India. The second attempt was thought to be nine months later after she reportedly "fell" from a building (Johnson, 2012; Ortiz, 2012). Inconclusive reports stated that Saldanha was thought to have a depressive disorder that stemmed from stress (Ortiz, 2012).

Literature Review

Crisis management is best understood by considering the type of crisis and the certain steps taken in order to effectively control the crisis. The type of crisis may also determine how key publics react to a specific crisis and the crisis communication strategies that an organization must engage in. However, there is little research that focuses on a crisis that is a result of a third party suicide. There is no typology that specifically addresses this matter; therefore, this type of crisis has not been sufficiently studied in the crisis communication field. A creation of an additional typology will not only allow for a better understanding of this type of crisis but also address how key publics place blame during a crisis.

Crisis Communication

What is a Crisis?

A crisis may be defined as an "anomalous event that may negatively affect an organization and requires efficient organizational communication to reduce the damage related to the event" (Zaremba, 2010, p. 21). All crises are considered anomalies because they violate the expectations of stakeholders (Coombs, 2010). All organizations are vulnerable to a crisis because certain external factors can often not be controlled (Ray, 1999). A crisis occurs not because of these external factors but because of the perception the key publics have of the occurrence. If stakeholders and other key publics deem the event that has affected an organization a crisis, then the organization is in crisis (Coombs, 2007; Coombs, 2010; Fearn-Banks, 2011). The key to an organization's success is the support of its stakeholders. Without this support during a crisis, the organization will not effectively recover (Massey, 2004).

What is Crisis Communication?

Crisis communication, crisis management, and risk communication are similar concepts that are often used interchangeably with one another. This thesis solely focuses on crisis communication, which is defined as an element of crisis management; it shapes the messages and story that is told to internal and external publics (Henry, 2000). Crisis communication includes communication processes that are meant to address those that are affected by a crisis in terms of how they will be assisted, accommodated, and ultimately recovered from such a crisis (Millar & Heath, 2004). Due to this expectation that organizations will correct its wrong doings, there is an increased need from publics for organizations to be able to communicate effectively during a crisis (Malone & Coombs, 2009).

The messages and direction of crisis communication practitioners directly relates to the type of crisis in defining the most effective strategies in dealing with a particular crisis (Sellnow & Seeger, 2013). According to Bell (2010), crisis communication has shifted toward identifying specific characteristics of a crisis in order to analyze effective response strategies. This further suggests that typologies are important in understanding effective crisis response strategies. The creation of an additional crisis typology will generate new ideas and explore psychological components that have not been previously studied in the crisis communication field.

Types of Crises

Several researchers have compiled general lists of the various types of crises that likely occur internally and/or externally of organizations. According to Zaremba (2010) there are ten types of crises: natural disaster, management/employee misconduct, product tampering, mega damage, rumor, technical breakdown/accident, technical breakdown/not entirely accidental, challenge, human error, and workplace violence. Sellnow and Seeger (2013) compile additional typologies based off of Lerbinger (1997), Seeger, Sellnow, and Ulmer (2003), and Coombs

(2010), including: natural disaster, technological crises, confrontation, malevolence, organizational misdeeds, economic crisis, terrorist attack, public perception, human breakdowns, megadamage, man-made disasters, transportation disasters, and rumors. Fearn-Banks (2011) lists typologies similar to the ones mentioned above with the addition of a death and injury typology.

Each typology is unique, in that it categorizes and defines what type of crisis an organization may be dealing with. However, suicide does not fit neatly into any of the categories. At first glance, suicide may seem to fit neatly into the typology of employee misconduct; however, categorizing suicide into employee misconduct seems inappropriate. Suicide is a result of an individual's inability to deal with his/her everyday life, overall hindering his/her well-being (Thompson, 2012). With this in mind, a crisis of suicide may not fit neatly into any type of crisis previously studied. There is a possibility to fit suicide within the death and injury type, however, Fearn-Banks (2011) analyzes death and injury as a result of physical acts of harm resulting in mass loss of life and injury. Death and injury crises have not been analyzed from a suicide perspective.

Employee misconduct, death, and injury are the closest types of crises that may add to the understanding of the current case. However, even with the understanding of these two types of crises, there are additions that need to be made to these typologies. Employee misconduct and death/injury are two types used as a base for the creation of an additional typology in understanding a crisis that results from a suicide.

Employee Misconduct

Employee misconduct refers to individuals of an organization that have either intentionally or unintentionally caused harm to internal or external publics by means of deviating from normal organizational practices (Zaremba, 2010). Employee misconduct is often studied

from an ethical point of view. Meaning, that employee misconduct is defined by the organization as an individual who takes unethical action against the organization (Dravesky, 2004). For example, founders accused of employee misconduct resigned after accusations that they were stealing money from Adelphi University for the use of personal items (Dravesky, 2004).

Zaremba (2010) suggests that normalized deviance often occurs within organizations. This term states that individuals of an organization have observed something that he/she believe is wrong but have observed it so often that this occurrence becomes normal. It is only until the normalized deviance has a negative outcome that it is perceived as negligent. In relation to this thesis, a routine event, although considered deviant, has gone array and causes the event to result in negative implications that gives rise to a crisis.

A suicide crisis has not been studied as a result of a normalized deviance. This idea is integrated with other psychological components to create an additional typology to effectively study a type of crisis not often studied within the crisis communication field.

Death and Injury

The death and injury typology is usually understood by studying crisis that involves mass loss of life and/or mass personal injury. Fearn-Banks (2011) studies this typology by analyzing the Columbine shootings and a metro transit crisis. Both of these crises are a result of individuals causing physical harm onto others that result in a mass loss of life and/or mass personal injury.

Death and injury are usually implied results of a variety of different typologies (Sellnow & Seeger, 2013), making it one of the most studied typologies in the crisis communication field. Death and injury crises have specific guidelines for disseminating such information, as well as

specific guidelines in maintaining a positive message that addresses the victims and the community as a whole (Hayes, Hendrix, & Kumar, 2013). Although useful in understanding crises that involve mass loss of life and mass personal injury, this typology does not address suicidal deaths.

Threat to Legitimacy

Any one of these types of crises may be a threat to an organization's legitimacy. Legitimacy is defined as "the stakeholder perception that an organization is good and has a right to continue operations" (Massy, 2004, p. 233). Legitimacy is the perceived image of the organization by its key publics. This legitimacy is threatened when key publics perceive that the organization's actions have been deemed irresponsible or problematic (Massy, 2004). After all, legitimacy is a "function of perception;" therefore, legitimacy can become easily damaged during a crisis (Zaremba, 2010, p. 32).

Foxconn is a corporation that manufactures parts for Apple, Inc. Foxconn experienced a great threat to its legitimacy after nine separate incidents of work related suicides occurred in its factory in China (Bush, 2010). Due to the large amount of suicide related deaths occurring within the organization, the factory was termed the "suicide factory" (Bush, 2010). This type of threat to legitimacy is essentially damaging because organizations may struggle with telling its story of how and why the suicides occurred. There is a need to understand the psychology behind suicide as well as how key publics perceived the incidents.

An Argument for a New Typology

The creation of a new typology is important in understanding and analyzing crises that occur because of suicide, especially when the suicide is thought to be the result of another individual's actions. Suicide, in and of itself, is an event that differs from the usual mass loss of

death/injury studied by crisis communication practitioners and researchers. The type of death usually studied by crisis communication researchers is a result of accidents, malfunctions, and/or violence. The act of suicide has prompted many researchers to study how media should portray the act as to not influence further acts of suicide (Norman, 2007; Pirkis, Blood, Skehan, & Dare, 2010; Skehan, Burns, & Hazell, 2009; Ziesenis, 1991). Although this idea is explored in the psychology filed, crisis communication researchers and practitioners have yet to explore the concept of suicide and how its negative implications effect an organization.

A new typology would allow practitioners and researchers the ability to understand the psychology behind suicide and how it may impact an organization as well as specific individuals of the organization. Three theories are utilized in the creation of the new typology: Worlds Theory, Attribution Theory, and Situational Crisis Communication Theory.

Theoretical Framework

The understanding of psychology as a perspective for studying crisis communication is essential in that it helps understand the interpersonal and organizational aspects of a crisis. Many times when a crisis occurs, practitioners set forth specific strategies that would best resolve the crisis dependent on the crisis typology. However, the uniqueness of the current case is that the initial crisis evolves into a crisis involving death due to the lack of preparation in understanding interpersonal needs of employees.

The following framework has integrated three theories, Worlds Theory, Attribution Theory, and Situational Crisis Communication Theory. In addition to these theories, psychological components and ideas have also been integrated within the framework. These ideas and theories will help to serve as a base for understanding the management of a crisis involving suicide as a result of possible negligence to interpersonal needs.

Within each theory, there are assumptions and variables that help to define the scope in which this thesis focuses. All of the variables are synthesized from each theory to create a framework that addresses both the interpersonal and organizational side of crises.

Worlds Theory

Worlds Theory, created by Bunford and Bergner, suggests that a person's world is measured in totality (Bunford & Bergner, 2012). This means an individual's world is captured through his/her eyes only, and is captured as a whole, not merely slices of occurrences; every single person has a different perception of his/her world. There are no classifications or types of worlds; there is only one unique world, specific to each human being. Individuals, such as clinicians, psychologists, and psychiatrists, are often tasked at capturing the relevant and critical parts of a person's world; they are responsible for studying separate incidents as opposed to the entire world (Bunford & Bergner, 2012). These individuals are personally involved within the lives of their patients, and therefore, can be sensitive to how an individual may react when put in a stressful situation. In terms of this thesis, there was no medical doctor personally involved within Saldanha's life, only the hospital management staff. Therefore, no one could have foreseen her sensitivity to the hoax.

Bunford and Bergner (2012) suggest that those who attempt and/or complete suicide create 'impossible' worlds. They see his/herself as irrelevant and as a heavy burden to his/her loved ones. As soon as the world is deemed no longer viable, the individual living in that world has nothing left to live for. Individuals with a sense of burdensome and distress within their interpersonal relationships are much more likely to feel as if their world is no longer viable (Wilson, Kowal, McWilliams, Henderson, & Peloquin, 2013). This theoretical reasoning explains why individuals commit suicide.

This theory serves as a basis for understanding the interpersonal side associated with a suicide. It also serves to assist in understanding the mentality of those who attempt and/or commit suicide. Aldrich and Cerel (2009) suggest that there is a link between behaviors of interest and expected outcomes. Individuals who intend to engage in certain behaviors base that decision on his/her own world and perception of that behavior. It is theorized that an individual who can imagine a more viable and worthy world would be less likely to experience ideations of suicide (Bunford & Bergner, 2012). Overall, people die by suicide because they can and want to (Aldrich & Cerel, 2009).

Assumptions

We can make one big assumption with the use of this theory. Individuals who die by suicide deem his/her world as impossible and/or unviable. Individuals who deem his/her world as 'impossible,' are not necessarily perceived as suicidal by other individuals (whom are not mental health physicians) because those individuals lack the ability to study a piece of the suicidal individual's world. Therefore, we can assume that, unless the suicidal individual has sought help from a mental health physician, then friends, family, employers, and/or colleagues would not be able to make a rational judgment about the suicide risk of the suicidal individual. However, this theory does not provide us with the cause for why individuals feel this sense of dread.

Using this theory we can also assume that suicide is strictly an act of escaping the impossible world and previous depressive symptoms and/or aggravating agents are not involved. This theory is strictly used in providing a theoretical idea into why individuals commit suicide but not so much as to the reasoning behind such acts. However, research on suicide has shown that many cases are a result of psychiatric disorders, usually prevalent within one month of the

victims' suicidal attempt and/or death (Paraschakis et al. 2012). Since Worlds Theory is used as a theoretical approach to understanding why individuals commit suicide, we cannot assume that other psychiatric disorders are involved as there is no evidence for this claim within Worlds Theory.

Variables

Suicide and interpersonal relationships are two important variables of this theory that are used in understanding the application of this theory to this thesis. Suicide is defined as the ability of an individual to escape his/her impossible world by taking his/her own life. Interpersonal relationships intertwine with the suicide variable as clinicians, psychiatrists, and psychologists are tasked with determining a piece of the world that the patient sees as impossible. The interpersonal relationship between patient and clinician determines the ability of the clinician to assess the severity of the patient's impossible world. However, this leads to the assumption that since no one can actually see another individual's world in totality, that preventing thoughts of an impossible world would be hard, if not impossible.

Within interpersonal relationships there is a degree of openness and understanding between two individuals. There is also a rate at which individuals disclose personal information with one another. If an individual deems their world as impossible and is at greater risk for suicide, then this information would only be known if it is explicitly disclosed between members of the interpersonal relationship. However, even if the information is not explicitly disclosed, members of the interpersonal relationship (depending on the strength) may be able to notice character change and/or emotional change. Having the ability to notice this change may impact the relationship in that members of the relationship may recommend a mental health physician's services.

Within this theory, we can assume that there are two variables, one being the dependent variable and the other being the independent variable. Suicide is the dependent variable as the strength of interpersonal relationship will determine the individual's capability to see his/her counterpart's world and determine risk of suicide. The strength of relationships will determine if there is a way to prevent a sense of an impossible world and whether or not suicide, is in fact, preventable. Overall, if an individual wants to take his/her own life he/she will find a way to make this happen.

Attribution Theory

Attribution Theory allows for a greater understating of how and why individuals attribute blame and/or responsibility to an organization. Weiner (1995) suggests that key publics are more prone to blame the actor (the specific person who made the error) and seek to blame specific individuals or groups within the organization when internal attributions are made toward an organization. Key publics are more likely to attribute external factors toward an organization in crisis when the organization has a favorable reputation (Weiner, 1995). Key publics are more likely to blame an outside factor than the actual organization during the emergence of a crisis. The theory is based on the assumption that when an event occurs, individuals tend to attribute the cause and responsibility to something or someone (Zaremba, 2010). This idea is especially evident in situations that contain highly negative events such as loss of human life.

To examine Attribution Theory, Park and Len-Rios (2010) hypothesized that as the severity of the crisis increased, the attribution of responsibility would be greater toward the organization. Results suggested that participants viewed the organization as similarly responsible regardless of the high or low severity conditions. However, participants attributed more responsibility to the organization when there were consumer injuries as opposed to company

injuries. Similarly, Coombs and Holladay (2010) found that participants attributed greater responsibility to the organization when there was human error at fault for consumer injuries. Participants attributed less responsibility to the organization in the technical error conditions.

Key publics tend to attribute greater blame toward an organization when human error is evident. This is due to the idea that human error is seen as something that could have been easily corrected or controlled (Coombs & Holladay, 2010). There is a mentality that if the incident is controlled, then there is no need for it to happen, therefore resulting in greater blame placing. However, it seems that human error is deemed the cause of suicide by key publics. Mental disorders, such as depression, are rarely taken into consideration because many key publics focus on the interactions and relationships the victim had prior to the suicide. The crisis communication field lacks research that could potentially address this concern. While Worlds Theory studies the individual, personal side of a crisis, Attribution Theory studies the effects of a crisis on the organization as a whole. In this thesis, these two ideas clash; therefore, there is a need for an alternative framework in order to study the context of the situation.

Assumptions

Attribution Theory assumes three things about blame and responsibility placing during a crisis. The first assumption states that individuals will place greater responsibility and blame toward an organization in cases of injury and/or death. This assumption stems from the need for individuals to hold someone or something accountable for the crisis. The severity at which individuals place blame on an organization will be dependent on the past reputation of the organization as well as the severity of the current crisis, which in this case, is suicidal death.

The second assumption branches off the first assumption. This theory assumes that individuals place greater responsibility and blame toward an organization when an external

member of the organization dies. When another party is fatally involved (dies) outside of the organization's internal team, greater responsibility is placed on to the organization. The death of an external member not working in the organization is thought to be an act of misconduct on the organization's part. The misconduct on the organization's part is from a human error made within the organization.

Lastly, this theory assumes that any crisis perceived to involve human error is seen as controllable by key publics and therefore, preventable. This last assumption is tricky, as it involves the perception of the key publics. Those who do not understand mental or physical wellness may be more inclined to blame the organization and/or an individual for an act of suicide. However, to change this perception would require information distribution on the facts of suicide and other mental/physical health wellness. Even then, it would be almost impossible to change the perception of key publics.

Variables

The key variables to identify within Attribution Theory are human error, responsibility, and blame placement. These variables serve to identify the scope in which Attribution Theory will help to contribute to this thesis. Human error is seen as the independent variable as the severity of responsibility and blame placement are dependent on the occurrence of a human error. If a perceived human error occurs within an organization, key publics are more likely to attribute responsibility and blame toward the organization and/or individual(s) involved in the error.

For the purpose of this thesis, human error is defined as an intentional and/or unintentional deviance made by individual members of an organization. It does not matter

whether or not the deviance was unintended. What matters is whether or not key publics perceived the deviance to have had great repercussions on members outside of the organization.

Blame placement and responsibility are two distinct terms, not to be used interchangeably. Blame placement refers to key publics' ability to place blame on an organization and/or individual(s) responsible for the occurrence of a crisis. In terms of the current case, key publics place blame on individuals who are not the cause of a suicide, but rather are *perceived* as the cause of the suicide. Blame placement refers to the mental processes used in attributing cause toward individuals within the organization. Responsibility refers to the organization's ability to manage the crisis. Responsibility also refers to the organization's ability to take ownership of the human error that is perceived to have caused the crisis. Therefore, responsibility placing refers to the key publics' belief that the organization must manage the crisis.

Situational Crisis Communication Theory

Situational Crisis Communication Theory (SCCT), created by Timothy Coombs, suggests that crises are negative events and key publics will automatically make attributions about how the crisis came about (Coombs, 2010). The base of this theory is the ability to link the crisis response strategy with the elements of a crisis (Bell, 2010). The importance lies within the ability to predict key publics' reactions to the strategies and their overall perception of the organization's efforts. The amount of reputational damage of a crisis decides the selection of the appropriate response strategy (Coombs, 2006).

SCCT is generally broken up into a variety of crisis clusters. Within each cluster, there is a level of responsibility placed on the organization depending on the type of crisis (Coombs, 2006). Three clusters include the victim cluster, accidental cluster, and preventable cluster.

Comparatively, Coombs combines each individual typology into a series of three clusters to better examine the amount of responsibility placed on to the organization. However, similar to other researchers, Coombs does not include a typology and/or cluster that effectively categorizes suicide as a crisis within an organization.

Situationally, it is important to understand the differences between the creation of a new typology and the typologies that already exist. While the typologies that exist focus on death from malevolence and violence, there is no typology that focuses on death from suicide. These two situations are different; therefore there is a need to study them differently. The basis of SCCT in conjunction with Worlds Theory and Attribution Theory will help to set up a framework that provides evidence for an argument of a new typology.

Assumptions

The one main assumption of this theory is that the type of crisis greatly depends on the situation in which the crisis has evolved. As far as clusters go, crises should fit into one of the three clusters, however, there are some types of crises that fall into multiple clusters. This theory does not successfully address those types of crises that fall within two or more of the clusters. The case in which this thesis focuses is too large and complex to successfully place it within one of the clusters. From this evidence, it is assumed that an additional typology must be created that accompanies the unique characteristics of the case.

Variables

The main variables of this theory are the situation and appropriate crisis response strategies. The crisis response strategy is dependent upon the situation. However, the response strategies cannot effectively address the crisis unless the situation has been properly considered and scoped. This is an important factor in laying the ground for the new typology. The case

studied in this thesis does not successfully consider and scope the situation of the crisis, which ultimately leads to the psychological-shift crisis (which is explained, in detail, in the sections to follow).

The variables of SCCT along with the other variables emphasized in Worlds Theory and Attribution Theory help limit the scope for this thesis. These variables are incorporated in understanding the creation of a new typology and how this typology successfully addresses the crisis strategies taken by an organization in managing a suicidal crisis.

Psychological Components of a New Typology

The addition of a new typology will also incorporate psychological components not typically found within other typologies. These components will provide greater insight toward the theories to explain the typology and its need within the crisis communication field. These components add to the understanding of suicide as a type of organizational and interpersonal crisis.

Cause vs. Blame

It is important to distinguish the differences between cause and blame. "Someone can cause an outcome, but not be to blame for it; someone can also be blameworthy for an outcome they did not cause" (Lagnado & Channon, 2008, p. 759). Cause refers to the actual event that led to another event; there is specific evidence that the cause had an effect on the event. Blame refers to a psychological process that validates the reasoning for why something has occurred. In this case, the DJs are seen as blameworthy for an outcome that they did not cause. The only person who caused the death of Saldanha was Saldanha. There is no specific evidence that can link the suicidal death to the hoax phone call; it is all based on perception.

Lagnado and Channon (2008) found that intentionality was a factor in the determination between cause and blame judgments. The study found that blame judgments were much higher for unintentional events (human error) as opposed to physical events (events not necessarily caused by human error, i.e. the machine labeled the medication wrong). This suggests that individuals engage in blame-validation, meaning they assign blame to human agents as opposed to external, environmental factors. Lagnado and Channon (2008) also found that participants are more likely to blame the agent when the agent expects the negative outcome and when the outcome is more likely. Lagnado and Channon's (2008) study focuses on concepts related to blame and assigning responsibility during crises involving suicidal death.

Blame

When individuals engage in blame-validation, they are more likely to exaggerate the agent's control "by lowering their evidential standards for blame or by seeking information to support their blame attribution" (Alicke, 2000, p. 558). Blame attributions refer to individuals' perceptions of the degree of control the agent has on the negative outcome (Alicke, Buckingham, Zell, & Davis, 2008). Alicke et al (2008) finds that the agent who acts negligently is judged as more blameworthy and more likely the cause of the avoidable condition. This is aligned with Coombs and Holladay's (2010) understanding that human error accidents tend to generate stronger attributions of responsibility during crisis. The severity of blame will depend on the control the agent has over the situation, the intention (whether good or bad) of the agent, and the degree of negligence.

Some researchers have suggested personal and situational similarity as indicators for placing blame (Burger, 1981; Shaver, 1970). According to Burger (1981) individuals who view the agent as someone similar to them, personally and situationally, are motivated to avoid future

blame of the agent by ascribing cause to an external factor. Individuals, who see his/herself as similar, may foresee that same outcome happening to him/her, therefore wish to blame someone or something else (Shaver, 1970). Shaver (1970) finds evidence for this phenomenon suggesting that individuals assign less responsibility and blame when the personal similarity condition is high. The blame process serves to aid this thesis in providing information on why key publics perceive the DJs as the blame agents for the crisis.

Counterfactual Thinking

Counterfactual thinking is a phenomenon that is studied throughout the psychology field. Counterfactual thinking refers to the “if only” mindset (Goldinger, Kleider, Azuma, & Beike, 2003). The idea behind this phenomenon is that individuals, in an attempt to validate circumstances, engage in thinking that alters a negative event into a positive one. For example, if only two DJs did not prank a hospital, then the nurse would not have committed suicide.

Goldinger et al. (2003) examined counterfactual thinking among participants and found that participants generally blamed the victim when counterfactual thoughts were more easily generated. Alicke et al. (2008) also suggested that “a person who causes harm will be blamed more when it is easy rather than difficult to imagine a more favorable outcome” (p. 1379). Wells and Gavanski (1989) refer to the alternative, more favorable outcome as the “default event.” The findings suggested that participants attributed greater cause to an event if the counterfactual default would have generated a different outcome (Wells & Gavanski, 1989). However, the study also found that participants attributed less cause to an event if the default alternative generated the same negative outcome. Had the same negative outcome occurred, no matter which scenario, there was a less likely chance that individuals would attribute causal significance to that event. Therefore, if it were known that Saldanha would die with or without the hoax

occurring, there would be less causal significance toward Southern Cross Austereo and the DJs. However, there is not enough evidence to support this claim, therefore, this thesis can only analyze the given information. Goldinger et al (2003) suggest that it takes a great deal of mental resources to correct counterfactual thinking.

Coombs and Holladay (2010) examine counterfactual thinking within the crisis communication context. The study draws upon research in the psychology and sociology field to examine the cause of attributions of blame. Coombs and Holladay (2010) also suggest that individuals find it easier to mutate a human error crisis so that the negative outcome is undone (it never happened). Individuals are easily able to mutate a human error accident because it is seen as more controllable, therefore follow the “if only” scenario. This supports the findings of Wells and Gavanski (1989) in that learning of someone’s death (which in this context would be Saldanha’s death) generates ideas on how that death could have been avoided.

Suicide

Physical and mental disarray causes stress that builds up to a point where it may break an individual (Norman, 2007). Mental health is a subject in today’s society that is filled with a negative stigma and is often the first health care service to be cut when funds are tight (Norman, 2007). Due to cuts in mental health services, and the stigma that mental health is a sign of weakness, many individuals who suffer from a mental disorder go untreated by professionals; they instead resort to self-coping methods (Rasmussen & Ewoldsen, 2013). According to a study conducted by Paraschakis, Michopoulos, Douzenis, Christodoulou, Koutsaftis, and Lykouras (2012), 70-90% of suicide victims suffer from at least one psychiatric disorder during the final months prior to his/her death. In a study conducted among female suicide attempters, researchers find that the most important category for grounds for attempting suicide was

interpersonal conflict (Li, Phillips, & Cohen, 2012). The second most important category is related to psychological problems, in that psychiatrists are able to identify a psychological issue in 38% of the participants (Li, Phillips, & Cohen, 2012).

Two key indicators of suicide are emphasized in the interpersonal theory of suicide. The individual's consistent feelings of thwarted belongingness and perceived burdensomeness on their family and friends are believed to be two of the likely indicators of suicide (Wilson et al. 2013). Thwarted belongingness is a cognitive affective state that constantly changes (Van Orden, Wite, Cukrowicz, Braithwaite, Selby, & Joiner, 2010). The degree to which individuals feel as if they do not belong depends on the perception of their world and external environmental factors that influence their world. Overall, the key element to suicide prevention is intervention by close others (Aldrich & Cerel, 2009).

Creation of a New Typology

The theoretical framework and psychological components are integrated in the creation of an additional typology that best examines a suicidal crisis. I have created the following typology based on the assumptions and variables of the theoretical framework and the research provided by the psychological components.

Psychological-Shift Typology

I have created a typology known as the psychological-shift typology. The psychological-shift typology is defined as the shift in a crisis due to an unforeseen psychological condition of an employee. The psychological condition specific to this thesis is suicide; however, the typology may also include any type of emotional distress and/or mental instability experienced by employees who are affected by a crisis within his/her organization. This typology is classified as a smoldering crisis, as it often evolves during a different type of crisis (the initial crisis) and is not evident until a suicide occurs. Therefore, the crisis that results is a completely different crisis than what the organization had originally been resolving.

The name, psychological-shift, stems from the idea that a crisis is classified as one type but then shifts into another type based on the mental well-being of individuals within an organization. This typology focuses on the interpersonal side of crises. It is created out of necessity; it urges practitioners and researchers to take into consideration the interpersonal relationships employees have within the organization as well as with others outside of the organization during a crisis. The importance of understanding interpersonal relationships is helpful toward researchers and practitioners as it allows them to gauge the severity of employee needs during the crisis. This is useful in that it helps prevent the psychological-shift from occurring.

The psychological-shift typology is not taken into consideration within organizations during the initial crisis. It appears that organizations do not address the mental state of its employees and how the organizational crisis may impact employees' interpersonal relationships and emotional well-being. The organization recognizes a crisis and takes the necessary steps in reducing that crisis according to the strategies previously set in place during the crisis planning phase. I argue that organizations address another component of its crisis communication plans and the overall execution of those plans in order to effectively prevent the psychological-shift typology from occurring. This argument is supported later on in this thesis.

The uniqueness of the psychological-shift typology is that it has a higher likelihood of occurring when a different type of crisis is identified. This means that with the proper knowledge and management, the psychological-shift typology is avoidable because there is an occurrence of another crisis. Of course, avoiding a crisis is the general goal for all crises, but the advantage of the psychological-shift typology is that the organization is already in crisis mode. Therefore, during the initial crisis, it is up to the organization to understand the psychological needs of individuals to prevent the psychological-shift typology from occurring. However, when the psychological-shift typology does occur there are several key indicators that help determine if, in fact, the organization must engage in interpersonal and organizational tactics to reduce the psychological-shift crisis.

Criteria for Typology

The following criterions are used in evaluating and understanding the psychological-shift typology: occurrence of a normalized deviance, evidence of impossible worlds (interpersonal crisis), evidence of attribution of blame (organizational crisis), evidence of counterfactual processing, and evidence of the smoldering effect.

Occurrence of a Normalized Deviance

There is an increased chance of this typology occurring when a normalized deviance is present. The normalized deviance, normally not seen as any type of threat, needs to go array. The deviance must be thought to bring no harm toward others or the organization. Individuals who commit the deviance thoroughly believe that the deviance is harmless. In order for this typology to occur, the deviance needs to occur and psychologically affect individuals within the organization. Psychologically affect refers to feelings of trauma, shame, guilt, blameworthiness, humiliation, and thwarted belongingness (feelings of not belonging). These are examples and psychologically affect is not limited to this list.

For the current thesis, hoax phone calls are the normalized deviance. However, a normalized deviance can range from hoax phone calls to incorrect work protocols. The deviance that occurs needs to be perceived as wrong by individuals external to the organization. Hoax phone calls are seen as a normalized deviance. Generally, they are wrong, because it is seen a form of trickery; however, because of the hoax phone call culture popularity, they are seen as a normal act to take part of. Generally, individuals working within the organization do not think twice about the normalized deviance; the deviance in employees' actions go unnoticed because of the perception that the normalized deviance has been done regularly over a period of time without consequence.

The normalized deviance that occurs must affect individuals within the organization. However, the deviance may also affect individuals and organizations external to the organization. The deviance has to be large enough that it causes the organization and any other effected organizations to utilize crisis strategies in an attempt to dissolve the crisis (this would be the initial crisis).

The importance for including this criteria stems from the research that individuals are more likely to blame human error as the source of a crisis. The normalized deviance is a human process that takes place within an organization and is deliberately done out of normalness. In the presence of a normalized deviance, there is a greater chance for individuals to be blamed for something that they did not necessarily perceive to be wrong, therefore forcing them to question their intentions (i.e. what have I done? how could this have been avoided? why did this happen?). Employees questioning their intentions is an important factor of this criterion as it emphasizes the interpersonal needs of employees. These thoughts are key to understanding how the crisis is affecting employees.

Evidence of Impossible Worlds (Interpersonal Crisis)

This criterion addresses the interpersonal side of crises in that it focuses on how individuals involved within the crisis are emotionally affected. In order for the psychological-shift typology to occur, an individual must deem his/her world as no longer viable and ultimately, take action in ending his/her own life. Although this seems to be extreme, it is the suicidal action of an individual external or internal to the organization that results in the psychological-shift. The actual cause behind the suicide is not known, but there is a chance that it could have been prevented with the proper attention needed by employees within the organization. Death is a key factor in the evolution of this typology. The suicidal death of an individual is large enough to gain attention, launching the organization to resolve a different type of crisis.

One way to combat this criterion from occurring is to assess the degree of emotional instability found within employees currently involved in the initial crisis. To avoid this criterion would involve organizations to take progressive actions in seeking out external help and

assistance for at-risk employees. Although this is a progressive step in avoiding the psychological-shift from occurring, psychological needs are not always addressed, thereby resulting in the crisis studied in this thesis.

There are other indicators involved within the impossible world criterion that assist in determining the relevance of this criterion. The sub-criteria are as followed:

1. Blame judgments are higher toward specific individual(s) of an organization as opposed to a physical object. A physical object is described as environmental factors and/or physical objects that would have caused the initial crisis. For example, a natural disaster is an environmental factor and a machine is a physical object. If the public places blame on specific individuals of an organization, it is an indicator that the public focuses on human error. This is an indicator that the individual(s) blamed for the error may be prone to emotional distress, leading to an impossible world mentality.
2. Employees have a great sense of thwarted belongingness (feelings of not belonging) and perceived burdensomeness on their family and friends (feelings that the employee is burdening their friends and family with their presence). It is possible to detect an employee who seems disconnected among others in the work environment (not belonging) especially after the occurrence of a crisis. The perceived burdensomeness that employee feels may be harder to detect among him/her following a crisis, as that is the perception of the employee. It may not be completely obvious to individuals of the organization that an employee feels this way.

Although there is no way to gain the totality of an employee's world, these sub-criteria act as a way to gain insight into how employees may feel during an initial crisis. These two

criteria allow other organizational members to understand a piece of an individual's world. This knowledge is useful in assessing another employee's state of mind following the initial crisis.

Evidence of Attribution of Blame (Organizational Crisis)

This criterion serves to address the organizational side of a crisis and how that influences the occurrence of the psychological-shift typology. Key publics will attribute responsibility to the organization regardless of the crisis. Studies have shown that the severity of the crisis does not have any sort of correlation with the degree of responsibility key publics place on the organization. As long as key publics deem an organization in crisis, it will be in crisis regardless of how severe the crisis may be.

In order for this criterion to be met, key publics outside of the organization must attribute responsibility and blame toward the overall organization for a human error which results in a human injury or death. Human error is seen as something that could have been avoided if proper precautions were taken. The blame for human death or injury narrows the scope for understanding this criterion.

The psychological-shift typology may only take place when the organization is blamed for unintentional events as opposed to events such as natural disasters. It is more likely that the attribution of blame will be greater for organizations that have acted negligently in the past and still hold that same stigma. The negative reputation may add to the greater attribution of blame the organization faces from key publics. For organizations with a more positive reputation, attributions are made externally to the organization; audiences will seek to blame an external force for the crisis.

The reason this criteria is included within the created typology is because it serves to show that there is an initial crisis that the organization must resolve. As stated earlier, the

psychological-shift typology refers to a shift based off psychological conditions of employees associated with the organization. Prior to the psychological shift occurring, there first needs to be an initial crisis that would affect employees within the organization.

Evidence of Counterfactual Processing

This criterion would be hard to decipher as it deals with mental processes of the key publics. However, this criterion will usually be present as long as the other criterions (occurrence of a normalized deviance, impossible worlds, and attribution of blame) are met first. This criterion deals with the reasoning behind why key publics feel the need to blame the organization and/or individuals involved. Combating this mental process is hard, if not, impossible; therefore, it can be assumed that counterfactual processing is present within key publics as long as the other criterions are met first.

Those who place blame on the organization and the individuals within the organization engage in counterfactual processing. In order to validate circumstances, key publics engage in thinking that alters the negative event into a positive one. This generally refers to the “if only” phenomenon. The “if only” phenomenon is defined as a mental process used to validate negative occurrences. In the aftermath of a negative outcome, many key publics engage in this action as to realize what type of alternate, positive outcome would have been available had something been done differently.

Other types of evidence that would demonstrate the counterfactual process is verbal and/or written responses from key publics. These responses are negative, as negative responses are likely to indicate the “if only” mindset. The presence of negative responses highlight the unfavorable perspective of key publics regarding the crisis.

This mental process allows key publics to generate ideas about how a death and/or injury could have been avoided. Once key publics recognize that this is an avoidable action, it causes more anger and attributes greater blame and responsibility toward the organization and individuals seen accountable for the act. Unfortunately, for unexpected deaths, it is easy to generate an alternative outcome; that being, the person does not die and lives a full life.

Evidence of the Smoldering Effect

Another criterion to take into consideration for the psychological-shift typology is the appearance of the smoldering effect. A smoldering crisis refers to the small internal actions of the organization. For example, the internal actions of the management staff to neglect the emotional stability of employees. The small action of not addressing employees' emotional and psychological state during the initial crisis, eventually results in the psychological-shift crisis. The organization does not consider the possibility of a psychological-shift, and therefore when the psychological crisis occurs, it quickly escalates.

Following the analysis of the case, this thesis will highlight recommendations for preventing the psychological-shift from occurring. For the organizations that have experienced the psychological-shift typology, this study will address its' tactics and strategies in resolving the crisis.

Methodology

The current thesis focuses on the creation of a new typology to analyze and understand a specific case unique to the crisis communication field. The ultimate decision to create a new typology stems from the consistent research in the crisis field. At first, I wanted to analyze the case according to a typology that was in existence. Soon enough, it appeared that there was no specific typology that this case would fit neatly into. It became evident that there was a need for a new typology to understand the uniqueness of this suicidal crisis.

Naturalistic inquiry is a human response to understanding and examining our world (Lincoln & Guba, 1985). As individuals, we are constantly observing our world and attempting to make sense of our surroundings. This thesis stems from this idea of naturalistic research. Data collection is used as a means for understanding and examining a certain situation that has not affected me directly. However, unlike some naturalistic data collection, this thesis was unable to obtain interviews and direct observations due to resource restraints. Instead, this thesis is based on research about the organizations involved and theories that provide the best examination of the case. My interest in psychology strengthens my ability to critically examine the world based on interpersonal and psychological needs.

According to Pearce (1977) naturalistic inquiry is synonymous with exploratory research in that it generates hypotheses but does not test them. The objective of naturalistic inquiry is to develop questions about the world in order to gain an understanding for the occurrence of specific phenomenon. This type of methodology is useful for the current thesis as it serves to examine the actions taken by organizations in resolving a crisis. The data collection process details in the section that follows.

Data Collection

In order to write the detailed description of the case, data was collected from the LexisNexis database accessed through the Ithaca College library. Data sources were primary newspaper articles. All information collected through the database was synthesized and summarized in examining the case from start to finish. The case briefly detailed the past of both organizations, and then discussed the crisis from the beginning. The case examined the crisis from two perspectives, the organization perspective and the interpersonal perspective.

The theoretical framework was devised from three theories that assisted in the creation of the psychological-shift typology. The research for these theories was obtained through the Ithaca College library's communication databases and psychology databases.

The one component of naturalistic research that this thesis does lack is the direct observation of the organizations during the crisis. Due to unattainable resources and time, direct observation was not possible. However, since the current thesis focuses on interpersonal needs, assumptions are made based on research about how individuals within the organization may have acted. These assumptions are based on the psychological components examined in the literature review. Although direct observation is nonexistent, there is substantial research that attempts to overcome this obstacle.

Analysis

Analyzing the case using the theoretical framework provides evidence to demonstrate the uniqueness of this case. The case study analysis describes the case from the two perspectives emphasized in the theoretical framework: interpersonal crisis and organizational crisis. Separately, I want to demonstrate the severity and importance of each type of crisis. Although the perspectives are analyzed separately, the analysis integrates information from the psychological components and theoretical framework that weaves the two perspectives together. The case and analysis are then compared and contrasted with the psychological-shift criteria to display how the case fits into the psychological-shift typology.

Interpersonal Crisis

King Edward Hospital

Jacintha Saldanha

The interpersonal crisis that is evident in the case is the suicidal death of Jacintha Saldanha. Derived from reports described in the case description, it is assumed that Saldanha was upset and struggled with the aftermath of the hoax. With Saldanha visibly upset, King Edward Hospital did its best to comfort and support Saldanha during the days consumed with media attention.

In the days that followed the royal hoax, certain employees testified that Saldanha had not acted herself. Reported in the case study are claims that Saldanha was traumatized and even with the support of the hospital's management staff, did not recover from the embarrassment and shame she felt. It was evident with these claims that employees and employers had a sense of the negative emotions that plagued Saldanha. Another sign that demonstrated Saldanha's potential feelings of embarrassment about the hoax, which employees and employers may not

have known about, was her choice to not call her family to discuss the matter. The family claimed that they did not know about the hoax or about Saldanha's involvement until it was too late. Her choice to not disclose the matter to her family was a sign that she was feeling a sense of burdensome toward her loved ones. King Edward Hospital did not disclose the information about the hoax to the family until after the suicide.

The claims made by employees and family members showed that Saldanha felt a sense of thwarted belongingness and perceived burdensomeness. According to Wilson et al (2013) these two characteristics are the likely indicators of suicide. However, without the proper research and knowledge, management was unable to recognize these signs within Saldanha. This inability to recognize the signs was due to the lack of attention to her interpersonal needs. Described later in the section, is the detailed account of the steps taken by management in resolving the organizational crisis prior to the suicide. Although reports claimed that management supported Saldanha, there was no evidence that suggested management sought out external counseling for her or other employees during that time.

The two variables associated with Worlds Theory are suicide and interpersonal relationships. A suicidal attempt is dependent on the strength of interpersonal relationship with a clinical physician, psychiatrist, or psychologist. Saldanha did not have any type of relationship with any of these mental health physicians, therefore, her suicidal ideation was not diagnosed. Ultimately, Saldanha did commit suicide, but whether it was directly linked to the hoax or a previous mental disorder is unknown. It cannot be assumed that even with a mental health counselor, Saldanha would have lived, because according to Worlds Theory, there is no guarantee that anyone would ever be able to understand the totality of another individual's world.

Southern Cross Austereo

Australian DJs: Mel Greig and Michael Christian

Understanding that King Edward Hospital did not provide mental health counseling to Saldanha proved interesting in how Southern Cross Austereo went about treating Greig and Christian after the news of Saldanha's death. In the aftermath of the suicide, Greig and Christian showed physical signs of mental instability. They were described as fragile and very upset at the occurrence of the suicidal death. Southern Cross Austereo provided mental health counseling for Greig and Christian. This step was crucial in that it took proactive measures to reduce the "impossible world" perception by Greig and Christian.

The ability to depict individuals as acting out of character is generally easy to do, especially among employees and employers. The employees and employers have a certain relationship with each other and a general understanding of how each other act. However, employees and employers are not responsible in understanding a piece of their counterpart's world that may be unviable. Since employers and employees do not have the general ability to capture this piece of another individual's world, it is important to acknowledge the severity of a crisis and then recognize the attitude change among the employees and/or employers. Once this is acknowledged and recognized, employers can obtain the services of mental health physicians who can assist employees with their mental wellness.

In the aftermath of the suicide, Southern Cross Austereo received vast amounts of death threats made toward organizational leaders and Grieg and Christian. These threats were an indicator of the severity of the crisis that evolved after the suicide. In acknowledging the severity of the crisis, Southern Cross Austereo recognized an attitude change in its DJs and took proactive measures to ensure their mental and physical well-being did not plummet. Due to the

psychological-shift, Southern Cross Austereo took into account the interpersonal needs of employees in preventing another potential death.

With Greig and Christian in therapy, there was less concern for another suicidal death. Unlike Saldanha, Greig and Christian were able to build an interpersonal relationship with a mental health physician that was able to pinpoint the parts of their world that they felt unviable. This was a successful way of preventing suicide, however, there was no evidence to support that Greig and Christian would have committed and/or attempted suicide if a mental health counselor was not involved. Although there was minimal evidence to support this "if only" scenario, the importance of this, was that Southern Cross Austereo sought the professional help of physicians to aid the recovery of Greig and Christian.

Overall Themes

By comparing the two organizations tactics in dealing with its employees at an interpersonal level highlighted the precautions needed in order to prevent a psychological-shift crisis. King Edward Hospital, although attempted to support Saldanha, fell short in fully providing the care she needed in order to successfully overcome the aftermath of the hoax. It was assumed that Southern Cross Austereo took a precaution in providing mental health counselors for the two DJs after the suicidal death of Saldanha.

The examination of the crisis communication plan set in place by both organizations is out of scope of this thesis. However, I argued that in order to address the interpersonal needs of employees, organizations needed to factor in costs and strategies that best dealt with preventing suicidal deaths. Having this strategy planned is just as crucial as having the organizational management of the crisis planned. Although both organizations were attempting to resolve a

larger crisis, ignoring employees who were affected, ultimately added to the severity of the crisis.

Recommendations

Overall, organizations need to pay some attention to its employees who are either directly or indirectly involved within an organizational crisis. If there is even a hint of an attitude change that shows an employee is mentally suffering from a crisis, attention must be placed on them to prevent any sort of psychological damage. Overall, the key element to suicide prevention is intervention by close others (Aldrich & Cerel, 2009). Small attempts in addressing psychological needs would allow employees to feel comfortable with the crisis and allow them to discuss the matter with a counselor, if they do not wish to discuss it with family members and/or friends.

Organizational Crisis

King Edward Hospital

Privacy Breach Crisis

Prior to the death of Saldanha, King Edward Hospital dealt with a different type of crisis. The crisis was a privacy breach of Kate Middleton's medical updates. The organization recognized the crisis as a privacy breach and took active steps in resolving that type of crisis. The statements made by the chief executive, John Lofthouse, clearly depicted the organization's sorrow for the invasion of privacy and emphasized the investigative action into phone protocols.

The problem that the organization failed to resolve was the interpersonal needs of its employees, specifically Saldanha. According to Situational Crisis Communication Theory, organizations must first define the scope of the crisis and address it accordingly. King Edward Hospital was successful in this part; it defined the scope of the crisis and took proactive measures

to dissolve the patient privacy breach. However, since the organization focused on the privacy component, it failed to address the situation as a whole. The situation included more than just a privacy breach. However, King Edward Hospital only focused on protecting the legitimacy of its organization and failed to consider the interpersonal needs of those who were directly involved in the initial crisis.

Psychological-Shift Crisis

There are three assumptions made by Attribution Theory that are applied to the actions taken by King Edward Hospital during the crisis following the suicidal death of Saldanha. These assumptions are greater blame placing on an organization in cases of injury and/or death, placing greater responsibility and blame toward the organization when an external member dies, and the perception that human error is preventable. Key publics did not blame King Edward Hospital for the death of Saldanha. At no point in time were there assumptions made about King Edward Hospital not doing enough to prevent the suicidal death. The organization goes against what is assumed by Attribution theory; that individuals will place greater responsibility and blame toward an organization in cases of injury and/or death. However, this may also be due to the positive reputation of the organization. King Edward Hospital did not have any past incidents that would cause key publics to doubt its intentions.

Since an internal member of the organization died, key publics were less likely to place blame and responsibility on to the organization. The suicidal death of Saldanha might have had a greater empathetic response with key publics as opposed to a negative response. Another reason for the lack of blame placing on the organization by key publics was that Southern Cross Austereo was in the media spotlight for the potential cause of the suicidal death. With the

attention drawn away from King Edward Hospital, the organization was not held to the high degree of responsibility that Southern Cross had been held to.

One group that did place great responsibility onto King Edward Hospital was the Saldanha family. Although media reports did not emphasize external blame placing by key publics and other members of the community, it did emphasize the anger the Saldanha family felt regarding the procedures King Edward Hospital took in disseminating the information to the family. In this case, assumption one of Attribution Theory -- individuals will place greater responsibility and blame toward an organization in cases of death -- holds true. In the case of the family relationship, the second assumption, greater responsibility and blame toward an organization when an external member of the organization dies, does not apply as the member of the organization was internal. The family relationship dynamic also cancels this assumption out as family is family and it does not matter whether the employee was a part of the organization or external to the organization. It was assumed that the family would still seek answers to the specifics of the crisis regardless of the severity. Family was the one key public that did not necessarily follow the assumptions made about Attribution Theory.

Although there is no evidence of a human error causing the suicidal death of Saldanha, the Saldanha family saw human error in not disseminating the information about Saldanha's death. The family wished that the hospital had done more in supporting them and informing them of the hoax and suicide. The family saw this as a human error as the hospital chose to not disclose the information to the family prior to the information found out from police authorities. The human error was seen as preventable, had the hospital taken proactive steps in discussing matters with the family, then the family could have gotten involved with Saldanha prior to her death. The family had also been upset with the organization's decision to not inform them of the

hoax that took place. The key here was that there was a perceived human error and because there was a perceived human error involved, there was greater responsibility placed on the hospital by the family.

Overall Themes

Situational Crisis Communication Theory assumed that strategies were developed from the situation in which the crisis had taken place. However, it seemed that there was not enough analysis within the Situational Crisis Communication Theory, that each crisis may fall into one cluster or category and depending on that cluster or category the crisis was addressed accordingly. From this thesis, we saw that this was not always the case. King Edward Hospital classified the crisis and went about strict protocols in dissolving that type of crisis without really analyzing other variables that were involved. For example, the involuntary participation of employees was a variable that needed to be taken into consideration. The crisis had negative implications for employees; it affected their mental, emotional, and physical well-being.

The theoretical framework of Attribution Theory assumes that key publics will place blame on to the organization based on three assumptions. These assumptions hold true for the most part, however, Attribution Theory does not specify the assumptions based for family members. Examining this case has shown that many assumptions of attribution do not apply as family members naturally hold the organization responsible for its management strategies in the aftermath of a death of a loved one.

Recommendations

The family concept is important in addressing the interpersonal crisis. The organization, according to reports, was tied by specific protocols and procedures that it claimed prevented it from contacting the family. There was a blockage between integrating the organizational

management of a crisis with the management of the interpersonal crisis. This idea tied back to interpersonal crisis and Worlds Theory; had the organization been able to depict the impossibility Saldanha associated with her world, the organization would have gone to greater lengths in seeking support and treatment for her. This would have been a pro-active approach in reducing the occurrence of the psychological-shift crisis.

Southern Cross Austereo

Breach of Ethics Crisis

Southern Cross Austereo found itself in the midst of an international scandal after questions of ethics were raised following the broadcast of the royal hoax on 2Day FM. For this organization, ethical questions did not constitute an immediate or severe crisis. The organization only perceived this incident as a threat to its legitimacy. Since Southern Cross Austereo had a negative past with probationary periods, the reputation of the organization played a role in attracting negative attention. On top of that, key publics attributed responsibility to the organization for airing a private conversation that key publics felt was not appropriate for broadcast.

Prior to the suicidal death of Saldanha, key publics placed responsibility on Southern Cross Austereo for an incident involving human error. Responsibility and human error are two of three variables associated with Attribution Theory. The third variable, blame placement, does not appear until after the suicidal death of Saldanha, in which key publics blamed the DJs for her death. Human error was evident in this case, as many key publics emphasized their distaste for airing such a private conversation. This type of error, the hoax, met the definition of intentional and/or unintentional deviance made by individual members of an organization.

Realizing that there were ethical implications for broadcasting the hoax, the DJs and the radio station apologized for the hoax through twitter feeds. However, even with this doubt of ethics, the hoax was still available on 2Day FM's website and YouTube. The organization did not successfully address the severity of the crisis. Similar to King Edward Hospital, Southern Cross Austereo did not successfully scope out the crisis. Although there were apologies for the hoax, the hoax was not immediately taken down from the organization's website. Had the situation been properly assessed, the organization would have implemented a strategy in dissolving the crisis, which would have included taking down the recording from the website.

Psychological-Shift Crisis

Once the crisis shifted to the psychological-shift typology, key publics began to place greater blame on to the DJs for conducting the hoax and holding the organization responsible for its actions. The increased blame and responsibility attribution stemmed from an external member's death. This aligned with the assumption of Attribution Theory that individuals placed greater responsibility and blame toward an organization in the case of a death. It also aligned with the second assumption that stated that individuals would place greater blame when the death was external to the organization.

The key focus for the psychological-shift was the perceived human error that was involved. Evidence, as stated in the case study description, highlighted the negative perception key publics had about the crisis. That perception included feelings of hatred toward the DJs and other executive members of the organization that were thought to have approved the hoax for broadcast. The perception of human error primarily stemmed from the idea of control; had the hoax not occurred (the DJs had control over the decision to conduct the hoax), then Saldanha would not have committed suicide.

The issue that the organization faced was that employees were blamed for a suicide that they may or may not have actually been to blame for. In this case, there was confusion between causation and blame. As mentioned earlier, cause and blame are not the same thing, someone may be to blame for an incident but may not have been the cause. In this case, the DJs were not the cause of the suicidal death, because they did not commit a physical act of violence that caused Saldanha's death. The DJs are seen as a blame agent, along with other executive members of Southern Cross Austereo who approved the hoax for broadcast. It did not matter whether the DJs actually caused Saldanha to commit suicide or not, what matters is that the public viewed them as the blame agent, therefore attributed the crisis to human error.
This aligned with the third assumption of Attribution Theory that stated human error is seen as controllable, therefore, preventable.

Overall Themes

Although the organization took ownership of the crisis by apologizing and donating money to Saldanha's memorial, it was still at a disadvantage. The psychological-shift crisis was not properly scoped and defined, therefore, there was no implemented strategy that would have dissolved the crisis. Since the crisis could fit into several different types of clusters, there was not one set option for a best practice to dissolve a crisis such as this one.

It was evident that the organization did not take into consideration the personal affects the hoax had initially caused. Although Southern Cross Austereo apologized for its actions, it seemed to be too caught up in the media attention to actually remove the recording from its website. It was not until after the suicide that the organization began to take proactive steps in reducing the crisis. However, at that point in time, the crisis typology had already shifted,

therefore the organization needed to take into consideration a new situation with different strategies in order to be successful.

Recommendations

The situation of crises is not thoroughly defined. This is the biggest problem in the escalation of crises. For an organization that finds itself in a crisis involving human-beings need to be weary of the psychological state of its employees and also the employees outside of the organization. The best recommendation is to address the crisis from multiple perspectives as opposed to just one. These perspectives, interpersonal and organizational, are emphasized throughout this thesis for good reason. The two perspectives should be integrated, therefore, organizations must set forth a strategy that identifies the employees involved in the crisis and how the crisis affects the employees' wellness. This is accomplished through observation and is dependent on the severity of the initial crisis. Not only does the legitimacy of the organization matter, but so do the employees who work within the organization. Researchers, practitioners, and managerial departments need to recognize that employees are not machines, and acknowledge their psychological needs.

Meeting Criteria for the Psychological-Shift Typology

The theoretical framework allowed us to make an argument for an addition of a new typology. The framework has highlighted key components of the case that are not typically addressed in the crisis communication field, as there was no set strategy of analyzing the integration of interpersonal and organizational perspectives of a crisis. This section further demonstrates how the crisis fits into the psychological-shift typology and why this typology is important to recognize.

Occurrence of a Normalized Deviance

The normalized deviance that took place in this crisis was the DJs decision to plan a hoax phone call in an attempt to speak to Kate Middleton. Although hoaxes in general are not common to the radio station, 2Day FM, they are a common practice. This was exactly why individuals of Southern Cross Austereo were so shocked at the outcome, because hoax calls are part of the radio culture. The DJs did something that they did not perceive as wrong or deviant, rather it was perceived as a normal, fun exercise.

The normalized deviance (the hoax) meets the criterion set forth in the typology section as the hoax is large enough to effect the organization (Southern Cross Austereo), affect employees within Southern Cross Austereo, and effect an external organization, King Edward Hospital. Once the deviance was linked to the suicide of a third party, it was evident that Southern Cross Austereo has landed itself in the middle of something big.

The normalized deviance also launched both organizations to engage in crisis management strategies to dissolve the crisis. Prior to the death of Saldanha, the management strategies focused on a privacy breach and an ethics breach. However, the normalized deviance was substantial enough to alter the crisis management strategies once Saldanha committed suicide. Employees of Southern Cross Austereo were blamed because of the perceived human error involved in the normalized deviance. The visible signs of psychological affect seen in the DJs were indicators of how the crisis had affected them.

Evidence of Impossible Worlds (Interpersonal Crisis)

The evidence of an impossible world lies within the suicidal death of Saldanha. In order for this criterion to be met, two sub-criteria must be met first. There needs to have been evidence of blame judgments toward a specific individual of an organization and that individual must have shown signs of thwarted belongingness and perceived burdensomeness. Although there was no

way to gain a totality of what Saldanha went through in the aftermath of the hoax, there were reports that stated she had been traumatized by the incident and even with management support, did not completely recover. In the initial crisis, there was blame placed on King Edward Hospital for not properly training nurse staff in receiving phone calls. Key publics were clearly focused on human error, which transmitted toward Saldanha since she was the one who patched the phone call to the ward. With these two sub-criterion met, it was evident that Saldanha had created an impossible world for herself, therefore, taking her own life.

The suicidal death meets this criterion set forth in the typology section as the actual cause of the suicidal death is unknown, but there is a perception that it is avoidable with proper attention from management. The suicidal death is large enough that it launches both organizations, King Edward Hospital and Southern Cross Austereo, to resolve a different type of crisis. While King Edward Hospital does not seek professional help for Saldanha, Southern Cross Austereo does seek professional help for its DJs, Greig and Christian. Southern Cross Austereo takes progressive steps in reducing the occurrence of another psychological-shift.

Evidence of Attribution of Blame (Organizational Crisis)

In this thesis, key publics have attributed blame and responsibility towards both organizations. Key publics hold King Edward Hospital responsible for not properly training its nurse staff in protecting its clients. Key publics attribute blame to the hospital for disclosing personal information to external individuals who were not related to the patient. King Edward Hospital has a positive reputation, therefore, once the psychological-shift occurs, key publics seek to blame external forces for the crisis. These external forces include the DJs and Southern Cross Austereo.

Southern Cross Austereo is held responsible for a breach in ethics and is blamed for the suicidal death of Saldanha. This satisfies the criterion that states key publics must blame the overall organization for a human error that results in a death. This human error is perceived to be avoidable as the DJs and Southern Cross Austereo had control over whether or not to conduct and broadcast the hoax call. With 2Day FM's negative reputation, it is also probable that key publics associated greater negativity toward the radio station and its parent company, Southern Cross Austereo.

Evidence of Counterfactual Processing

As specified earlier in the thesis, as long as the other criterion have been met, it can be assumed that this criterion has also been met. From evidence examined in the case description, it was evident that many key publics engaged in counterfactual processing in the case of Saldanha's death. Many key publics blamed the DJs for the death because they saw it as avoidable. By engaging in the "if only" mindset, key publics were able to validate the negative occurrence; if the DJs had not involved Saldanha in the hoax, she would still be alive.

This type of mental process is used to validate a negative occurrence. Key publics search for validation of a death and look for reasons to justify and make sense of this death. The verbal and written messages sent to the DJs and Southern Cross Austereo demonstrate the negative perception key publics have on the suicidal death and is done out of justification for the death.

Evidence of the Smoldering Effect

The evidence of a smoldering crisis was prevalent throughout the thesis. The research and analysis had shown that there were psychological issues that affected individuals on a personal level. What made this a smoldering crisis were the psychological issues that were not addressed until it was too late. Although there was evidence to support King Edward Hospital's

claims that it supported Saldanha, it was not enough to successfully address her psychological needs. The small steps not taken by King Edward Hospital were the components of the smoldering effect. The psychological-shift typology occurred because of the neglect toward employees involved within an organizational crisis. The unsuccessful efforts of the hospital to attend to Saldanha's interpersonal needs may have ultimately been a contributor to her suicidal death.

With all the criterions met, it is evident that this case aids in the creation of an additional typology to study a suicidal death crisis.

Conclusion

This thesis has answered five questions that further synthesize the need for an additional typology. The following section directly answers the questions, poses ideas for future research, and concludes with some limitations of the study.

Questions Answered

What are the theories that support the psychological typology?

The theories that support the psychological-shift typology are a mix between interpersonal and organizational theories. The theories include Worlds Theory, Attribution Theory, and Situational Crisis Communication Theory. Together, these theories are integrated to create a theoretical framework that has been applied to the case to further understand the gaps and needs for an additional typology.

What are the key psychological and blame components that will aid in the creation of the psychological crisis typology?

There are several components that are used in the aid of the psychological-shift typology. These components include the differences between cause and blame, blame, counterfactual thinking, and suicide. Research and data from these components are integrated in to the creation of the criteria for the psychological-shift typology.

How can we better understand this typology through studying a specific case?

This thesis analyzes the case using the theoretical framework, and then applies the criteria for the psychological-shift typology. This demonstrates that the case did fall within the criteria specified by the psychological-shift typology. I am able to understand the typology by analyzing the steps and processes taken by each organization in resolving its crises. It also allows me to

recognize the need for additional attention to be placed on interpersonal needs of employees affected by an organizational crisis.

What are key distinctions that make the psychological typology different from other typologies frequently studied in the crisis field?

This idea is explored throughout the thesis. The key distinctions that make the psychological-shift typology different from other typologies are the interpersonal and blame components that are emphasized and examined throughout this thesis. While other typologies examine crises from a human malevolent perspective, this typology focuses on the needs of individuals and how neglecting those needs have consequences. Rather than focusing on a mass loss of life/injury, this typology focuses on the aftermath of a suicide. This typology also addresses the needs of employees and how addressing those needs would help to prevent the psychological-shift typology from occurring.

How can this typology be used by practitioners and/or scholars to help further understand the psychological components of a crisis?

This typology is important because it contains components that are not usually addressed in other typologies. During the initial crisis, there are minimal steps taken to protect the mental health of the employees involved. An understanding of this crisis allows practitioners to take steps in actively avoiding the psychological-shift crisis. This thesis demonstrates gaps in the management of a crisis that results in a psychological-shift. The themes that emerge throughout the analysis are helpful in understanding the steps dedicated to the attention of psychological needs of employees within the organization. An attempt to dedicate time and care toward organizational members, allow researchers/practitioners to avoid a psychological-shift occurrence.

Future Research

This thesis allows us to understand a new typology based in the psychology field. One of the unique characteristics of this thesis is the main focus of the crisis that evolves after a suicidal death. This crisis is a result of two different crises faced by two related organizations.

Future research in to the subject should explore crisis planning processes and overall management of crisis situations. Research in to understanding the mental needs of individuals in how crises affect them is crucial in preventing the psychological-shift typology from occurring. Taking into consideration that employees are affected on a personal level, is an important component that organizations do not necessary recognize until it is too late.

Since this thesis is based on a theoretical framework, it may be useful to conduct quantitative research on understanding the needs of employees who have been through an organizational crisis. Having this type of statistical data would allow practitioners and/or researchers to develop certain methods and protocols in addressing the interpersonal needs of employees. Future research, in general, should also seek to continuously evolve and challenge the typology. This would include future analysis into case studies that are similar to this one, and/or crises that have evolved because of other mental instabilities.

Limitations

One of the limitations of this thesis is the inability to collect interview data and direct observation data from the organizations and individuals involved in the crisis. Interviews and direct observation would add a qualitative richness to this thesis. This type of information would also address specific points of interest that the media missed or chose to ignore.

Another limitation of this study is the lack of generalization toward other crises. This study is not meant to have the ability to generalize to other crises, but serves as an example to

further understand the need for an additional typology. The typology is based on research in the psychology and crisis communication fields that tailors to the events detailed in the case description.

Overall, the case has the ability to demonstrate the need for a new typology that focuses on psychological components of individuals involved within a crisis and how, without this attention, the crisis may shift into something else. Pro-active steps should be taken in order to ensure the well-being of the organization's employees. Not only do organizations need to focus on rebuilding its image, but it must also pay equal attention on providing professional services to its employees who are emotionally and/or mentally affected by the crisis.

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