

**SITUATIONAL CRISIS COMMUNICATION THEORY:
ITS USE IN A COMPLEX CRISIS WITH SCANDINAVIAN AIRLINES'
GROUNDING OF DASH 8-Q400 AIRPLANES**

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Summary

Organizational crises and disasters are becoming increasingly frequent and devastating. In fact, business crises occur daily. One major threat of a crisis is that it might damage the corporate reputation. While most crises have early warning signals that might be detected and acted upon, and thereby prevented, an organization must at times directly respond to threats to their good names. A growing body of crisis management research has emerged that focuses on how communication are best used to protect the organization's reputation during a crisis.

W. Timothy Coombs has developed one influential theory in this field. His Situational Crisis Communication Theory (SCCT) is a theory-based, empirically tested method for selecting crisis response strategies. Coombs introduced the SCCT in 1995 as a symbolic approach to crisis communication, but has during the last 13 years tested, refined, and developed it into a more coherent theory. The SCCT consists of three core elements: (1) the crisis situation, (2) crisis response strategies, and (3) a system for matching the crisis situation and crisis response strategies. SCCT recommends selecting the crisis response strategies that are appropriate to the characteristics of the crisis situation. Although the SCCT is premised on the belief that it is the stakeholders' perceptions of the crisis situation that decide what response strategies are appropriate, Coombs has been critiqued for treating stakeholders as a unitary actor. The SCCT does not acknowledge the fact that different groups of stakeholders might view a crisis situation differently.

To explore this issue further, a case study of a crisis that Scandinavian Airlines System (SAS) experienced in 2007 that resulted in the grounding of Dash 8-Q400 aircraft was employed in this thesis. This crisis affected and involved multiple groups of stakeholders, such as customers, employees, suppliers and the government. The stakeholders' perceptions and responses to the crisis were analysed through Danish news articles. Further, the communication strategies that SAS employed in response to the crisis were assessed through company press releases and statements in the media, using the analysis of SCCT and relating SAS' actions to prescriptions from the SCCT in similar situations.

The analysis of the case study confirms that the SCCT was applicable in this complex crisis situation, in that the stakeholders' perceptions were relatively consistent and did not vary noteworthy, suggesting that the SCCT is applicable also in situations where there are multiple actors involved. Although SAS overall did not follow the prescriptions from the SCCT, certain measures indicated that the corporate reputation was preserved after the crisis.

Preface

The Situational Crisis Communication Theory (SCCT) caught my interest in a course in corporate communications during the second semester of my master study programme. I used my project report that semester to explore the SCCT. This report was limited to 15 pages, which only allowed a brief exploration of the theory. I decided that I wanted to use my master's thesis to explore the SCCT more in depth. Although there is something appealing about the SCCT and its normative guidelines for selecting crisis response strategies, I must admit that my first thoughts were somewhat sceptical. Could it really be that simple? Might not an actual crisis be more complex than the theory takes into account? If it is this simple, why do so many organizations fail to protect their reputation during a crisis? After discussing it with my supervisor, I decided to investigate this complex issue further.

List of abbreviations

EASA – European Aviation Safety Agency

CM – Crisis Management

CRS – Crisis Response Strategies

Dash 8 – Dash 8-Q400

NAS - Norwegian Air Shuttle

NTB – Norsk Telegrambyrå AS

RI – Reputation Institute

SAS – Scandinavian Airlines System

SCCT – Situational Crisis Communication Theory

STK - Skandinavisk Tilsynskontor

Q400 – Dash 8–Q400

1 INTRODUCTION

1.1 Background

Crises are no longer rare, random or peripheral, but have become an inevitable and natural feature of our everyday lives and an integral feature of the new information/systems age. Hardly a day goes by without the occurrence of a new crisis, or the unfolding and “dragging on” of old ones (Mitroff and Anagnos 2001: 3-4). The world has recently witnessed a severe increase in crises of all kinds. It is literally crisis du jour, or the “crisis of the day”. Major crises can happen anywhere, anytime and to anyone (Mitroff and Anagnos 2001: 20, 21).

No company, no matter how financially successful, powerful or reputable, is immune to crises (Regester and Larkin 2005: 142). Crises are threats that actually do or have the potential to severely damage an organisation (Coombs 1999b: 1, 3).

An organization faces a variety of challenges during a crisis. One challenge is to protect/rebuild the organization’s reputation (Coombs 2004a: 276). Regester and Larkin explain that the forces of globalisation and the internet are pushing us from a so called “old world” or industrial economy, dependent on the value of physical assets such as property and equipment, to a “new world” or knowledge economy characterised by the intangible assets of reputation, knowledge, competencies, innovation, leadership, culture and loyalty (2005: 2). Good corporate reputations are increasingly recognized as having strategic value for an organization because it offers competitive advantage as an intangible asset (Cornelissen 2006: 79; Coombs 2007d: 164). In the global marketplace, differentiation is increasingly the crucial determinant of competitive advantage rather than price. A good corporate reputation will attract employees, investors and customers (Tucker and Melewar 2005: 379).

According to Fombrun (quoted in Cornelissen 2006: 83) reputation is “*a perceptual representation of a company’s past actions and future prospects that describe the firm’s overall appeal to all of its key constituents when compared to other leading rivals*”. Cornelissen explains that there are certain elements of importance in this definition. Firstly, a reputation is stakeholders’ perceptions of an organisation. Secondly, multiple stakeholder groups, who are likely to form different perceptions of an organisation, form a reputation. Thirdly, a reputation involves evaluation by stakeholders, meaning that reputations are long lasting and stable and develop with the stakeholders over time (2006: 83-85).

Crises threaten to damage reputations because a crisis gives people reasons to think badly of the organization (Coombs 2007d: 164). Threats to reputation, whether real or perceived, can destroy, literally in hours or days, an image or brand developed and invested in

over decades. These threats need to be anticipated, understood and planned for (Regester and Larkin 2005: 2). Coombs suggests that because no organisation is immune to crises, all organisations should learn as much as they can about how to manage crises (1999b: 1,3).

Over the past ten years, a rapidly growing body of crisis management research has emerged that focuses on what organizations say and do after a crisis hits, the use of crisis response strategies. The focus of this research is on the use of communication to protect the organization's reputation during a crisis (Coombs 2006c: 242). Coombs have offered the Situational Crisis Communication Theory (SCCT) as a theoretical framework to integrate the various ideas that have emerged from the crisis response research. Briefly, the SCCT holds that to protect a reputation, the responsibility acceptance of the organization's crisis response must be consistent with the stakeholder attributions of crisis responsibility generated by the crisis (Coombs 2006b: 175).

Just as multiple stakeholders' multiple perceptions of an organization form a corporate reputation (Cornelissen 2006), a crisis will affect multiple groups of stakeholders (Shrivastava and Mitroff 1987: 6). Lee claims that Coombs' categorization of crisis types overlooks the possible variations of attributions that may occur within a particular crisis. An audience could vary in their opinion that a company is accountable for a particular crisis (2004: 602). She suggests that future studies would have enhanced validity if they included the analysis of stakeholders' opinions expressed in newspapers or the Internet (Lee 2004: 614). Coombs does not devote much attention to this central issue of differentiated stakeholder attributions in his research, but treats stakeholders as if they were one big homogeneous group (Johansen and Frandsen 2007: 245). This, however, is the focus of this thesis.

1. 2 Aim and problem statement

The objective of this report is to give the reader a thorough understanding of the Situational Crisis Communication Theory, the theory's development, and to examine the theory in a new context with multiple actors. The following is the report's problem statement:

To what extent can the Situational Crisis Communication Theory (SCCT) be applied to complex crises involving multiple groups of stakeholders?

More specifically, this thesis aims to:

- (1) Present the SCCT and the theory's development from 1995 to 2007.

- (2) Examine the SCCT's applicability in a complex crisis case with multiple groups of stakeholders, by assessing what crisis response strategies SAS used after the accidents with the Dash 8 aircraft.

Although Coombs himself have provided excellent overviews of the research conducted in relation to the SCCT and the successful and the failed applications of the tests (Coombs 2004a; Coombs and Holladay 2004), there is no one complete examination of the development and changes made to the SCCT since its introduction in 1995.

2 METHOD

This chapter gives an overview of the approach used in this thesis.

2.1 Overview of the thesis

The first part of the thesis, that is chapter 3 and 4, describes a theoretical framework to understand and describe crises, the SCCT, and its development. To be able to describe and explain how the theory has evolved, it was necessary to collect all of Coombs' works and research using the SCCT since the introduction in 1995. This was achieved through systematic examinations of reference lists from Coombs' works and other authors discussing the SCCT, and bibliographic searches on the internet. The date of publishing of the works is used to explain the development of the theory, which could differ from the order in which Coombs produced them.

The second part of the thesis, namely chapter 5, is a case study, where the framework of the SCCT is used. To apply the SCCT, a complex crisis case that involved and affected multiple groups of stakeholders was selected. The case examines the crisis that Scandinavian Airlines experienced in 2007, which resulted in the airline permanently grounding 27 Dash 8-Q400 aircraft produced by Bombardier.

The third part of the thesis, chapter 6, is an analysis and discussion of the case. Here, the stakeholders' and SAS' perceptions and responses are described and discussed; again using the framework described in chapter 4 and relating the actions to the SCCT.

2.2 Data collection for the case study

The Scandinavian Airlines Dash 8-Q400 case received a lot of media attention, and a large amount of material exists that could have been used in this thesis. I have chosen to use news articles and press releases about the incidents, SAS and the important stakeholders for the analysis in this report.

SAS press releases and news stories were retrieved from the organization's web page (www.sasgroup.net) where there is an archive. This archive provides access to all press releases that SAS released in response to its crisis. Relevant news articles were retrieved from the Danish news archive Infomedia. The selected articles are mainly collected from Danish national newspapers from September 9, 2007, when the first landing incident happened, until November 1, 2007, about a week after the latest accident. The articles were identified through systematic database searches and selected based on perceived relevance for the case analysis.

To be considered relevant, the articles had to contain stakeholders' or SAS' spokespersons' statements regarding the crisis. The reason for using a Danish news archive to assess the crisis is that two of the accidents happened at Danish airports, and the last accident aircraft took off from a Danish airport, resulting in the crisis receiving the most attention in Denmark.

It could be that other methods for data collection, such as interviews or survey questionnaires, would have yielded different results and more accurately accounted for the various actors' opinions toward the crisis. However, secondary sources of data, such as news articles and media interviews, do reveal a lot about the attitudes and values attached to certain phenomenon or the reality of society (Askheim and Grenness 2000: 100-101). Moreover, the opinions of stakeholders are to a large degree based on information from the media. The public perceives not the objective facts of a crisis event, but the facts as constructed by the media or news releases from the organization in crisis (Cho and Gover 2006: 420).

2.3 The case study method

Case study methods involve systematically gathering enough information about a particular person, social setting, event, or group to permit the researcher to understand effectively how the subject operates or functions. The case study is not actually a data-gathering technique but a methodological approach that incorporates a number of data-gathering measures (Berg 2004: 251).

Researchers have different purposes for studying cases. The case study in this thesis can be classified as an instrumental case study (Stake 1994 in Berg 2004: 256), in that it seeks to provide insights into an issue or refine a theoretical explanation. The case study actually becomes of secondary importance in that it serves a supportive role, a background against which the actual research interest plays out. The intention is to assist the researcher to understand better some external theoretical question or problem. Instrumental case studies may or may not be viewed as typical of other cases (Berg 2004: 256). The SAS crisis case was chosen because the researcher believes that her own and others' understanding about the SCCT will be advanced when studied and applied to this specific crisis situation.

Further, this case study can be classified as a descriptive case study (Winston 1997: 4). A descriptive case exploration requires that the investigator presents a descriptive theory, which establishes the overall framework for the investigator to follow throughout the study (Berg 2004: 257). The SCCT constitutes the theoretical framework for the case study in this thesis. As will be explained in more detail in chapter 4, the SCCT outlines specific steps for a

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crisis manager to follow in order to evaluate a crisis situation and choose the appropriate responses. The SAS case study is presented following the same procedures.

3 CRISIS: THEORETICAL FRAMEWORK

The literature on crisis communication and crisis management is fragmented, as people write about crises from very different perspectives (Coombs 2007c: x). Authors often focus on their specialties and fail to make connections to ideas and concepts developed in other specialties. In turn, this fragmentation prevents a fuller understanding of crisis management gained by integrating the various perspectives (Coombs 2007c: x). Both as a field of research and as a corporate function, crisis management (CM) is still new, and as a result is neither well understood or widely accepted (Mitroff 1994: 101).

3.1 Crisis defined

Reger and Larkin claim that in business as in life, crises come in as many varieties as the common cold. The spectrum is so wide it is impossible to list each type (2005: 133). No two crises are alike. Each has its own causal factors, ramifications, duration, rhythm, and unknowns (Dilenschneider 2000: 121). A crisis does not necessarily mean casualties or personal injuries by the hundreds with devastating effects. A crisis may also be the result of some undesirable, and often banal, situation that may have a negative impact on the organization in some respect (Fagerli and Johansen 2003: 233). A crisis imposes severe strain on the organization's financial, physical, and emotional structures, and might even jeopardise the survival of the whole organization (Pearson and Mitroff 1993: 49). There are many books written about crisis management but there is no one accepted definition of a crisis (Coombs 2007c: 2). One reason for this might be the many different perspectives and focuses of researchers writing in this discipline.

Fearn-Banks (2002: 2) defines a crisis as *“a major occurrence with a potentially negative outcome affecting an organization, company or industry, as well as its publics, products, services or, good name”*. She explains that crises interrupts normal business transactions and can sometimes threaten the existence of an organisation. Mitroff and Anagnos (2001: 34-35) suggests, *“a crisis is an event that affects or has the potential to affect the whole of an organisation”*. If something affects only a small and isolated part of an organisation, it may not be a major crisis. A major crisis is something that cannot be completely contained within the walls of an organization.

Each corporate actor exists within a complex web of relationships with other organizations that can stimulate, constrain, or challenge its actions (Allen and Caillouet 1994: 44). It is no longer enough for any organization to consider merely its own crisis management

interests in isolation from the environment. A crisis has the potential to affect not only the organization and its products, but also the broadest array of potential stakeholders: consumers, competitors, suppliers, and members of their general environment (Pearson and Mitroff 1993: 57). It has even been suggested that a crisis in one corporation has the ability to threaten an entire industry (Coombs 2006a: 5).

Their inherent ambiguity further complicates crises (Ulmer and Sellnow 2000: 146). Pearson and Clair (1998: 60) suggests that: "*An organizational crisis is a low-probability, high-impact event that threatens the viability of the organization and is characterized by ambiguity of cause, effect, and means of resolution, as well as by a belief that decisions must be made swiftly*". The larger the amount of ambiguity surrounding a crisis, the greater its uncertainty (Coombs 1999b: 92). The uncertainty surrounding a crisis situation creates pressures for explanation or accounts of why the crisis has occurred, and the actions necessary to resolve it (Dutton 1986: 509). Ambiguity demands to be resolved, and organizations must expend extra effort and resources when crisis ambiguity increases (Coombs 1999b: 92-93). However, crises are also characterized as information-poor and knowledge-poor situations (Coombs 2007c: 113). Typically, an organization does not know the cause of an accident, it is difficult to collect the necessary information or the information is not immediately available, or the complexity of the situation makes it difficult to get an overview (Johansen and Frandsen 2007: 167). Mysteries around a crisis may increase and keep attention from the media and publics for a longer time (Coombs 1999b: 92-93).

Virtually no crisis ever happens in isolation, and the simultaneous occurrence of multiple crises is the norm. If handled improperly, every crisis can set off a chain reaction of other crises (Pearson and Mitroff 1993: 52; Mitroff 1994: 105). Davies, Chun, da Silva and Roper (2003: 99) suggests that a crisis is "*an event or series of events that can damage a company's reputation*". They explain that typically crises interfere with normal operations, attract external, particularly media, attention, damage profitability, and escalate if not well handled.

Johansen and Frandsen (2007: 79) offer a definition of a specific sort of crisis escalation, what they term a double-crisis or a communications-crisis. "*A double-crisis is a crisis, where the original crisis is superposed by a communications-crisis, as the organization fails in managing the communication processes that should have contributed to the handling of the original crisis*". They explain that the handling of a crisis set off a communications-crisis, and that their definition considers both types as crises. Crises are, by definition, dynamic unanticipated events, characterized by high levels of uncertainty. Real crisis rarely

follow planning scenarios (Seeger, Sellnow and Ulmer 2001: 159). In fact, a cardinal rule of crisis management is that no crisis ever unfolds exactly as it was envisioned or planned for (Mitroff, Shrivastava and Udvardia 1987: 285).

Another definition of crises that captures many of the common traits other writers have used when describing crises is suggested by Coombs: *“the perception of an unpredictable event that threatens important expectancies of stakeholders and can seriously impact an organization’s performance and generate negative outcomes”* Coombs (2007c: 2). Coombs explains that a crisis is perceptual, and that it is the perception of an organization’s stakeholders that help define an event as a crisis. If the stakeholders believe that an organization is in crisis, a crisis does exist. Further, a crisis is unpredictable but not unexpected. Wise organizations know that they will experience crises, they just do not know when. A crisis may also violate expectations that stakeholders hold about how organizations should act. When these expectations are breached, stakeholders perceive the organization less positively and the reputation is harmed. Coombs further claims that a crisis has a serious impact on an organization in that it disrupts or affects the entire organization or has the potential to do so. Last, crises have the potential to create negative or undesirable outcomes for organizations, their stakeholders, and their industries (2007c: 3-4).

From the above discussion of different crises definitions and perspectives, several factors emerge, which complicate and add to the complexity of a crisis:

- Multiple groups of stakeholders involved in the crisis.
- Multiple organizations involved in the crisis.
- Lack of necessary crisis related information, resulting in ambiguity toward crisis evidence, the organization’s intentions and its responsibility for the crisis.
- A crisis is dynamic, in that it is not static and might well evolve in unforeseen directions over time, sometimes resulting in additional crises for an organization to handle.

Fagerli and Johansen explain that they strongly believe that, except in many cases of natural disaster, every crisis is foreseeable and that the difficult part is foreseeing when the crisis will occur (2003: 233). Whereas public relations practitioners cannot always predict a specific disaster or crisis, they can anticipate that the unexpected will occur. It is the “unexpected” nature of events that creates a crisis (Cutlip, Center and Broom 2006: 326). What all crises

have in common is that if a company prepares itself for a crisis, it has a better chance of getting some degree of control over the crisis (Dilenschneider 2000: 121).

3.2 Crisis management

The most common practice for dealing with crises in organisations is called crisis management (CM). CM has been extensively researched over the past few years, and, like crisis itself, has been variously defined by many different authors (Fagerli and Johansen 2003: 237). Fearn-Banks' (2001: 480) definition of the concept is as follows "*Crisis management is strategic planning to prevent and respond during a crisis or negative occurrence, a process that removes some of the risk and uncertainty and allows the organization to be in greater control of its destiny*". She further explains (Fearn-Banks 1996: 2) that in a crisis, emotions are on edge, brains are not fully functioning, and events are occurring so rapidly that drafting a plan during a crisis is unthinkable, and simply following one is difficult.

The objective of organizational CM is to make timely decisions based on best facts and clear thinking when operating under extraordinary conditions (Pearson 2002: 70). If one has, a thorough understanding of the essential basics of CM the impacts of all crises can be lessened. By having, the right plans and capabilities in place before a crisis occurs, crisis damage to an organization can be minimized and the time to recover from it can be shortened immensely (Mitroff and Anagnos 2001: 6, 20). Regester and Larkin suggest that virtually every crisis contains within itself the seeds of success as well as the roots of failure. Finding, cultivating and harvesting the potential success is the essence of CM. They further state that "*Successful management of a crisis situation is about recognizing you have one, taking the appropriate actions to remedy the situation, being seen to take them and being heard to say the right things*" (2005: 163).

A consistent theme that permeates the CM literature is the idea that a crisis has an identifiable life cycle. Understanding the crisis life cycle is important because it can be used to foresee expected outcomes for each stage of the cycle (Gonzales-Herrero and Pratt 1995: 26). Crisis managers need to approach each of these crisis stages with a focus to meet the different management needs and challenges represented by different dynamics and dimensions in each stage (Sturges 1994: 300). The crisis life cycle has also been termed a staged approach to CM. A staged approach means the divide of the CM function into discrete segments executed in a specific order (Coombs 2007c: 13).

One of the most influential staged approaches is crisis expert Ian Mitroff's (1994) five-staged model. The first phase in his model is Signal Detection. Virtually all crises leave a trace of early warning signals. If management can detect and act upon these signals, then many crises can be prevented before they occur, which is the best possible kind of CM. The second phase, which often takes place simultaneously with signal detection, is Probing and Prevention (Mitroff 1994: 105; 2000:40). The aim is to do as much as possible to prevent crises from occurring in the first place and to manage effectively those, which still happen despite best efforts (Pearson and Mitroff 1993: 53). The next phase is Damage Containment. The purpose is to contain the effects of a crisis from spreading further and, hence, from infecting other uncontaminated parts of an organization or the environment. The fourth phase is Recovery. Its primary purpose is to recover normal business operations as soon as possible so that key customers will not be lost. Learning, the last phase of CM, refers to the process of reflecting upon what was done well and what was done poorly so that the organization can handle crises better in the future (Mitroff 1994: 106-107).

Coombs offers a different staged approach to CM in his book *Ongoing Crisis Communication* (2007c). This book develops a systematic approach for synthesizing the diverse CM insights into one comprehensive framework. Coombs divide the CM process into the three macro stages precrisis, crisis, and postcrisis, which each contains separate substages or set of actions that should be covered during that stage. The three stages are general enough to accommodate other dominant CM models, such as Mitroff's (1994) five-stage approach, and to allow for the integration of ideas from other CM experts (Coombs 2007c: 14, 17-18). Coombs divide of the CM process includes the following stages:

- *Precrisis stage:* The precrisis stage involves actions before a crisis is encountered and consists of the three substages: (1) signal detection, (2) prevention, and (3) crisis preparation. Crisis managers must develop a system for detecting potential crisis and responding to them. Once potential crises are detected, actions must be taken to prevent them from happening. Crisis managers must be prepared if a crisis still occurs (Coombs 2007c: 18-19).
- *Crisis event:* The crisis event stage begins with a trigger event that marks the beginning of the crisis and ends when the crisis is considered resolved. This crisis phase has two substages: (1) crisis recognition and (2) crisis containment. Crisis recognition includes an understanding of how events are labelled and accepted as crises and the means for collecting crisis-related information. Crisis containment

focuses on the organisation's crisis response. Communication with stakeholders through words and actions is a critical part of this phase (Coombs 2007c: 19).

- *Postcrisis stage:* CM does not end when the crisis ends. There are key activities that must transpire after the crisis. Coombs claims that the best learning experience for CM is a real crisis (2005a: 219-220). This stage should involve three steps: (1) evaluating CM, (2) learning from the crisis, and (3) other postcrisis actions such as follow up communication with stakeholders and continued monitoring of issues related to the crisis (Coombs 2007c: 19).

The life cycle perspective shows that effective CM must be integrated into the normal operations of an organisation. It is not just about developing a plan and executing the plan during a crisis, but is an ongoing process. Crisis managers continually work to reduce the likelihood of a crisis occurring and to prepare the organization for the day when a crisis does occur. Moreover, crisis managers carefully dissect each crisis in order to improve prevention, preparation, and response (Coombs 2007c: 13-14, 20). While Mitroff's model also attempt to both describe and to give recommendations for how to handle precrisis and crisis stages as well as the postcrisis stage, Coombs' model has a stronger focus on all three stages by dividing the postcrisis phase into three substages as well. Further, the several substages in Coombs' model, show that the field of CM have more nuances than ever, and is continuously developing with an increased interest in the pre- and post-crisis phases as well as the crisis-event phase (Johansen and Frandsen 2007: 136-137).

Fagerli and Johansen claim that in the discussion of CM, terms such as detecting, analysing, sensing, diagnosing, and assessing abound in the various descriptions. Successful execution of these activities enables organizations perhaps not to avoid crisis, but certainly to be proactive in that they are able to prepare for and possibly prevent them. They further argue that what organizations need to emphasise is perhaps not CM but crisis planning (2003: 238-239). Pearson and Mitroff argue that the purpose of CM is not to produce a set of plans but to prepare an organization to think creatively about the unthinkable so that the best possible decisions will be made in time of crisis. A fixed preparation for all crises is not a sensible target. However, a systematic, integrative process of CM is a proper and attainable goal. Anything less invites disaster (Pearson and Mitroff 1993: 59). In today's world, there is no option but to prepare broadly for the unthinkable. It is no longer a question of if a major crisis will strike an organization, but only when (Mitroff 1994: 113). Seeger et al. (2001: 159)

suggest that remaining open to new information, perspectives, contingencies, interpretations, and alternatives are particularly critical to effective CM.

An important part of CM is the consideration of the organization's stakeholders. It is crucial that organizations consider how they might be labelled or perceived by the outside world; given the CM actions they are considering (Pearson and Mitroff 1993: 56). The organization always should know who its stakeholders are, know which are most important, rank them according to importance, and strive to develop and maintain strong relationships with them (Fearn-Banks 2001: 482).

Freeman (1984 quoted in Cornelissen 2006: 61) defines stakeholders as "*any group or individual who can affect or is affected by the achievement of the organization's purpose and objectives*". Cornelissen explains the concept of stakes in Freeman's definition as the interest or share that individuals or groups have in an organisation, and that these interests or shares might be varied (2006: 61). Clarkson (1995: 106) divide stakeholders into primary and secondary stakeholder groups. He explains that there is a high level of interdependence between an organisation and its primary stakeholder groups. An organisation is dependent on these groups in order to survive in the market. Primary stakeholder groups are typically comprised of shareholders and investors, employees, customers, suppliers, and public stakeholder groups, which is the government and communities. If primary stakeholders withdraw their support it can severely damage the organisation and hinder it from continuing as an operating organisation. Defined as secondary stakeholder groups are as those who influence or affect, or are influenced or affected by the corporation, but they are not engaged in transactions with the corporation and are not essential for its survival. This includes the media and a wide range of special interest groups (Clarkson 1995: 106-107).

An organization's stakeholders are impacted by crises to varying degrees, and their interests and needs are often contradictory. Addressing these multiple and competing needs of an organization's complex audiences during a crisis is an integral component of crisis resolution for both the organization and its stakeholders. Failure to meet the needs of stakeholders in reasonable time can result in these groups intensifying the crisis for the organization (Ulmer and Sellnow 2000: 143-145). Successful organizations are those that communicate openly and accurately to their multiple audiences immediately after a crisis occur (Seeger et al. 2001: 163).

3.3 Crisis communication

Planning cannot prevent every crisis (Mitroff et al. 1987: 285), and at times, corporations must directly respond to corporate crises (Benoit 2004: 263). Effective communication is essential to the success of every organization. Hence, it should be no surprise that identifying and carrying out a series of communication strategies is essential for effective CM (Barton 2001: 62). Fearn-Banks (2002: 2) defines crisis communication as “*the dialog between the organization and its publics prior to, during, and after the negative occurrence*”. She explains that the strategies and tactics used are designed to minimize damage to the image of the organization (Fearn-Banks 1996: 3). Although crises can have devastating effects on the organization and its stakeholders, these events can also be resolved positively. The communication following a crisis plays an integral role in this success (Ulmer 2001: 592). Effective CM includes crisis communications that not only can alleviate or eliminate the crisis, but also can sometimes bring the organization a more positive reputation than before the crisis (Fearn-Banks 1996: 2).

Coombs claims (2005b: 223) that crisis communication is the lifeblood of the entire CM effort and plays a vital role in all stages of CM. Crisis communication strategies represent the actual responses the organisation uses to address the crisis and have both verbal and nonverbal aspects. Different crises can necessitate the use of different communication strategies as well as an emphasis on different stakeholders (Coombs 1999b: 121, 127). Coombs divides crisis response research into two categories that reflect different emphasises: form and content. Form is how the response should be presented. Content is what is said (2006b: 171; 2007c: 128).

The form of a crisis response is mentioned more frequently in the CM writings than any other topic. According to Coombs, this represents the most basic and primitive line of research concerning crisis response, usually resulting in lists of what to do and what not to do. The form recommendations for crisis communications are to be quick, consistent and open (Coombs 2006b: 172; 2007c: 128). Register and Larkin explain that in crisis situations, it is imperative to tell your own story, to tell it all and to tell it fast (2005: 174).

Coombs suggests (2006b: 174) that content research is a more recent development in CM and has proven to be more thorough than the form research. What is actually said during a crisis has serious ramifications for the success of the CM effort. Key goals in the CM process are to prevent or minimize damage, maintain the organization’s operations, and repair reputational damage. Clear communication is essential for each of these three goals (Coombs

2007c: 133). Sturges divides crisis communication content into three sequential categories (1994: 308):

- 1) Instructing information, which is information that tells people affected by the crisis how they should physically react to the crisis.
- 2) Adjusting information, which is information that helps people psychologically cope with the magnitude of the crisis situation.
- 3) Internalizing information, which is information that people will use to formulate an image about the organization.

Coombs explains that people are the first priority in any crisis, so instructing information must come first. Adjusting information help stakeholders cope with stress created by the uncertainty and potential harm of a crisis. Stakeholders are reassured when they know what happened and what is being done to protect them from future crisis. Further he explains (Coombs 2007c: 133-137) that internalising information is about reputation management. The idea is that crisis response strategies (CRS) affect how stakeholders perceive the crisis and the organization in crisis (Coombs 2007c: 150). Instructing and adjusting information must always come before internalising information. Audiences may react negatively to messages about “what a great company we are” in the face of the audience’s primary concern for the deeper meaning of the crisis’ impact (Sturges 1994: 309).

Johansen and Frandsen claim that Coombs’ divide of the research has its advantages, but does not offer much when it comes to the actual scientific research. They suggest a divide of the crisis communication research into two main research traditions, which has developed in two different dimensions. The first research tradition, they explain, is the text-oriented or rhetorical tradition where the primary interest of study is what an organization actually communicates verbally or in writing when facing a crisis. The most influential fields of study in this tradition are apologia, which studies rhetorical defence strategies, and impression management, where the emphasis is on how people through self-representation tries to control their impression on others (Johansen and Frandsen 2007: 200).

The second tradition of research is the context-oriented or strategic tradition, which to a larger degree focuses on the context or the situation of research. The first tradition focus on the what and how of communications, while the second tradition is more concerned of where and when it is strategically beneficial to communicate what and how, in order to preserve an organizations image and reputation. In the context-oriented or strategic tradition, the most

influential theories are in the fields of CM, reputation management and public relations (Johansen and Frandsen 2007: 201-202). Coombs' Situational Crisis Communication Theory is a clear representative for this context-oriented research tradition within crisis communication, and this theory will be examined in detail below.

4 SITUATIONAL CRISIS COMMUNICATION THEORY (SCCT)

4.1 Introduction to the SCCT

W. Timothy Coombs is Professor in Communication Studies at Eastern Illinois University, where he teaches crisis management, corporate communications, and public relations. Coombs holds a Ph.D. from Purdue University in Issues Management and Public Affairs. His primary research area is crisis research with a focus on the development and testing of the Situational Crisis Communication Theory (SCCT).

Coombs initially presented this theory in his 1995 article “*Choosing the Right Words: The development of guidelines for the selection of the “appropriate” crisis response strategies*”. However, the theory was not named Situational Crisis Communication Theory (SCCT) before 2002 (Coombs and Holladay 2002). Before that, the theory was referred to as “the symbolic approach to CM/communication” (i.e. Coombs 1995: 447; 1998: 177).

SCCT consists of three core elements: (1) the crisis situation, (2) crisis response strategies, and (3) a system for matching the crisis situations and crisis response strategies (Coombs 2006c: 243). The belief is that the effectiveness of communication strategies is dependent on characteristics of the crisis situation. By understanding the crisis situation, a crisis manager can choose the most appropriate response. SCCT is an attempt to understand, to explain, and to provide prescriptive actions for crisis communication (Heath and Coombs 2006: 203, 207).

The CRS are what Sturges (1994) calls internalizing information, and are used by stakeholders to help form their perception of the organizational reputation (Coombs 1999b: 128). To be ethical, crisis managers must begin their efforts by using communication to address the physical (instructing information) and psychological (adjusting information) concerns of the victims (Coombs 2007d: 165). Although one study, which examined the effects of vague and detailed instructing responses in accident crises, found no effect on organizational reputation, accepting the organization’s story, or willingness to engage in potential supportive behaviour for the organization, the SCCT maintains that instructing information should be taken as given in any crisis situation (Coombs 1999a: 137; 2006b: 185). It is only after this foundation is established that crisis managers should turn their attentions to reputational assets. SCCT provides guidance when crisis managers have met their initial obligations and are prepared to address reputational concerns (Coombs 2007d: 165).

Coombs explains that although crisis responses are a common topic in the crisis management literature, the discussions are heavily descriptive (1999a: 125-126). Although offering some interesting ideas, the image restoration literature is heavy on description and retrospective sense making through case studies, whereas it is short on predictive value and causal inferences. Scientific evidence demands the process of comparison (Coombs and Schmidt 2000: 163). Relying on single case studies and untested assumptions, limit our understanding of how people respond to crisis and CRS and weakens the field of crisis management (Coombs 1999a: 125; Coombs 2007d: 171).

SCCT is offered as an alternative to case studies for understanding how to protect reputational assets during a crisis. Research using SCCT relies on experimental methods and social-psychological theory rather than case studies (Coombs 2007d: 163, 174). SCCT advances and tests hypothesis related to how perceptions of the crisis affect the crisis response and the effects of crisis responses on outcomes such as reputation, emotions, and purchase intention (Coombs 2007a: 137). In most cases, this involves specification of one or several hypothesis. The population for the study typically consists of students from a Midwestern university, the number of participants for the different studies being anywhere between 49 and 518. Different crisis scenarios with following questionnaires are constructed, and randomly distributed to the respondents. Statistical analyses based on the respondents' answers are carried out, and the hypothesis are then confirmed or disconfirmed.

The SCCT has since its introduction been the subject of extensive testing and revising. In the following, the major changes of the SCCT from 1995 until 2007 will be presented.

4.2 Sources of inspiration for the SCCT

The SCCT builds on elements from other theories or approaches.

4.2.1 Attribution Theory

Attribution Theory provides the rationale for the relationship between many of the variables used in the SCCT (Coombs 2007d: 166), and provides a useful framework for conceptualising crisis management, and serves as the basis for explaining the relationships between crisis-response strategies and crisis situations (Coombs 1995: 448).

Attribution Theory expert Bernard Weiner claims that if the outcome of an event is negative, unexpected or important, then people will search for the cause of that outcome. His Attribution Theory posits that people make judgements about the causes of events based upon the dimensions of locus, stability, and controllability (Weiner 1986: 50, 127). Wilson, Cruz,

Marshall and Rao (1993: 353) explain that Locus assesses whether the cause for an event is in the actor (internal) or in the situation (external). Stability assesses whether the cause for an event always is present (stable) or varies over time and context (unstable). Controllability assesses whether the actor can affect causes that determine the outcome of an event (controllable) or whether these causes are beyond the actors influence (uncontrollable).

Coombs suggests that two key traits of crisis are that they are unexpected and negative and, therefore, are logical situations for triggering an attributional search. He translated the principles of attribution theory into language appropriate for crises and organizations (Coombs 2001: 111; 2007a: 136). He suggests that stakeholders will make attributions about the cause of a crisis and they will assess crisis responsibility (Coombs 2007a: 136). Attributions of internal locus, controllability, and stability create the perception that the organization is responsible for the crisis. The reverse is true when the attributions are external, uncontrollable, and unstable. Different crisis situations facilitate certain attributions of organizational responsibility for a crisis. The stronger the attributions of organizational responsibility, the more likely it is that the negative aspects of the crisis will damage the organization. The stakeholders will perceive an organization's image more negatively and will be less likely to interact with the organization (Coombs 1995: 449).

Weiner explains that causal attributions and their underlying properties of locus, stability, and controllability in turn generate differentiated affective reactions. Moreover, these diverse affective reactions could generate disparate actions or behaviours (1985: 559; 1986: 127). The attributions stakeholders make about a crisis will generate emotions about the organization and these emotions will affect their future interactions with the organization. Sympathy, anger and schadenfreude are identified as the most important emotions from Attribution Theory for application to post-crisis communication (Coombs and Holladay 2005: 265). Crisis responsibility is related to the affect created by a crisis. Stronger perceptions of crisis responsibility strengthen the negative affect (anger and schadenfreude) while lower perceptions of crisis responsibility are related to positive affect (sympathy). The emotions may require certain CRS in order for the response to be effective and protect the organizational reputation (Coombs and Holladay 2005: 269, 271).

One way crisis-response strategies attempt to repair the damage from a crisis is by altering how publics perceive the attribution dimensions (Coombs 1995: 449), or the subsequent feelings attached to those attributions (Coombs and Holladay 2004: 97).

4.2.2 Relationship management

The relationship perspective of public relations suggests that balancing the interests of organizations and publics is achieved through management of organization-public relationships (Ledingham 2006: 465). John Ledingham and Steven Bruning have been the primary researchers advancing relationship management theory. Relationship becomes the core of public relations and is defined as “*the state which exists between an organization and its key publics in which the actions of either entity impact the economic, social, political and/or cultural well-being of the other entity*” (Ledingham and Bruning 1998: 62). Relationship management theory shifts the central focus of public relations from communication to relationships, with communication acting as a tool in the initiation, nurturing, and maintenance of organization-public relationships (Ledingham 2006: 466).

Coombs claims (2000a: 75) that both primary and secondary stakeholders are interdependent with an organization. Stakeholders and an organization have a connection that binds them together, whether grounded in economic, political or social concerns. Hence, it is appropriate to talk about relationships between an organization and its stakeholders. Coombs have applied the relational perspective to the public relations function of crisis management. He suggests that crises are episodes embedded in a larger and ongoing relationship between an organization and its stakeholders (Coombs 2000a: 73).

The relational history is the result of the collection of events in a relationship. The relational history is functionally equivalent to reputation. A reputation is based on a stakeholder’s experiences with an organization. Thus, both reputation and relational history results from past interactions between the organization and the stakeholders (Coombs 2000a: 74-76). Stakeholders use the relational history as a lens through which to view the current crisis situation. Crisis managers must anticipate how the ongoing relationship might affect how the stakeholders perceive the crisis and its impact on the organization (Coombs 2000a: 86-87). Thus, the ongoing relationships with stakeholders provide a practical context from which to analyse a crisis episode, and helps managers to develop effective responses to crises. A relational approach adds depth to the attributional analysis of the crisis. The relational history of the stakeholders and the organization provide a value context for interpreting the current crisis. The relational history may colour the current crisis so that the appropriate CRS differ from those suggested by attribution theory (Combs 2000a: 73, 89).

4.2.3 Neo-institutionalism

Neo-institutional theory posits that a corporate actor's actions and message strategies are partially constrained by forces within its organizational field, that is, those stakeholders that either affect or are affected by the corporate actor's goals and operations. Thus, there is a focus on an organization's institutional environment. Power dynamics within an organizational field result in an institutional environment characterised by norms, rules and requirements (Allen and Caillouet 1994: 45). Organizations attempt to incorporate norms from their institutional environments so that they can gain legitimacy, resources, stability, and enhanced survival prospects (Chizema and Buck 2006: 492).

A key premise of neoinstitutionalism is that conformity to social rules within the external institutional environment potentially enhances a corporate actor's legitimacy (Allen and Caillouet 1994: 45). Legitimacy management is a cultural process whereby organizations attempt to gain, maintain, and in some cases regain stakeholder support for organizational actions. When organizational actions are perceived as consistent with stakeholder expectations, legitimacy are managed successfully (Massey 2001: 154-156). Neoinstitutionalism is a popular perspective for understanding how to manage the stakeholder-organization relationship. The stakeholder-organization relationship is then defined in terms of social rules or expectations, that is, the stakeholders' perception that the organization is meeting their expectations. The relational history becomes a function of events related to either meeting or failing to meet stakeholders' expectations (Coombs 2000a: 75-77).

One dimension of a crisis is that it is a threat or challenge to an organization's legitimacy. A crisis can be viewed as a violation of the social rules or expectations held by stakeholders and, thus, a disruption to the relationship (Coombs 2000a: 76). Research has indicated that to maintain legitimacy an organization must engage in successful crisis management (Massey 2001: 169). From a neoinstitutional perspective, organizations should favour the use of CRS that reflect efforts to re-establish legitimacy. Organizations should shift focus from the violation of the social norms, which is the crisis, to efforts designed to repair the violation, and use strategies that show how the organization has returned to the norms held by its stakeholders (Coombs and Holladay 1996: 281).

Organizational management utilizes CRS to rebuild legitimacy and to protect the organizational reputation during a crisis. As a crisis threatens organizational legitimacy, it simultaneously threatens to damage the organization's reputation, how stakeholders perceive the organization (Coombs 2006c: 249). Crises are a form of reputational damage. Relational

damage is a form of reputational damage because the reputation arises from the relational history. Any threat to the relational history is a threat to the reputation (Coombs 2000a: 77).

4.3 Coombs’ symbolic approach in 1995

This section outlines the three elements of the SCCT as introduced in 1995.

4.3.1 The crisis situation

The crisis situation has four central factors that affect the attributions publics make about the crisis. The first factor is the crisis type. The crisis types are classified using a two dimensional crisis type matrix. The internal-external dimension of the matrix corresponds to the locus of control dimension in Attribution Theory, while the intentional-unintentional dimension reflects Attribution Theory’s controllability dimension. Internal means the crisis was something done by the organization itself, and external means the crisis was caused by something done by some person or group outside of the organization. Intentional means the crisis event was committed purposefully by some actor, and is thereby perceived as more controllable than an unintentional crisis event, which is not committed purposefully by some actor (Coombs 1995: 454-455). Figure 1, shows the four mutually exclusive crisis types that derive from the matrix, while table 1 offers an explanation of the same crisis types.

Figure 1. Crisis Type Matrix in 1995 (Coombs 1995: 455-457):

Unintentional	Intentional	
Faux Pas	Terrorism	External
Accidents	Trans- gressions	Internal

Table 1. Crisis types 1995.

<i>Crisis type</i>	<i>Explanation</i>
Faux Pas	External agents challenge the appropriateness of an organization's actions
Accidents	Unintentional happenings during normal organizational operations. Includes both acts of nature and human induced error.
Transgressions	Intentional actions taken by an organization that knowingly place publics at risk or harm.
Terrorism	Intentional actions taken by external actors with the goal of harming an organization directly or indirectly.

A *faux pas* is an unintentional action that an external agent tries to transform into a crisis. The challenge typically comes in the form of protests and boycotts. The unintentional nature and external challenge of faux pas favour attributions of minimal organizational responsibility. *Accidents* include product defects, employee injuries and natural disasters, among other. The unintentional and generally random nature of accidents leads to attributions of minimal organizational responsibility (Coombs 1995: 455-456). A *transgression* creates attributions of internal locus and controllability due to the intentional nature of the action, meaning an organization is held responsible for the crisis. Examples of transgressions are management knowingly selling defective or dangerous products, withholding safety information from authorities or violating laws. *Terrorism* covers actions such as product tampering, hostage taking, sabotage, and workplace violence. Terrorism is intentional acts controlled by external agents, which should favour minimal organizational responsibility for a crisis (Coombs 1995: 457).

The first factor, that is the crisis type, cannot capture all the major variables involved in perceptions of the crisis situation. Therefore, three additional factors are suggested relevant when publics assign attributions to crises (Coombs 1995: 454, 457-461):

- *Veracity of the evidence*: Refers to the proof of whether or not a crisis event occurred, and might be true, false or ambiguous.
- *Damage*: Classified as severe or minor. Severe damage involves serious injury, death, or massive property damage whereas minor damage involves negligible injuries or property damage. Publics are here divided between victims and non-victims.

- *Performance history*: Classified as positive or negative. A history of similar crisis makes the cause of the crisis appear to be stable, while a positive performance history makes the cause of the crisis appear unstable.

4.3.2 Crisis response strategies

The repertoire of CRS is composed of messages designed to repair organizational images (Coombs 1995: 449). Table 2 presents the strategies and sub-types as presented in 1995.

Table 2. Crisis response strategies 1995.

Strategy	Sub type/tactic	
Nonexistence Strategies	Denial Clarification Attack Intimidation	
Distance Strategies	Excuse	Denial of intention Denial of volition
	Justification	Minimizing injury Victim deserving Misrepresentation of the crisis event
Ingratiation Strategies	Bolstering Transcendence Praising others	
Mortification Strategies	Remediation Repentance Rectification	
Suffering Strategy		

The *non-existence strategies* seek to eliminate the crisis, with the objective of showing that there is no link between the fictitious crisis and the organization. *Denial* is the simple statement that nothing happened, while *clarification* also attempts to explain why there is no crisis. *Attack* implies confronting those who wrongly report that a crisis exists, and *intimidation* involves threats to use organizational power against some actor such as lawsuits and physical violence (Coombs 1995: 450-451).

The *distance strategies* acknowledge the crisis and serve to create public acceptance of the crisis while weakening the linkage between the crisis and the organization. *Excuse* tries to minimize organizational responsibility for the crisis by denying intent and/or volition. *Justification* seeks to minimize the damage associated with the crisis. The organization attempts to convince publics that the situation is not that bad, perhaps by stating that the crisis is not as bad as similar crises. Justification tactics include denying the seriousness of an injury, claiming that the victim deserved what happened, and claiming that the crisis event has been misrepresented (Coombs 1995: 451).

The *ingratiation strategies* seek to gain public approval by connecting the organization to things positively valued by publics. *Bolstering* reminds publics of existing positive aspects of the organization. *Transcendence* tries to place the crisis in a larger, more desirable context. Moreover, *praising others* is used to win approval of the target of the praise (Coombs 1995: 452).

The *mortification strategies* attempt to win forgiveness of the publics and to create acceptance for the crisis. *Remediation* willingly offers some form of compensation or help to victims. *Repentance* involves asking for forgiveness and apologizing for the crisis. *Rectification* involves taking action to prevent a recurrence of the crisis in the future (Coombs 1995: 452-453).

The *suffering strategy* tries to win sympathy from publics by portraying the organization as an unfair victim of some malicious, outside entity (Coombs 1995: 453).

4.3.3 Matching process

Attribution theory serves as the basis for explaining the relationship between CRS and crisis situations. The belief is that the crisis situations should vary in terms of how publics perceive the three attribution dimensions (Coombs 1995: 448). As explained above, there are four factors that shape the perceptions of the crisis situation. The process begins with deciding on the crisis type, then adds veracity of evidence, crisis damage and performance history, in order to assess the perceived organizational responsibility for a crisis (Coombs 1995: 461). Because multiple publics can make different attributions, organizations must consider how the various publics might view evidence, damage and performance history differently (Coombs 1995: 457-458).

The CRS attempt to protect the organizational image during a crisis by modifying public perceptions of the responsibility for the crisis or impressions of the organization itself. The non-existence, distance, and suffering strategies all attempt to influence attributions publics make about organizational responsibility for a crisis. The mortification and ingratiation strategies attempt to offset negative crisis attributions with positive impressions of the organization (Coombs 1995: 449, 453). The organizational image should be evaluated more positively when the appropriate response strategies are used, as opposed to the when the wrong response strategies are used (Coombs 1995: 473).

In 1995, Coombs also presents specific guidelines for choosing the appropriate CRS with detailed decision flowcharts for each of the four crisis types. Coombs combines the four crisis situation factors to form decision flowcharts, which indicate which crisis-response

strategy or strategies fit best with the particular crisis (Coombs 1995: 469). The flowcharts are not described in this report, but two examples of Coombs' guidelines from the accident flowchart are provided below:

- For an accident crisis with true evidence, major damage, victims, and a positive performance history, use the mortification and ingratiation CRS.
- For an accident crisis with true evidence, minor damage, no victims, and a negative performance history, use the distance strategies (Coombs 1995: 465).

4.4 Development of the SCCT from 1995 to 2007

The SCCT was developed further and refined from 1995 to 2007, into a more coherent and comprehensive theory. The following section will describe the evolution of the elements of the SCCT over time, with an emphasis on describing the theory as of 2007.

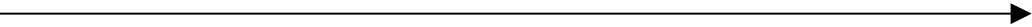
4.4.1 The crisis situation

i. Crisis type

Crisis managers follow a two-step process to assess the reputational threat of a crisis. The first step is to determine the basic crisis type. A crisis manager considers how the news media and other stakeholders are defining the crisis (Coombs 2007b: 10). The categorization system of crisis types in the SCCT has been refined several times since its introduction.

As the previous overview of the theory from 1995 shows, the crises situations were first presented in a two dimensional crisis-type matrix. A preliminary study by Combs and Holladay (1996) found support for this system for categorizing crisis types. However, when examined, the external control attribution dimension was found to be unrelated to either crisis responsibility or organizational image, while the personal control attribution dimension was positively related to crisis responsibility and negatively related to organizational image. Coombs thereby suggests that crisis types are best arrayed along a continuum with endpoints of low and high personal control. Crisis types near to the high endpoint of greater personal control elicit stronger perceptions of crisis responsibility than those crisis types near the lower end (Coombs 1998: 186-188). Table 3 gives a brief overview of the main changes regarding the crisis types.

Table 3. Changes in crisis types 1995-2007.

1995  2007

2*2 crisis type matrix: intentional- unintentional, external- internal	Continuum with end points of low and high personal control	3 cluster solution reflecting an increasing amount of crisis responsibility and reputational damage	3 cluster solution reflecting an increasing amount of crisis responsibility and reputational damage
<i>Faux Pas</i>	<i>Rumor</i>	<i>Victim cluster:</i> Natural disasters, rumors, workplace violence and product tampering.	<i>Victim cluster:</i> Natural disaster, rumor, workplace violence and product tampering.
<i>Accidents</i>	<i>Natural Disasters</i>		
<i>Terrorism</i>	<i>Malevolence</i>		
<i>Transgressions</i>	<i>Accidents:</i> Technical breakdowns, challenges, workplace violence, megadamage.	<i>Accidental cluster:</i> Challenges, megadamage, technical breakdown accidents and technical breakdown recalls.	<i>Accidental cluster:</i> Challenges, technical- error accident, technical- error product harm.
	<i>Organizational misdeeds:</i> Organizational misdeeds, human breakdowns	<i>Preventable cluster:</i> Human breakdown accidents, human breakdown recalls, organizational misdeeds – management misconduct; with injuries and without injuries.	<i>Preventable cluster:</i> Human-error accident, human-error product harm, organizational misdeed with no injuries, organizational misdeed with injuries, organizational misdeed management misconduct.

In 1999, Coombs have synthesized different crisis typologies into what he calls one master list represented by nine basic crises, which can be grouped into five families with organizational responsibility as the sorting mechanism. Crisis in the same family were believed to be associated with similar perceptions of organizational responsibility and could therefore be managed in similar ways (Coombs 1999b: 61,126; 2000b: 38).

This list was further refined and expanded for a study by Coombs and Holladay in 2002, to reflect two important variations in crises. First, accidents and product recalls were each differentiated to reflect the fact that such crises may be caused by either technical breakdowns or human breakdowns. Second, three variations of the crisis type organizational misdeeds were included: (a) those involving injury, (b) those involving no injury, and (c) those involving a legal or regulatory violation (Coombs and Holladay 2002: 169). This study indicated that the Personal Control and Crisis Responsibility scales seemed to measure the same factor, thus, they were combined and given the name Crisis Responsibility (Coombs and Holladay 2002: 176). Crisis responsibility was used to form groupings of similar crisis types that produced similar levels of crisis responsibility. Thirteen crisis types were reduced to and formed three distinct clusters: the victim cluster, the accidental cluster, and the preventable

cluster. The clusters are in a sequence that reflects an increasing amount of crisis responsibility and reputational damage (Coombs and Holladay 2002: 179-180). That is, crisis responsibility can be a threat to an organization’s reputation because stronger attributions of crisis responsibility produce greater reputational damage (Coombs 2007c: 142). Several studies have found support for this critical relationship between crisis responsibility and organizational reputation, suggesting it to be applicable to all three crisis clusters in the SCCT (Combs and Holladay 1996; 2001; 2002; Coombs and Schmidt 2000).

Only slight changes have been made to this part of the SCCT since the identification of the three crisis clusters in 2002. The crisis type categorization as of 2007 is summarized in table 4 below.

Table 4. Crisis types 2007.

Crisis cluster	Crisis type	Explanation
<i>Victim cluster</i>	Natural disaster	Acts of nature damage an organization such as an earthquake
	Rumor	False and damaging information about an organization is being circulated
	Workplace violence	Current or former employee attacks current employees onsite
	Product tampering	External agent causes damage to an organization
<i>Accident cluster</i>	Challenges	Stakeholders claim an organization is operating in an inappropriate manner
	Technical-error accident	A technology or equipment failure causes an industrial accident
	Technical-error product harm	A technology or equipment failure causes a product to be recalled
<i>Preventable cluster</i>	Human-error accident	Human error causes an industrial accident
	Human-error product harm	Human error causes a product to be recalled
	Organizational misdeed with no injuries	Stakeholders are deceived without injury
	Organizational misdeed management misconduct	Laws or regulations are violated by management
	Organizational misdeed with injuries	Stakeholders are placed at risk by management and injuries occur

The SCCT as of 2007 posits that each crisis type generates specific and predictable levels of crisis responsibility – attributions of organizational responsibility for the crisis. By identifying the crisis type, the crisis manager can anticipate how much responsibility stakeholders will attribute to the organization at the onset of the crisis thereby establishing the initial crisis responsibility level (Coombs 2007d: 166, 168).

The victim cluster includes crisis types in which the organization is considered a victim of the crisis along with the stakeholders. All of these types of crisis produce minimal attributions of crisis responsibility, thereby representing a mild reputational threat to the organization (Coombs and Holladay 2002: 179; Coombs 2007d: 168).

In the second group of crises, namely the accidental cluster, all of the crises represent unintentional actions by the organization. The organization did not intend to create the crises. The crises in this cluster produce moderate attributions of crisis responsibility, meaning that they constitute a moderate reputational threat (Coombs and Holladay 2002: 179; Coombs 2007d: 168).

The preventable cluster consists of crises, which involve either purposefully placing stakeholders at risk, or knowingly taking inappropriate actions, or human error that could have been avoided. These crisis types produce strong attributions of crisis responsibility, and thus, represents a severe reputational threat to an organization (Coombs and Holladay 2002: 179; Coombs 2007d: 168).

Crisis responsibility triggers affective reactions as well as being a reputational threat (Coombs 2007d: 169). The attributions stakeholders make about a crisis will generate emotions about the organization and these emotions will affect their future interactions with the organization. Increased attributions of crisis responsibility generate stronger feelings of anger and in some extreme cases *schadenfreude* toward the organization while reducing feelings of sympathy for the organization (Coombs and Holladay 2005: 205 Coombs 2007d: 169). Results of a study found that organizational misdeed crisis produced the strongest feelings of anger and *schadenfreude*. Crisis from the victim cluster produced the strongest feelings of sympathy, while the crises in the accident cluster tended to produce muted emotional responses (Coombs and Holladay 2005: 275-276). Anger and crisis responsibility, in turn, can have an impact on negative word-of-mouth and purchase intention. This relationship between anger, crisis responsibility and intended negative word-of-mouth, have been termed the negative communications dynamic (Coombs and Holladay 2007: 300, 307).

ii. Intensifying factors

The second step in evaluating the crisis situation is to review the factors that might intensify the reputational threat of the crisis. The three intensifying factors originally believed to be relevant when stakeholders assign attributions to a crisis were veracity of evidence, damage and performance history (Coombs 1995). Nevertheless, since its introduction in 1995, Coombs (2000b) have only mentioned “veracity of evidence” as a crisis factor in one article,

and not empirically tested its usefulness. Regarding damage severity, a study by Coombs in 1998, found virtually no support for the belief that crisis damage intensifies perceptions of crisis responsibility and image damage for an organization (Coombs 1998: 186-188). However, severity of damage is frequently, but not consistently suggested as an intensifier in Coombs works (Coombs 2000b: 39; Coombs and Holladay 2002: 169; Coombs 2004a: 283; Coombs 2004b: 271; Coombs 2006b: 182; Coombs 2006c: 243). The discussion of damage from 1995 also separated between victims and non-victims of a crisis. The belief was that the two groups would require different CRS (Coombs 1995: 459). The SCCT related research has not explored this issue further.

Table 5 shows the intensifying factors believed to be important in 1995 and in 2007.

Table 5. Intensifying factors 1995-2007.

1995	2007
Intensifying factors	
Veracity of evidence Damage (victims- non victims) Performance history	Performance history: Prior relationship reputation Crisis history

Performance history, however, has proven to increase perceptions of crisis responsibility and reputational damage to an organization in crisis. Performance history was initially examined as one-time or repeated crisis. Research supports that a history of many crises intensifies both perceptions of crisis responsibility and image damage for organizations in crisis (Coombs and Holladay 1996: 293-294; Coombs 1998: 186-188).

Coombs later divided performance history into crisis history and past relationships-good works (1998: 188; 2000a: 81). *Crisis history* refers to whether or not an organization has had similar crises in the past. A history of crises suggests an organization has an ongoing problem that needs to be addressed. *Prior relationship reputation* concerns how well or poorly an organization has or is perceived to have treated stakeholders in other contexts. An unfavourable prior relational reputation suggests an organization shows little consideration for stakeholders across a number of domains, not just in this crisis (Coombs 2007d: 167).

Results from a study by Coombs and Holladay in 2001 found that an unfavourable relationship history or crisis history does lead people to perceive the organization as having more responsibility for the crisis, but the direct effect on perceptions of organizational

reputation were much stronger than those on crisis responsibility. A favourable relationship or crisis history, on the other hand, appears to be no different from a neutral relationship or crisis history. Hence, there was no benefit to a favourable prior reputation over a neutral reputation, just harm from the unfavourable prior reputation. Coombs and Holladay term this the *velcro effect*. A performance history is like velcro; it attracts and snags additional reputational damage (Coombs and Holladay 2001: 335). Another study by Coombs in 2004, examining the impact of a history of similar crisis, replicates the results from this study (Coombs 2004b: 282-283). That is, either a history of crisis or an unfavourable prior relationship reputation intensifies attributions of crisis responsibility thereby indirectly affecting the reputational threat. But both factors also have a direct effect on the reputational threat posed by a crisis (Coombs 2004a; 2004b; 2007d: 167). The results from these studies indicated that when an organization had a history of crises or a negative relational reputation, a crisis which originally was considered a mild reputational threat moved to the moderate threat level, and a crisis originally considered a moderate reputational threat moved to the severe threat level (Coombs and Holladay 2001; Coombs 2004b).

Results from further exploration of a prior reputation's effect in crises, indicated that the halo effect as a shield (deflects the potential reputational damage from a crisis) does exist in a limited crisis domain but works only for organizations with very favourable prior reputations. Further the results suggest that there is little reason to believe that the halo effect creates a benefit of the doubt (reduce attributions of crisis responsibility) (Coombs and Holladay 2006: 123, 128).

SCCT of 2007 centres on the crisis manager examining the crisis situation in order to assess the level of reputational threat presented by a crisis. The threat is the amount of damage a crisis could inflict on the organization's reputation if no actions are employed. Three factors in the crisis situation shape the reputational threat: (1) initial crisis responsibility, (2) crisis history and (3) prior relational reputation (Coombs 2007d: 166).

4.4.2 Crisis response strategies

The list of crisis response strategies (CRS) has undergone changes and refinements since 1995, but has not been the object of much empirical testing. Coombs refined the original list of five categories of crisis communication strategies and in 1998 suggested that they be arrayed on an accommodative – defensive continuum. Accommodative strategies accept responsibility, take remedial action, or both, whereas defensive strategies claim there is no problem or try to deny responsibility for the crisis (Coombs 1998: 180). This continuum

reflects an organizations focus on helping victims (accommodative) or on defending organizational interests (defensive) (Coombs 1999a: 129).

The CRS were later categorized into the three postures: deny, diminish and repair (Coombs and Holladay 2004: 99; Coombs 2004a: 281). Each posture represents a set of strategies that share similar communicative goals, reflecting the amount of responsibility an organization seems to accept for a crisis and the amount of aid that it seems to provide for the victims of the crisis. Results from a later study by Coombs, indicated that how researchers view the CRS is consistent with how respondents evaluate the CRS, and that they perceived the response strategies as intended in terms of crisis responsibility and helping the victim (Coombs 2006c: 253, 255). For this study, three changes were made to the original list of strategies (Coombs 1998; 1999b). Coombs explains that firstly, corrective action was removed because it fits better as adjusting information than as a reputation repair crisis response strategy. Secondly, scapegoat was added because of previous research finding it to be such a problematic crisis response strategy. Third, the compassion, concern, and regret CRS were added because of consistent calls in the management literature to express some form of sympathy for victims (Coombs 2004c: 468; 2006c: 252). The belief was that these ten strategies would cluster according to the three response options of deny, diminish and deal (repair), which they did (Coombs 2006c: 250, 253).

The list of crisis responses was initially based on the accommodative-defensive continuum developed by Marcus and Goodman (1991). However, Coombs claims that this continuum was found to be problematic because of the distinction between protecting the victim and protecting the organization. Respondents had indicated that some strategies could do both. Moreover, this continuum was perceived as similar to the mitigation-aggravation continuum found in interpersonal communication (McLaughlin, Cody and O'Hair 1983), and which had come under question with recent research (Dunn and Cody 2000). Coomb thereby reframed the categorization of the CRS to reflect the amount of responsibility that each strategy is perceived to accept for a crisis, which is consistent with the attribution theory roots of SCCT (Coombs 2006b: 180-181). Table 6 outlines the major changes in the categorization of CRS.

Table 6. Changes in crisis response strategies 1995-2007.

1995	→			2007
Categories that attempt to modify either public perceptions of crisis responsibility or the impressions of the organization.	Continuum with end-points of accepting responsibility (accommodative) and denial (defensive) of a crisis.	3 cluster solution-reflecting emphasis on protecting the victim of the crisis and acceptance of responsibility for the crisis.	Clusters reflecting perceived acceptance of responsibility for the crisis.	
<i>Nonexistence Strategies:</i> Denial Clarification Attack Intimidation	<i>Attack the accuser</i> <i>Denial</i> <i>Excuse</i>	<i>Deny Response Option:</i> Attack the accuser Denial Scapegoat <i>Diminish Response Option:</i> Excuse Justification <i>Deal Response Option:</i> Ingratiation Concern Compassion Regret Apology	<i>Primary CRS:</i> <i>Deny CRS:</i> Attack the accuser Denial Scapegoat <i>Diminish CRS:</i> Excuse Justification <i>Rebuild CRS:</i> Compensation Apology	
<i>Distance Strategies:</i> <i>Excuse</i> Denial of intention Denial of volition <i>Justification</i> Minimizing injury Victim deserving Misrepresentation of the crisis event	<i>Justification</i> <i>Ingratiation</i> <i>Corrective action</i> <i>Full apology</i>		<i>Secondary CRS:</i> <i>Bolstering CRS:</i> Reminder Ingratiation Victimage	
<i>Ingratiation Strategies:</i> Bolstering Transcendence Praising others				
<i>Mortification Strategies:</i> Remediation Repentance Rectification				
<i>Suffering Strategy</i>				

The list of CRS in the SCCT of 2007 is built around this perceived acceptance of responsibility for a crisis inherent in the response. When CRS become more accommodative and show greater concern for victims, stakeholders perceive the organization as taking greater responsibility for a crisis (Coombs and Holladay 2004; 2005; Coombs 2007d: 170). The CRS are further divided between primary and secondary CRS. The secondary strategies are only supplemental to the primary strategies. Because these strategies focus on the organization, they would seem rather egocentric if used alone (Heath and Coombs 2006: 205; Coombs 2007c: 141). Table 7 presents the CRS in the SCCT of 2007.

Table 7. Crisis response strategies 2007.

Strategy		Sub-type/tactic
<i>Primary CRS</i>	Deny CRS	Attack the accuser Denial Scapegoat
	Diminish CRS	Excuse Justification
	Rebuild CRS	Compensation Apology
<i>Secondary CRS</i>	Bolstering CRS	Reminder Ingratiation Victimage

The *primary CRS* are divided into three groups.

The *deny strategies* seek to remove any connection between the organization and the crisis. If the organization is not involved in a crisis, it will not suffer any damage from the event. This group has three sub-strategies. The *attack the accuser* strategy involves that the crisis manager confronts the person or group claiming something is wrong with the organization. *Denial* occurs when crisis manager asserts that there is no crisis. *Scapegoating* takes place when the crisis manager blames some person or group outside of the organization for the crisis (Coombs 2007d: 170-171).

The *diminish CRS* argue that a crisis is not as bad as people think or that the organization lacked control over the crisis. If crisis managers lessen an organization's connection to the crisis and/or have people view the crisis less negatively, the harmful effects of the crisis are reduced. This group consists of two strategies. With the *excuse strategy*, a crisis manager tries to minimize organizational responsibility by denying intent to do harm and/or claiming inability to control the events that triggered the crisis. The *justification strategy* involves the crisis manager trying to minimize the perceived damage caused by the crisis (Coombs 2007d: 170-171).

The *rebuild CRS* attempt to improve the organization's reputation by offering material and/or symbolic forms of aid to victims. The crisis manager says and does things to benefit stakeholders and thereby take positive actions to offset the crisis. Offering compensation or a full apology both are positive reputational actions. *Compensation* involves the crisis manager offering money or other gifts to victims. *Apology* means that the crisis manager indicates the organization takes full responsibility for the crisis and asks stakeholders for forgiveness (Coombs 2007d: 170, 171).

The *secondary CRS* consists of the *bolstering strategies*, which are best used as supplements to the three primary strategies and adjusting information. Managers who have had positive relationships with stakeholders can draw upon that goodwill to help protect the organizational reputation, praise stakeholders for their efforts during the crisis as a means of improving relationships with them, or draw sympathy from being a victim of the crisis. The *reminder strategy* is used to tell stakeholders about past good works of the organization. *Ingratiation* occurs when crisis manager praises stakeholders and/or reminds them of past good works by the organization. Moreover, *victimage* is used when crisis manager remind stakeholders that the organization is a victim of the crisis too (Coombs 2007d: 170-172).

CRS are used to repair the reputation, to reduce negative affect and to prevent negative behavioural intentions. The belief is that the more accommodative strategies will be more effective at reducing anger and the negative communications dynamic (Coombs and Holladay 2007: 308).

4.4.3 Matching process

i. Basic matching process

The SCCT posits that by understanding the crisis situation, the crisis manager can determine which CRS will maximize reputational protection (Coombs 2007d: 166). The development concerning the matching of crisis situations and CRS have paralleled the changes made to the aforementioned. As previously explained, the initial matching process included locating the crisis type in the matrix, thereby deciding the perceived responsibility for the crisis, and next, selecting crisis responses based on the need either to alter perceptions of responsibility or of the organization itself (Coombs 1995).

When the external control dimension of the matrix failed to contribute in forming perceptions of crisis responsibility or organizational image, the categorization of crisis types and the list of CRS were refined and both were arrayed on continuums reflecting crisis responsibility and accommodation – denial of a crisis. The rationale for developing the continuums was the value of their abilities to provide a coupling between the CRS and crisis situations (Coombs 1998: 180, 186). By locating a crisis on the responsibility continuum, crisis managers have an idea of the range of CRS they might use (Coombs 1998: 188).

The matching process was further refined when the crisis situations were divided into three clusters (victim, accidental and preventable), and the CRS were grouped into three postures (deny, diminish and deal) (Coombs and Holladay 2002; 2004; Coombs 2004a; 2006c). Organizations can use the crisis clusters to construct crisis portfolios, which are

efficient because an organization may not have the time to develop plans for every major crisis type and sub-variation it may encounter. The crisis types within each cluster will produce similar attributions of crisis responsibility (Coombs and Holladay 2002: 173, 180), and the crisis response clusters reflect different degrees of accepting responsibility and helping victims (Coombs 2006c: 256-257). Crisis managers can thereby use similar CRS to address crisis types within the same cluster (Coombs and Holladay 2002: 180).

The effectiveness of matching crisis situations to CRS have not received a lot of testing, but two studies did find that organizations suffered the least reputational damage when a matched crisis response strategy was used (Coombs and Holladay 1996; Coombs and Smith 2000). Results from a third study, however, showed that instructing and adjusting information seemed to be sufficient in victim crises (Coombs and Holladay 2004: 109).

In the SCCT as of 2007, responsibility provides the conceptual link. The evaluation of the reputational threat, that is the crisis situation, is largely a function of crisis responsibility, and the list of CRS is built around the perceived acceptance of responsibility for a crisis embodied in the response (Coombs 2007d: 170). The theory states that crisis communication is more effective at protecting an organization's reputation if the emotional reactions of stakeholders are taken into consideration when selecting response strategies. Research indicates that crisis responsibility and the original crisis clusters are useful indicators of the emotions a crisis might generate (Coombs and Holladay 2005: 265). The SCCT holds that as the reputational threat and negative affect increases, both of which are functions of situational factors, crisis managers should utilize CRS with the requisite level of accepting responsibility (Coombs 2007d: 172).

Thus, the SCCT recommends that crisis managers use instructing information alone or a deny crisis response strategy in the victim cluster; the diminish CRS should be used in the accident cluster, and deal, including apology, CRS should be used in the intentional cluster (Coombs 2006c: 256-257). Results of a study found stakeholders to be sympathetic to an organization facing a victim crisis, which supports the recommendations of using instructing and adjusting information in such crises. The lack of strong emotions in the accident crisis cluster should facilitate the effectiveness of using the excuse and justification strategies in such crises. In addition, because intentional cluster crises generate strong anger and schadenfreude, with organizational misdeeds as the clearly highest, this supports the use of more costly and highly accommodative strategies (Coombs and Holladay 2005: 273- 277).

The choice between apology and the other accommodative crisis response options is primarily a legal one. An apology admits guilt and opens an organization to legal liability.

Financial concerns can act as a factor that limits how the crisis manager responds to a crisis (Coombs 1998: 188; Coombs 1999a: 139). Crisis managers are advised against accepting responsibility if an organization cannot afford to do so (Coombs 2006b: 191). Moreover, the most recent SCCT related study by Coombs and Holladay (2008), concluded that respondents had similar reactions to sympathy, compensation and apology response strategies in low to moderate responsibility crises. All three responses were rated the same for scores on post-crisis reputation, account acceptance, anger and negative word-of-mouth. However, it would be unethical to evade responsibility if management knows it is at fault. An apology is recommended in such cases. However, not accepting responsibility (expression of sympathy and/or compensation) is an important and viable option to an apology when responsibility is unknown or ambiguous (Coombs and Holladay 2008: 255-256).

ii. Intensifying factors

Research supports that part of SCCT which suggests that a negative performance history should result in crisis managers selecting response strategies that accept greater responsibility and that demonstrate increased concern for victims' needs than would normally be used for a given crisis situation. By increasing the reputational threat, performance history alters what CRS are appropriate (Coombs and Holladay 2001: 338; Coombs 2004b: 284).

4.5 SCCT guidelines (2007)

Based on the SCCT related research, Coombs provides a set of normative guidelines for the use of CRS. This section will not outline every minor change in regard to the SCCT guidelines, but focus on some overall developments that I find especially important, namely that the guidelines:

- Have become more user friendly
- Have an increased focus on instructing and adjusting information
- Show greater understanding of the complexity and dynamics of a crisis

The first point above refers to the development of the guidelines from their presentation in extensive decision flow charts in 1995, through the prescriptions based on the continuums, and finally to providing guidelines based on the three cluster solutions. The guidelines have been reframed to reflect the idea of simplifying the work for crisis managers by making it possible to create crisis portfolios by matching groups of responses to clusters of crises. Crisis

managers cannot make decision flow charts for every crisis. They were too complex. Crisis portfolios are more manageable.

The second development that I find interesting is the increased focus on instructing and adjusting information in the SCCT guidelines. Obviously, the guidelines were refined to reflect the finding of instructing and adjusting information as sufficient to protect organizational reputation in a mild reputational threat crisis. However, some of Coombs' recent SCCT works also include normative guidelines stating the importance of providing instructing and adjusting information for all crises with victims (Heath and Coombs 2006: 206; Coombs 2007c: 143). What is interesting is that Coombs resolutely explains that the SCCT is about reputation repair, while instructing and adjusting information are not. The SCCT provides guidance only after these initial obligations are met. For something that is not actually part of the theory, instructing and adjusting information surely take up a lot of space in Coombs SCCT related works. This, and the fact that instructing and adjusting information are included in the normative guidelines, might indicate a changing view of what reputation repair does encompass.

The third development that I find interesting is the incorporation of guidelines recommending consistency in crisis responses, and to be prepared to change the response if this is necessary to protect the organizational reputation (Heath and Coombs 2006: 206; Coombs 2007c: 143; Coombs 2007d: 173). The focus on consistency might be an indication of an increased understanding of the complexity of crises, in that Coombs acknowledge the use of several CRS in the same crisis. The same might hold true considering the guideline concerning preparedness to change an organization's response. This suggests an increased understanding of the dynamics of a crisis, in that a crisis is not static and may well change, resulting in a need for a different organizational response.

Regarding the developments explained in this section, they are not all reflected in the normative guidelines from 2007 outlined below. This could be the result of some elements in the theory having been found not to work and have therefore been excluded or replaced. However, it is more likely that the slightly different sets of guidelines appearing in different works by Coombs the last couple of years are because Coombs' write his works in different forums. Meaning that Coombs, whose articles frequently appear in different scientific journals and who is the author and co-author of several teaching books, might and probably do, adapt his writing to fit with the intended audience. However this, the guidelines from 2007 form the basis for evaluating the case study conducted in the next chapter.

SCCT crisis response strategy guidelines as of 2007:

1. Instructing and adjusting information alone can be enough when crises have minimal attributions of crisis responsibility (victim crises), no history of similar crisis and a neutral or positive prior relationship reputation.
2. Victimage can be used as part of the response for workplace violence, product tampering, natural disasters and rumors.
3. Diminish crisis response strategies should be used for crisis with minimal attributions of crisis responsibility (victim crises) coupled with a history of similar crises and/or negative prior relationship reputation.
4. Diminish crisis response strategies should be used for crises with low attributions of crisis responsibility (accident crises), which have no history of similar crises, and a neutral or positive prior relationship reputation.
5. Rebuild crisis response strategies should be used for crises with low attributions of crisis responsibility (accident crises), coupled with a history of similar crises and/or negative prior relationship reputation.
6. Rebuild crisis response strategies should be used for crises with strong attributions of crisis responsibility (preventable crises) regardless of crisis history or prior relationship reputation.
7. The deny posture crisis response strategies should be used for rumor and challenge crises, when possible.
8. Maintain consistency in crisis response strategies. Mixing deny crisis response strategies with either the diminish or rebuild strategies will erode the effectiveness of the overall response.

(Coombs 2007d: 173)

- Use reinforcing crisis response strategies as supplements to the other crisis response strategies (Coombs 2007c; Heath and Coombs 2006: 206).

The last of the guidelines were actually not included in the guidelines from the 2007 article. One can only speculate if it was purposefully left out, or if it was simply an oversight. Because it is considered important in regard to the case study, it is included here as it is stated in the guidelines presented in two other SCCT' related works.

5 CASE STUDY: SCANDINAVIAN AIRLINES AND ACCIDENTS WITH THE DASH 8-Q400

The purpose of this case study is to examine the Situational Crisis Communication Theory's applicability in a complex crisis situation. The selected case is the crisis that Scandinavian Airlines (SAS) faced in the fall of 2007 when several of the organization's aircrafts experienced problems with their landing gears. This specific crisis was chosen because it happened recently, and because it fulfils several of the complexity criteria outlined in the theoretical framework. Multiple groups of stakeholders were involved in and affected by the SAS crisis. The crisis also had implications for several organizations in proximity of SAS, such as SAS' individually branded airline Widerøe, which had four Dash 8 aircraft in its fleet. SAS' competitors using the Dash 8 aircraft were affected by the crisis, as well as the industry in general because of an increased focus on flight safety. The situation was also characterised by lack of information concerning an established explanation of the cause of the crisis. This ambiguity resulted in speculations in the media about what caused the emergency landings and who was responsible. Finally, the crisis was certainly dynamic in that three similar incidents happened within two months, and that the crisis evolved along with new evidence and discoveries concerning the accidents. The complexity of the SAS crisis resulted in the media focusing on the organization for several months.

5.1 Scandinavian Airlines (SAS)

5.1.1 Presentation of Scandinavian Airlines

SAS was founded in August 1946 as a consortium of the national airlines of Denmark, Norway and Sweden. Scandinavian Airlines is part of the SAS Group, which is the Nordic region's largest listed airline and travel group. The Group is listed on the Stockholm; Oslo and Copenhagen stock exchanges through the parent company SAS AB. The Group also includes the business areas SAS Individually Branded Airlines (Spanair, Blue1, Widerøe and airBaltic) and SAS Aviation Services. The SAS Group has a 50/50 ownership structure divided between private shareholders (50%) and the governments of Denmark (14.3%), Norway (14.3%) and Sweden (21.4%) (SAS Group 2004; 2008a).

Scandinavian Airlines is The Group's largest business area with 65% of gross revenue in 2007. The business area comprises Scandinavian Airlines Norge, Scandinavian Airlines Danmark, Scandinavian Airlines Sverige, and Scandinavian Airlines International. All together, these airlines had 185 aircraft, which flew 25.4 million passengers to 126

destinations in Scandinavia, Europe, North America and Asia in 2007, with an average of 822 daily departures. Scandinavian Airlines is also a founding member of the world's largest global airline alliance, that is, Star Alliance (SAS Group 2008a).

5.1.2 Scandinavian Airlines' Stakeholders

As explained in the theoretical framework one categorization of stakeholders divide them into primary and secondary stakeholder groups (Clarkson 1995: 106). SAS has a broad range of both types, and to make a complete stakeholder map of all of SAS' stakeholders would be too extensive for this report. Table 8 gives an overview of the stakeholders considered relevant for this case study.

Table 8. Scandinavian Airlines' stakeholders.

Scandinavian Airlines' Stakeholders	
<i>Primary stakeholders</i>	Investors Ministry of Transport (DK) Ministry of Transport and Communication (NO) Ministry of Enterprise, Energy and Communications (SE) Civil Aviation Authorities in DK, NO and SE OPS-utvalget Skandinavisk Tilsynskontor (STK) European Aviation Safety Agency (EASA) Employees Customers Suppliers
<i>Secondary stakeholders</i>	Media Unions Non-governmental organizations Special interest groups Competitors
<i>Additional stakeholders in the Dash 8 crisis</i>	Victims/passengers and crew The Danish Accident Investigation Board The Lithuanian Aircraft Accident and Incident Commission

Some groups immediately appear to have more power over SAS than others, and are considered as primary stakeholder groups. Among these influential groups, the government plays an important part. The government is both an investor and a public stakeholder group to SAS. The three Scandinavian governments watch SAS closely, but the organization has its own CEO and board of directors. The highest authorities watching SAS are the Ministry of Transport (DK), the Ministry of Transport and Communications (NO) and the Ministry of Enterprise, Energy and Communications (SE). Subordinated the ministries are the three states' Civil Aviation Authorities. To manage the challenge of safely regulating the

multinational consortium of SAS, the Aviation Authorities established a coordinating body between the three countries named OPS-utvalget. In addition, Skandinavisk Tilsynskontor (STK) was established, which serves as a joint inspection office between the three Scandinavian civil aviation authorities. The main task of the STK is to coordinate the Scandinavian authorities' technical oversight of SAS's aircraft material maintenance (Aasen 2008). In addition, Scandinavian Airlines has to follow European safety standards as established by the European Aviation Safety Agency (EASA), which promotes common standards of safety and environmental protection in civil aviation in Europe and worldwide (EASA 2008). These groups have direct power over SAS in that they control laws and regulations in which the airline is obliged to follow. Additionally, the government has the power to sell its shares, which could have severe consequences for SAS.

Other of SAS' primary stakeholder groups are the organization's employees and its customers. In 2007, SAS had an average of 6139 employees, and the same year, 25.4 million passengers flew with the company (SAS Group 2008a). If the customers withdrew their custom or the employees withdrew their labour, the organization would stop functioning. Moreover, SAS has a wide range of suppliers, ranging from manufacturers of aircrafts to fuel deliverers and so on.

In addition to primary stakeholder groups, SAS has several of what Clarkson (1995: 106) have termed secondary stakeholder groups to manage. Among these are the media, which frequently report on SAS in the news, as it is a big multinational corporation partly owned by the Scandinavian states. Unions are another important group of secondary stakeholders to SAS. The SAS Group has around 30 major unions to deal with, many of which organize pilots and flight attendants in Scandinavian Airlines System (SAS Group 2006). Also considered as secondary stakeholder groups to SAS, is a wide array of different non-governmental organizations and special interest groups. This might be organizations concerned with environmental issues, such as emission control, or that is concerned with the best interests of consumers. In addition, competing airlines both in the home market and in Europe/globally classify as secondary stakeholders. These groups are considered secondary stakeholders because they are not engaged in transactions with SAS and therefore, according to Clarkson (1995), are not essential for its survival. However, the accuracy of Clarkson's divide can be questioned. Stakeholder groups with indirect influence on an organization, i.e. the media can hold enormous sway over the opinions of people in the first group of stakeholders and thereby equally hold significant power (Scholes and James 1997: 277-278).

Crises also have the potential to create an entirely new class of stakeholders, which are the victims. Victims are those people who have suffered physically, mentally, or financially from the crisis (Coombs 2007c: 136). In addition, when aircraft accidents or serious incidents occur, the accident investigation board of the country of the happening becomes involved and responsible for the following investigation.

5.1.3 Crisis history and relationship history

As previously explained, a history of similar crises or a negative relationship reputation will increase the reputational risk from a crisis. Scandinavian Airlines has experienced several crises in recent time.

The year of 2001 was especially turbulent for SAS. A clear economic slowdown in summer 2001 coupled with the terrorist attack on September 11, resulted in a dramatic fall in demand. For the SAS Group the year ended with a loss of almost SEK 1.8 billion, the worst result in the company's history. This was the beginning of years of rationalizations forcing SAS to close destinations, reduce frequencies, remove aircrafts from production and dismiss employees (SAS Group 2001). 2001 was also the year of the probably worst aircraft disaster in the history of SAS. On October 8, 2001, Scandinavian Airlines flight SK686, a Swedish registered MD-87 plane, headed to Copenhagen Airport when it collided on take-off with a Cessna Citation business jet at Linate Airport, Milan, Italy. There were no survivors of the accident. In addition to the 110 people in the MD-87 and the four people in the Cessna, an additional four people were killed when the MD-87 crashed into a baggage hangar. The accident happened in thick fog. Investigations showed that the Cessna had not followed the control tower's instructions correctly, and the plane had erroneously moved onto the runway. In April 2004, four officials accused of negligence and multiple manslaughter were sentenced to jail terms ranging from 6 ½ to 8 years (Aviation Safety Network 2008). The investigation concluded that the MD-87 had no responsibility for the disaster.

Another event that attracted considerable negative attention to the SAS Group in 2001 was the discovery of an unlawful division of the market between the SAS Group and Maersk Air in 2001. This illegal agreement, which lay outside the cooperation between the two companies notified to the EU in 1998, resulted in the European Commission imposing heavy fines, in the person responsible for the arrangement leaving the Group, and in SAS's Board deciding to resign (SAS Group 2001).

Moreover in 2006, SAS Norway (SAS Braathens) was accused by competitor Norwegian Air Shuttle (NAS) of unlawfully accessing data about NAS in the Amadeus

reservation system. SAS Braathens was in 2008, found guilty in court and instructed to pay NOK 132 million in compensation to NAS (SAS press release 2008).

SAS has also been the subject of massive media attention due to a high number of strikes. During the last ten years, the organization has had about 100 strikes, and 70 of those have been illegal. The year of 2006, was especially eventful regarding striking employees. In the first quarter of 2006, the pilots at Scandinavian Airlines Denmark went on a wildcat strike, resulting in the cancellation of nearly all flights from Copenhagen for 3 days. At the same time, an unusually high number (about 100) of pilots at SAS Braathens called in sick, resulting in more cancelled flights. The cost of the cancelled flights was an estimated SEK 160 million. Moreover, 1070 SAS Braathens cabin attendants went on strike for two days, before Easter the same year, resulting in tens of thousands of frustrated SAS Braathens customers having to cancel their Easter holidays. The loss was an estimated 70 million, and in addition, the company received demands of refunds from over 5000 angry passengers (SAS Group 2005; 2006; Verdens Gang 19/4-06).

Although not all of these previous crises are similar to one another, or similar to the Dash 8-Q400 incidents, they have probably nonetheless affected SAS' relationship reputation with its stakeholders.

5.1.4 Stakeholders' perceptions of SAS' previous crisis history

The focus of the media during the Scandinavian Airlines Dash 8-Q400 crisis was on completely different incidents in the history of SAS. More specifically, the media gave two themes considerable attention, both of which could be traced back to beginning around year 2000. The first subject concerned previous incidents with SAS' Dash 8 aircraft. Most newspapers rapidly reported about problems with the Dash 8. For example, September 10, Politiken printed two stories regarding this issue with the headlines "*Dash 8-Q400 a problem-plane*" and "*Canadian aircraft with many problems*". The second subject concerned SAS' safety procedures in general. The Danish online newspaper "erhverv på nettet" printet a story with the headline "*Frequent critique of safety in SAS*" on September 12. The article reported on a number of headlines from Jyllands-Posten from 2000 until 2007, all of which concerned safety issues with SAS.

The most frequently cited SAS Dash 8 incident in the media, was the episode where an aircraft was near crashing in Kalmar, Sweden, in 2006. Barely 2 weeks before the September 9 accident, had the Swedish Accident Investigation Board released a report containing unusually harsh critique of SAS regarding the Kalmar incident. The commissions' conclusion

was that SAS' technical maintenance had not been good enough, and that SAS among other had failed to meet expected safety demands (Politiken 10/9-07). Other SAS Dash 8 incidents reported by the media, was an aircraft experiencing problems with the right landing wheel in Copenhagen in 2002 and smoke development in the engine of a Dash 8 aircraft when ready for take-off at Copenhagen Airport in 2001 (Politiken 10/9-07). The media also reported on several other Dash 8-Q400 incidents both with SAS and with other airlines. SAS was also frequently critiqued of not following legal maintenance procedures, thereby failing to meet expected safety standards. Politiken (27/9-07) reports that SAS in 2006 had about 2300 illegal flights, and between 2003 and 2006 the number of illegal flights was somewhere between 6000 and 10000. Rationalizations of maintenance procedures were reported as a direct cause when an SAS aircraft was involved in an accident in Shanghai in 2005.

The different incidents with the SAS Dash 8 aircraft from previous years, does not qualify as crises when looked at separately. Neither does the issues concerning SAS' flight safety, or the lack of it. Nevertheless, accumulated, as will be evident from the following analysis, all these issues served to reinforce the Dash 8 crisis that SAS experienced in the fall of 2007. SAS and its stakeholders did obviously not agree upon whether or not the organization had a crisis history. Coombs does not specify if it is the stakeholders or the organization that decides this. I will assume that it is the stakeholders' perception that is deciding in this case too, meaning that SAS did have a crisis history.

5.2 Scandinavian Airlines' crisis in 2007

In the fall of 2007, Scandinavian Airlines experienced three similar emergency landings during seven weeks. All incidents happened with the aircraft type Dash 8-Q400, produced by Bombardier. In January 2000, SAS was the first customer to use the Dash 8-Q400 in its traffic operations. The SAS Group had at the time of the accidents 27 registered aircrafts of the type Dash 8-Q400. Widerøe operated four of these aircrafts while SAS Sweden and SAS Denmark used the remaining aircrafts (NTB 19/9-07). The aircraft accounted for approximately five percent of the Group's passengers. The director of SAS Denmark, Susanne Larsen, explains that the Dash 8-Q400 is a good aircraft. It is efficient, silent and uses less fuel, thereby releasing less CO₂ than most other aircrafts. On short distances, which are important for SAS' Scandinavian customers, the aircraft is as fast as a jet plane (Jyllands-Posten 21/10-07).

5.2.1 Flight 1209: Aalborg on September 9

The first accident happened with Scandinavian Airlines Flight 1209 on September 9, 2007. The aircraft was a scheduled domestic passenger flight from Copenhagen International Airport to Aalborg Airport, and carried 69 passengers and 4 crewmembers. The landing gear was selected down when approaching Aalborg Airport, but the right main landing gear failed to lock in position and was thereby unsafe. The landing was disrupted, and the cabin was prepared for a controlled emergency landing (Preliminary report 13/9-07). After landing the right main landing gear collapsed, the right wing hit the runway and immediately broke into fire. Powerful flames arise and a there is a severe development of smoke, but it is only a matter of seconds before the fire extinguishers reaches the aircraft. According to Peter Reinau, who was in charge of the emergency preparedness team in Aalborg, the accident was “*very, very close to a serious disaster*” (Politiken 10/9-07). The emergency landing substantially damaged the aircraft, and during evacuation, five passengers were lightly injured (Havarikommissionen for Civil Luftfart 2007a). The Danish Accident Investigation Board was to investigate the accident. Scandinavian Airlines referred to the Aalborg accident as an “isolated incident”, and decided to continue its operations as scheduled. The Dash 8 producer, Bombardier, supported SAS’ decision and confirms, “*What happened in Aalborg has never occurred before with this aircraft type at any airline in the world*”.

SAS’ reference to the Aalborg accident as a one-time and isolated incident sparked off strong reactions from the media and other stakeholders claiming the opposite was true and reporting of endless problems with the Dash 8 aircraft. In spite of the organization’s perception of the accident as a one-time occurrence, SAS decides to implement a number of extraordinary checks of the landing gear on the entire fleet of Dash 8-Q400 aircraft within four days. These inspections would take place without affecting the scheduled traffic (SAS press release 9/9-07; 10/9-07). The Dash 8-Q400 aircraft would not necessarily be inspected before the next takeoff, but would continue in operation and be attended to when appropriate within these 4 days.

The Danish Accident Investigation Board’s preliminary report presented on September 13, established that the cause of the accident on September 9 was due to the corrosion of a bolt that secures the landing gear in the hydraulic cylinder that opens and closes the gear (SAS press release 18/9-07).

5.2.2 Flight 2748: Vilnius on September 12

One aircraft not inspected before the next flight was Scandinavian Airlines Flight 2748, which needed to make a prepared emergency landing at Vilnius International Airport in Lithuania on September 12, 2007. Flight 2748 took off from Copenhagen Airport, Denmark and was headed to Palanga, Lithuania, but was redirected to Vilnius when landing gear problems were discovered before landing. Upon landing, the right landing gear collapsed and the aircraft slid off the runway. All 48 passengers and four crewmembers were evacuated safely and no injuries occurred (SAS press release 12/9-07). The Lithuanian Aircraft Accident and Incident Commission was responsible for conducting the investigation regarding the Vilnius accident. Scandinavian Airlines and Widerøe decided to ground the entire fleet of Dash 8-Q400 aircraft. SAS explained in a press release September 12, that Bombardier was working on developing an inspection programme, and that the organization would not release any aircraft for operations until it had carried out the recommended inspection. Further, the press release explained that Bombardier highly recommended the grounding of all aircraft worldwide of this type with 10,000 landing gear cycles or more, until the recommended inspections had been conducted. The Civil Aviation Authorities in Denmark, Norway and Sweden declared the Dash 8-Q400 not airworthy and grounded until further notice (Politiken 13/9-07).

The previous accident in Aalborg could no longer be considered an “isolated event”. The media and the stakeholders were proven right. SAS’ initial statement might have brought a second type of crisis upon SAS, what Johansen and Frandsen (2007: 79) termed a double-crisis or a communications-crisis. Implicit in Coombs’ definition of a crisis is the belief that improper handling of a crisis will seriously impact an organization’s performance and generate negative outcomes, while proper crisis management will reduce these same things (Coombs 2007c: 2-4). Johansen and Frandsen notes that even if it seems like a “double-crisis” is an integrated part of Coombs’ crisis definition, his typology of crises does not include this type of crisis (2007: 243). Nonetheless, SAS and its stakeholders strongly disagreed upon this issue. As a journalist from Berlingske Tidende, September 16, explains: *“Technically, John Dueholm and his people were probably right when they claimed that the incident in Aalborg was “isolated”, meaning that the specific problem with the right main landing gear and the following collapse was probably never seen before. However, there had been so many previous problems, including faults that resulted in emergency landings, that the aircraft seemed everything but 100 percent safe”*.

Tuesday September 18, the Lithuanian Aircraft Accident and Incident Commission, concluded that the emergency landing September 12 in Vilnius was with almost certainty

caused by the exact same corrosion problem that caused the Dash 8 accident at Aalborg Airport (Jyllands-Posten 19/9-07). According to Bombardier, the part of the landing gear that failed should hold at least 22 400 landing gear cycles. The two accident aircrafts had barely had 14 500 landing gear cycles (avisen.dk 3/10-07). SAS decided to replace parts of the landing gear on all aircrafts regardless of whether the fault was detected (SAS press release 18/9-07). However, eventually the same corrosion problem was revealed in all of the organization's Dash 8-Q400 aircraft (Politiken 21/9-07). September 19, the Scandinavian Civil Aviation Authorities issued a certificate of airworthiness for the Dash 8 aircrafts, on the conditions that the vital parts in the landing gears on all aircraft were replaced, not repaired, and that all aircrafts underwent extensive test-flights before they were used to transport passengers (Berlingske Tidende 20/9-07). SAS returned eight of its Dash 8-Q400 to traffic on October 4, with the rest of the fleet following successively (SAS press release 3/10-07).

Based on the events that occurred on September 9 and 12 in Aalborg and Vilnius, the prosecutor in Stockholm informed SAS that a preliminary investigation had commenced regarding suspicion of "creating danger to another person" (SAS press release 19/9-07). The loss for SAS resulting from grounding the 27 Dash 8 aircrafts was an estimated 8-12 million Danish kroner per day. Only in the first week 783 departures were cancelled which affected about 44,200 passengers (Ritzau 19/9-07).

5.2.3 Flight 2867: Copenhagen on October 27

Three weeks after the first Dash 8-Q400 were returned to traffic, on October 27, the Scandinavian Airlines flight 2867, made a prepared emergency landing at Copenhagen Airport. The aircraft was a scheduled international passenger flight from Bergen International Airport, Norway, to Copenhagen International Airport, Denmark. Similar to the previous two incidents in Aalborg and Vilnius, the right main landing gear of the aircraft failed to lock safely and the landing was disrupted. The aircraft was prepared for an emergency landing and the crew re-seated passengers in order to facilitate a rapid evacuation of the aircraft after landing. The aircraft was substantially damaged during landing, but all 40 passengers, including 2 infants, and 4 crew members were evacuated safely in about 30 seconds and no injuries occurred (Havarikommissionen for Civil Luftfart 2007b).

The Danish Accident Investigation Board was to investigate the accident. The SAS Group decided to ground the entire fleet of Dash 8-Q400 aircrafts once again (SAS press release 27/10-07), and the Scandinavian Civil Aviation Authorities reacted immediately by removing the certificate of airworthiness from the Dash 8 aircraft until further notice. The

accident at Copenhagen Airport also caught the attention of EASA. The Agency expressed concern about the recent accident and the possible relation with the other recent Dash 8-Q400 accidents. EASA called the Canadian Authorities and Bombardier for an immediate crisis meeting to discuss the continued airworthiness of the aircraft type (EASA press release 29/10-07).

Although the cause of the Copenhagen accident was still unknown, the day following the accident, October 28, SAS decided to remove the Dash 8-Q400 aircraft from service permanently (SAS press release 28/10-07). Bombardier issued a press release where the company expressed disappointment with SAS' decision to remove the aircrafts from its fleet, with the cause if the accident still unknown. Further Bombardier claims that it is not a matter of a general problem with the landing gear, and that Bombardier and the manufacturer of the landing gear Goodrich had conducted thorough inspections of the landing gear of the Dash 8 and concluded that they are safe and secure. Bombardier advised all airlines operating Dash 8-Q400 to continue using the aircrafts in traffic as normal (Politiken 29/10-07).

A preliminary report from the Danish Accident Investigation Commission, released October 29, established that the examination identified a blocked orifice within the actuator assembly, which prevented the complete extension of the right main landing gear. The retraction/extension actuator restrictor valve was blocked with an O-Ring. The report further states that this finding is not related to the two previous accidents that occurred in September 2007 (Havarikommissionen for Civil Luftfart 2007b). A meeting between EASA, Scandinavian and Canadian Civil Aviation Authorities, Bombardier and Goodrich, November 7, confirmed that the incident at Copenhagen Airport was not due to a design error and that the airworthiness of the aircraft was maintained. The meeting also confirmed that the incidents on 9 and 12 September were not related to the incident on 27 October (EASA press release 7/11-07).

On March 3, 2008, SAS issues a press release stating that the company has agreed a settlement with Bombardier and Goodrich regarding the incidents involving the Dash 8 aircraft. SAS Group confirm that the total financial compensation is slightly more than SEK 1 billion in the form of a cash payment and credits for future firm and optional aircraft orders. As part of the agreement, the Board of Directors of SAS AB has approved an order for 27 aircraft, with an option for a further 24 aircraft (SAS press release 10/3-07). Finally, May 22, 2008, the Public Prosecutor in Stockholm decides to discontinue the preliminary investigation of SAS regarding suspicions of the crime of "creating danger to another person" (SAS press release 22/5-07).

6 CASE ANALYSIS AND DISCUSSION

6.1 Stakeholders' perceptions and responses to the crisis

As is evident from Coombs' crisis definition (2007c: 2), it is the perception of stakeholders that determine what type of crisis an organization is facing. Several different groups of stakeholders speculated and expressed their opinions regarding who was responsible for the aircraft accidents.

6.1.1 Flight 1209: Aalborg on September 9

Representatives from one of the first stakeholder groups to take an active part in the media discussion following the Aalborg accident were SAS' customers. September 10, Ekstra Bladet printed a story with the headline "SAS scandal: I emergency landed with the same aircraft". The statement belonged to a customer that, in January 2006, had experienced an emergency landing with a SAS Dash 8 due to problems with the landing gear. This passenger, named Christian Bjergløk, explains about a conversation he had with an SAS employee at a dinner party:

"At my sister's place, I met a stewardess with a terrible story to tell. She told me that there are often problems with this aircraft. She flew on exactly the route between Aalborg and Copenhagen, and had through a couple of years been involved in about 15 emergency landings". He further states, "I am very angry. Both because SAS continues to use those aircrafts when there are so many problems with them. And also because they don't make sure to get things straighten out".

Bjergløk evidently believes that SAS has knowingly continued to use the Dash 8 aircraft in spite of a solid history of problems and without bothering to fix the problems.

Another of SAS' customers, Frederik Ohsten, tells B.T. that:

"The pilots do their best, of course. It is not their fault that the aircraft does not function. However, one could easily suspect that SAS has prioritised keeping aircraft that in reality are dangerous for the passengers, and in stead has chosen to use the limited resources on bonuses for the management and on dividends payments for the investors" (11/9-07).

Ohsten too, obviously suspect SAS management of knowingly placing stakeholders at risk. He believes that the management of SAS would compromise the safety of passengers in order to earn more money. Both of these customers hold SAS responsible for the accident, and

according to the SCCT, their perception places the SAS crisis in the preventable cluster. Further, because the accident lightly injured five passengers the crisis would classify as an organizational misdeed with injuries (Coombs 2007d: 168).

Representatives from the Danish Civil Aviation Authorities, another central stakeholder group to SAS, points to the possibility of the accident being the organization's responsibility. The director of communications, Thorbjørn Ancker, tells Politiken that he cannot make a statement concerning the Aalborg accident, but that:

“In recent years, SAS has had some serious incidents where it has not ensured the technical maintenance of different types of aircraft. Which means that SAS has not met with expected standards and that the authorities are keeping an eye on SAS' technical maintenance program” (10/9-07).

One of Ancker's co-workers, Tina Larsen, explains that:

“The authorities in Denmark, Norway and Sweden are very alert when it comes to SAS for the moment. There have been problems with SAS not handling warnings from the aircraft manufacturers regarding technical defects. For instance, that one should replace a spare part earlier than prescribed because defects are discovered. SAS' safety system has failed there, so they don't get their aircrafts to the statutory maintenance checks”. She further states, “Some day it will be serious for flight safety” (Ekstra Bladet 10/9-07).

These statements suggest that Ancker and Larsen believe that the accident might be due to safety negligence by SAS, which would imply that the management has violated laws and regulations. According to Coombs' SCCT, this could both qualify as organizational misdeed management misconduct and as an organizational misdeed with injuries. Both of which are located in the preventable cluster in the SCCT (Coombs 2007d: 168). In the case of SAS, violating safety regulations would mean placing stakeholders at risk.

Not all of SAS' stakeholders believed SAS to bear responsibility for the emergency landing in Aalborg. Helge Torp, a representative from Skandinavisk Tilsynskontor (STK), says to Politiken that he has nothing to comment on how SAS handle safety, and states that:

“There is nothing that I can see in the approval or about this type of aircraft, that tells us, one could have predicted an incident like the one in Aalborg”. He further explains, “It is our definite impression that SAS takes problems seriously, and turn around if there are indications of faults” (12/9-07).

The implications would be that SAS followed safety procedures and could not have predicted and thereby not prevented the incident. This suggests that Torp is of the opinion that the organizational actions leading to the crisis were unintentional, meaning it was an accident. This would place the SAS crisis in the accidental cluster in the SCCT, and further as what Coombs have termed a technical-error accident (Coombs 2007d: 168).

Already after the Aalborg accident, several Danish communication experts criticised SAS for what they believed were wrong handling of the situation. The manager of the communications bureau, Advice AS, namely Anders Bruun, states to Urban September 12:

“What is grotesque is that SAS won’t admit that they have a problem with flight safety, but just hold on to that they have done all they could. One cannot keep from wondering how many others of their aircrafts that also have safety problems. The confidence in SAS is under severe pressure in advance, and the impression they leave is tat they do not have control over their organization”.

In the same article, the manager of the PR-bureau Rescu Kommunikation, Christian Bogh, claims that:

“It is no good telling parts of the truth, because sooner or later it will be discovered, whether there is a journalist, a citizen or an anonymous source that dig it out. And when that sort of thing happened, people will search for information, and two simple presses on Google will rapidly verify that there have been problems with the type of aircraft previously”.

While Bruun directly blames the accidents on safety negligence by SAS, Bogh refers to the fact that there have been several previous incidents with the Dash 8-Q400 aircraft. Both of them seems to believe that SAS has wrongfully denied responsibility for the crisis, and even presented the publics with half-truths. When, as the two communication experts suggest, SAS management has been aware of the organizations’ problems with safety standards and the general problems with the Dash 8 aircraft in general, but still have chosen to ignore the problems, the crisis would classify as an organizational misdeed management misconduct and/or with injuries (Coombs 2007d: 168).

6.1.2 Flight 2748: Vilnius on September 12

When the second Dash 8 aircraft is forced to emergency land in Vilnius, a high number of representatives from different stakeholder groups are quoted in the media, having an opinion about the accidents. Among them is Benedicte Federspiel from the Danish Consumer Commission, who tells Viborg Folkeblad, September 12, that:

“The airlines and that include SAS, have seen a pattern here for a long time. Now, the rest of us see what they have been able to see for a long time, and that is simply not reassuring. SAS should have reacted.”

The statement indicates that she believes that SAS is responsible for the accident, in that the organization has been aware of the problems with Dash 8 aircraft for a longer period without reacting upon the information. Federspiel evidently perceives the crisis as what Coombs has labelled as an organizational misdeed in the preventable crisis cluster in the SCCT (Coombs 2007d: 168).

After the Vilnius incident, SAS' customer stakeholders are of varied opinions about SAS' responsibility for the accidents. Claudia Madsen, one of SAS' regulars, thinks that:

“It is to gamble with peoples' safety. It is clearly unsatisfactory that they were not grounded after the Aalborg accident. But I trust that they will put on a more reasonable type of aircraft now” (Politiken 12/9-07).

Madsen obviously believes that SAS knowingly placed passengers in danger by not grounding the aircraft after the first accident in Aalborg occurred. She holds SAS responsible for the crisis, which suggests a fit with an organizational misdeed crisis in the preventable crisis cluster in the SCCT (Coombs 2007d: 168).

Passenger Mogens Alsted, on the other hand, is of the opinion that:

“It is fair enough to cancel first after this second accident. Neither does one trash all cars because one of them ends up in the ditch” (Politiken 12/9-07).

The implication of Alsted's statement is that SAS could not have foreseen the Vilnius accident, thus not prevented it. He evidently perceives the crisis as an accident, which would

suggest that the crisis type is a technical-error accident located in the accidental cluster in the SCCT (Coombs 2007d: 168).

Helge Torp from STK does also seem to view the second emergency landing as an accident when he tells Politiken September 13 that:

“No, Vilnius could not have been predicted. Moreover, nothing indicates that SAS has done something wrong. I have examined our logbooks of both accident aircrafts. And everything related to security is carried out, including the replacements in the landing gear of this Dash-aircraft that has previously been demanded”.

Moreover, when the Danish Accident Investigation Board states the cause of the Aalborg accidents as corrosion, the director of STK, Karl-Erik Mortensson, explains to Politiken that the corrosion could not have been discovered beforehand:

“The inspections follow regular routines set in the maintenance programs for the aircraft. These programs determine the intervals for how many flights are allowed between every inspection. We have checked in our papers, and SAS has followed the inspection program for both accident aircrafts. Nevertheless, something can happen before the next limit is reached. And it seems like that is the case here” (14/9-07).

Both representatives from STK seem to believe that SAS has done everything by the book, and that something accidentally went wrong with both Dash 8 aircraft in between maintenance checks. The blame lies with the Dash 8 aircraft, suggesting a fit with the technical-error accident from the accidental cluster in the SCCT (Coombs 2007d: 168).

Two Danish communications experts, on the other hand, are of the opinion that SAS knew of the previous problems and they both criticize the organization for not telling the truth. This is evident from the statement made by Jesper Kunde, the executive director of Kunde & Co, to Jyllands-Posten September 13:

“Confidence in safety is what counts in the aviation industry. It creates distrust when the management one day calls it an isolated incident, and the next day, it turns out that that is not the case. SAS must put all cards on the table, if it is to avoid a long term negative influence on the organizations reputation”.

Moreover, Christian Bogh from Rescu Kommunikation points out to Urban September 14:

“With their misleading statements about lack of knowledge of problems with the Dash 8-Q400, SAS have dug a big black hole, which it is going to be difficult for them to get out of in short-term. SAS’ trust with its customers has been severely damaged, and it will take time to restore it. Moreover, to try to drag the manufacturer in as some kind of scapegoat, might well backfire”.

The above statements indicate that Kunde and Bøgh perceive SAS management to have knowingly violating regulations and placed stakeholders at risk which would fit as an organizational misdeed in the preventable crisis cluster in the SCCT (Coombs 2007d: 168).

However, the communication director of Bombardier, Bert Cruickshank, says that he is convinced that SAS thoroughly has followed the rules for inspection and maintenance of the accident aircraft, and admits that:

“The area in the landing gear that is affected by corrosion is not immediately visible in regard to the general maintenance of the aircraft. It requires the system to be separated, which is not part of the ordinary inspection”. (Jyllands-Posten 26/9-07)

Meaning that the representative from Bombardier perceives SAS to have followed standard procedures, thereby suggesting that the cause of the emergency landings are technical failures in the aircraft. This would indicate the crisis to belong in the accidental cluster in the SCCT, more specific as a technical-error accident (Coombs 2007d: 168).

Thorbjørn Ancker from the Danish Civil Aviation Authorities directly blames the Canadian manufacturer Bombardier for the accidents. In response to the public prosecutor in Stockholm announcing a preliminary investigation of SAS, Ritzau report him to say, October 3, that:

“We do not know what laws the Swedes claim are violated. Regarding the two accidents, everything point in the direction of a design flaw in the aircraft. Meaning, a weakness in the construction, which has nothing to do with the way SAS flies or maintains the aircraft. The manufacturer did also accept the responsibility”.

Further Ancker tells Jyllands-Posten the same day:

“It is Bombardier and the Canadian authorities, which has approved the aircraft that alone have the responsibility for the maintenance program. Moreover, they have responsibility for a component to last as long as promised”. (3/10-07).

Thorbjørn Ancker’s statements could indicate that he perceived the crisis both as a technical-error accident and as a challenge. Both of which are located in the accidental cluster in the SCCT (Coombs 2007d: 168). It appears that Ancker defends SAS, which he believes are wrongfully accused of operating in an inappropriate manner by the Swedish public prosecutor, which suggest he views the crisis as a challenge to SAS. Nevertheless, two accidents did happen with SAS aircraft, even if Bombardier is to blame for it and not SAS, which suggests that the crisis is a technical-error accident. The SAS crisis is perceived as a technical-error accident in that it was a failure in the technology or equipment used by SAS that caused the two emergency landings.

Even though the preliminary investigation by the Swedish public prosecutor is not in itself an accusation, it is evident that the prosecutor, Gunnar Jonasson, is not convinced that SAS is without responsibility for the crisis. As he explains to Ritzau (2/10-07):

“This concerns the issue of whether one has with gross negligence placed others in mortal danger or the like. Translated to air terms it means, if one has kept these aircraft in traffic with gross negligence. I am not saying that is the case, but that is what we are going to control”.

The implication of Jonasson’s statement is that he views it as a possibility that the accidents are due to SAS seriously violating laws and regulations regarding flight safety. Meaning that, according to the SCCT, the crisis type classify as an organizational misdeed located in the preventable cluster (Coombs 2007d: 168). Again, the SAS crisis could fit as any of the three organizational misdeed crisis in Coombs’ theory.

One of SAS’ pilots, Steen Parmo, which has flown the Dash 8 aircraft for 7 years, is of the opinion that neither the Dash 8-Q400 nor SAS have problems with safety. Parmo’s statements shown below indicate that he believes the accidents are due to technical-error, which can frequently occur, suggesting the crisis to belong in the accidental cluster in the SCCT (Coombs 2007d: 168):

“The corrosion was inside and was not visible. The fault is detected, the part is replaced. And one can be completely confident that we, as pilots, do not seat ourselves in a machine, unless we have

confidence in it". Further Parmo explains, *"The Dash-aircraft has had more minor defects than other types of aircrafts. That cannot be denied.. I have myself had to safety land in Gdansk, because of a propel defect. But many defects is not the same as there being security problems"* (Politiken 5/10-07).

A victim of the Dash 8 accident in Aalborg, namely passenger Sara Villadsen, is clearly unsatisfied with SAS. In an article from Nordjyske Stiftstidende, October 6, she is quoted stating that:

"SAS have not checked the company's planes well enough or followed up on the information from the aircraft manufacturer. I almost feel like SAS has played with my life. Afterwards SAS have tried to hush up everything and not taken us seriously. An example is a letter we received from SAS, where the emergency landing was only referred to as a security landing. It was a clear sign that SAS does not take us passengers seriously. It was not only a security landing, but a violent emergency landing, where we had a clear experience of that this could end terribly wrong".

Villadsen obviously believes that SAS knowingly have placed passengers in mortal danger by neglecting flight safety and ignoring vital information. Her perception of SAS as the responsible party for the accidents, suggests the crisis to belong in the preventable crisis cluster of the SCCT. SAS' management has violated laws and regulations, meaning the crisis fit as organizational misdeed management misconduct. But in the two accidents stakeholders are placed at risk and deceived, one accident resulting in five minor injuries, the implications being that the Dash 8 crisis also might be categorised both as organizational misdeed with and without injuries. (Coombs 2007d: 168)

Verner Lundtoft Jensen, a representative for the cabin crews' union, on the other hand, does not blame SAS for the crisis. He states that:

"We have confidence in the aircraft but out of consideration for the organization and everyone, one should probably see if there is a possibility of finding another type of aircraft, one immediately has confidence in. This has not been SAS' fault but the aircrafts fault". (Jyllands-Posten 16/10-07)

He directly blames the aircraft for the accidents, meaning he perceive the incidents to have been created by technical failure in the Dash 8 aircraft. This places the crisis in the accidental cluster as a technical-error accident (Coombs 2007d: 18).

6.1.3 Flight 2867: Copenhagen on October 27

When the third SAS Dash 8 emergency landing occurred at Copenhagen Airport, several representatives from the Danish government involved themselves in the media discussion. Among them was the Danish secretary of transport, Jacob Axel Nielsen, who stated to Berlingske Tidende October 28:

“We are going to find out if this accident is due to the same cause established in Aalborg and Vilnius. Because, if we are talking about the same cause, I would like to know what has been the matter with the repairs carried out by SAS. Were they not thorough enough?”.

It is clear from Axel Nielsen’s statement that he perceived it as a possibility that the same corrosion problem as in the two previous emergency landings was responsible for the Copenhagen accident. This would imply, as he directly states, that this third accident was the result of carelessness from SAS. The secretary of transport also emphasize that SAS has ensured all parties that the problems are corrected, which he obviously feels are not the case. As he explains to Extra Bladet October 28:

“We have received insurances from SAS, and now this happens once again. It is impossible to understand. I cannot imagine these planes carrying people around the world, before everything is investigated and explained and the problems are solved”. Further, “The passengers have been through a very traumatic experience. Through the last couple of months, they have witnessed the problems, been ensured that they no longer exist, and then this happens. Now SAS really needs to show that they are aware of their responsibility and exert all possible concern for the passengers”.

It is evident that Axel Nielsen also perceives the crisis to have created victims, namely the passengers onboard the three accident aircraft, and further that they are the responsibility of SAS. The implications of the minister’s statements are that he obviously holds SAS responsible for the accidents, or at least for not being able to solve the problems even though they claimed they had. Meaning that the crisis most likely could have been prevented if SAS had been in control of the situation. Delegating the responsibility for the victims of the crisis to SAS, also suggests that Axel Nielsen perceive SAS to bear responsibility for the crisis. The crisis thereby fits as an organizational misdeed in the preventable crisis cluster (Coombs 2007d: 168).

The secretary of transport is not alone in his perceptions of a similarity between the three accidents and of SAS' being responsible for the crisis. Another statement, suggesting the appropriateness of classifying the crisis type as an organizational misdeed in the preventable cluster in the SCCT (Coombs 2007d: 168), belong to Walter Christophersen, a representative from Dansk Folkeparti:

“I am shocked to learn that another Dash 8 aircraft from SAS had to emergency land in Kastrup Airport, and that the emergency landing to all appearances is identical with the recent incident in Aalborg. Fortunately, none of the passengers was injured – but what happens next time? I cannot underline strongly enough that our patience with SAS is over” (Ritzau 27/10-07).

Thorbjørn Ancker, from the Danish Civil Aviation Authorities, is of the opposite opinion and claims that SAS did everything they were supposed to do:

“SAS has satisfied all requirements for being allowed to return the aircraft to traffic that were imposed after the two previous incidents. What caused this emergency landing is up to the Danish Accident Investigation Board to establish” (Epn.dk 28/10-07).

Ancker's statement indicates that he, also this time, perceive the crisis as an accident. SAS did what they could, meaning the accident could not have been foreseen and thereby not prevented by the organization. He does not seem to view the crisis as an organizational misdeed, leaving the technical-error accident in the accidental cluster in the SCCT (Coombs 2007d: 168).

The day after the Copenhagen accident, October 28, Politiken quoted SAS passenger Niels Halleløv explaining his view of the crisis:

“I don't know if SAS is responsible for these problems, or if it is due to the supplier, but it seems rather unprofessional. I fly 30-40 times a year and am not insecure with it, but I think it is annoying with cancellations. I have not changed my view of SAS. It is the aircraft there is something wrong with”.

Halleløv, although he perceive the situation as somewhat unprofessional and annoying, clearly place the blame with the Dash 8 aircraft and not with SAS. His suggestion of the cause of the crisis being something with the aircraft, place the crisis in the accidental cluster as a technical-error accident (Coombs 2007d: 168).

In addition, SAS' competitors take an active part in the discussion in the media. One of them is the director of the Australian airline, Porter, which has four Dash 8-Q400 aircraft in its fleet. The Porter director is very direct in his statement:

"It is easy to blame the producer, but I ask myself if the maintenance of the aircraft is good enough. Safety has top priority, and I would not hesitate boarding an aircraft of this type".

The implication of his statement is that he is completely confident in the Dash 8 aircraft, and suggests SAS' maintenance procedures as the cause of the crisis. The crisis thereby fits as an organizational misdeed (Coombs 2007d: 168).

6.1.4 Overall reactions by the stakeholders

The first step in deciding the reputational threat of a crisis is to determine the crisis type (Coombs 2007d: 168). The evaluation of the stakeholders' responses to the crisis indicated varied opinions concerning SAS' responsibility for the accidents. However, the stakeholders' responses did not change noteworthy after the second and third emergency landing, but was fairly stable during the whole crisis period.

Representatives from several groups of stakeholders clearly blamed SAS for the crisis and felt that management had consciously kept the Dash 8-Q400 in traffic, in spite of many warning signals indicating that something was wrong. Thus, the crisis type can be classified as an organizational misdeed in the preventable cluster in the SCCT. Deciding between the three variants of misdeeds is difficult, because the SAS crisis fits all three crisis types. If management ignored safety standards it is a matter of violating laws and regulations, but it also implies that stakeholders are deceived and placed at risk by the organization. The Aalborg accident resulted in five injuries, although minor, while the two following accidents did not. However, Coombs and Holladay (2002: 183) have claimed that there is no difference in how people perceive the three variations of organizational misdeeds in terms of crisis responsibility or organizational reputation. Thus, organizations should respond in the same way to the three misdeed crisis types. According to the SCCT, an organizational misdeed produces strong attributions of crisis responsibility, meaning they represent a severe reputational threat to an organization (Coombs 2007d: 168).

Not all of SAS' stakeholders perceived the crisis to be the organization's responsibility. Several representatives from groups of stakeholders viewed the emergency landings as accidents, coincidentally happening to SAS' aircraft. A technical-error accident in

the accidental cluster in the SCCT normally produces minimal attributions of crisis responsibility, representing a moderate reputational threat (Coombs 2007d: 168).

However, the second step in determining the reputational threat of a crisis is, according to the SCCT, to establish if the organization has a crisis history or an unfavourable relationship reputation with stakeholders (Coombs 2007d: 168). SAS did have a performance history, whereby the SCCT claims that stakeholders’ attribution of crisis responsibility increases, thus the Dash 8-Q400 crisis moves from the moderate reputational threat level to represent a severe reputational threat to SAS.

The implication is that the Dash 8-Q400 crisis produced strong attributions of crisis responsibility toward SAS, thereby representing a severe reputational threat to the organization. The table below summarizes the stakeholders’ perceptions and the reputational threat presented by the Dash 8-Q400 crisis.

Table 9. Stakeholders’ perceptions and reputational threats summarized

	Stakeholders’ perceptions	Reputational threat of crisis
Flight 1209: Aalborg	Accident cluster: Technical-error accident w/crisis history Preventable cluster: Organizational misdeed w/crisis history	Strong attributions of crisis responsibility = severe reputational threat
Flight 2748: Vilnius	Accident cluster: Technical-error accident w/crisis history Preventable cluster: Organizational misdeed w/crisis history	Strong attributions of crisis responsibility = severe reputational threat
Flight 2867: Copenhagen	Accident cluster: Technical-error accident w/crisis history Preventable cluster: Organizational misdeed w/crisis history	Strong attributions of crisis responsibility = severe reputational threat

6.2 Scandinavian Airlines’ response to the crisis

6.2.1 Flight 1209: Aalborg on September 9

When the first emergency landing took place in Aalborg, Scandinavian Airlines employed a combination of what Coombs (2007d: 170) have termed justification and reminder crisis response strategies. SAS did acknowledge that an incident occurred, but it is obvious that the organization did not view the incident as an actual crisis. At a press conference in the evening of September 9, the vice president of SAS, namely John Dueholm explains that:

“We have Sunday been in contact with the manufacturer to hear if they are familiar with similar incidents. They said that they are not, and therefore we view the accident in Aalborg as an isolated

incident. We perceive it as a safe and secure aircraft. When a new type of aircraft enters the market, several things arise that needs to be corrected. There have been some teething troubles, but they have continuously been corrected". (Randers Amtavis 9/9-07).

Dueholm employs the justification strategy by referring to the accident as a one-time and isolated incident and comparing the accident to normal teething troubles. He attempts to minimize the perceived severity of the crisis. The bolstering crisis response strategy, reminder, is evident in a press release issued the next day, September 10, where SAS states that:

"SAS conducts regular checks and maintenance programs that meet official requirements. However, after consultation with Bombardier and although this must be regarded as an isolated incident, SAS has decided to implement a number of extraordinary checks of the landing gear on the entire fleet of Q400 aircraft. These checks are additional to the official requirements" (SAS press release 10/9-07).

SAS refers to the organizations regular checks and maintenance programs, meeting of official requirements and the continuously correction of problems with the aircraft. That is, SAS reminds stakeholders of its past good deeds and works. The decision to continue traffic as normal, should also be viewed as a statement from SAS that no real crisis exists, and that the organization has confidence in the Dash 8 aircraft.

Excuse, which is a diminish crisis response strategy (Coombs 2007d: 170), was also employed by SAS management. Head of press relations in SAS Denmark, Jens Langergaard, stated to Politiken, September 10:

"We can only state as a fact that the aircraft we operate have logbooks, they have certificates of airworthiness, and we have had some dialogues with the Danish Civil Aviation Authorities, which we will not go into details about. We are definitely satisfied that there is a focus on flight safety in Denmark and Europe".

Langergaard claims that SAS take safety maintenance seriously and that the organization are satisfied with there being focused on flight safety, the implications being that SAS neither intended for the accident to happen nor did the organization control it (Coombs 2007d: 170).

6.2.2 Flight 2748: Vilnius on September 12

When the second Dash 8 emergency landed, September 12, in Vilnius, SAS can no longer claim that the Aalborg accident was an isolated incident or deny that there is something wrong with the Dash 8. Instead, the organization employs the diminish crisis response strategy of excuse (Coombs 2007d), by suggesting it to be an industry-wide problem. A press release from SAS, September 12 explains that:

“The Canadian manufacturer of Dash 8-400, Bombardier, is in the process of developing an inspection programme. As a precautionary measure, Bombardier is highly recommending that all aircraft worldwide of this type with 10,000 landing gear cycles or more will be grounded until the recommended inspection is carried out”.

By emphasising that the problem most likely concerns all Dash 8-Q400 aircraft in the industry, SAS tries to minimize organizational responsibility for the crisis by claiming that there is something wrong with all Dash 8 aircraft, not just the ones belonging to SAS, meaning SAS had no control of the event that triggered the crisis.

In defence of the organization’s decision of keeping the Dash 8 aircraft in traffic, SAS employed the denial crisis response strategy, scapegoating (Coombs 2007d: 170), by passing the blame to Bombardier, the manufacturer of the aircraft. John Dueholm, SAS’ vice president, explains to Ekstra Bladet, September 16, that:

“The manufacturer judged the Aalborg accident to be an isolated incident. That is why we perceived it as safe to continue flying with the other aircraft. Now we know that that was not the case”. Further, he states, *“If Bombardier had expressed the least doubt about what this was, we would have grounded the whole fleet. But we got a very prompt message from Bombardier”.*

Dueholm uses Bombardier as a scapegoat, in that he claims that SAS’ statements concerning the first accident was based on information from the manufacturer. He also directly passes the blame regarding the decision of keeping the Dash 8 aircraft in traffic to Bombardier. Dueholm’s statements can also be perceived as the diminish crisis response strategy of excuse (Coombs 2007d: 170). By blaming Bombardier for the decision of keeping the Dash 8 aircrafts in traffic, SAS tries to minimize its own responsibility for the accidents by claiming that the organization did not control the event – Bombardier did. SAS also clearly states that

the organization would have grounded the aircrafts if advised to do so, thereby denying any intent to do harm.

Further, SAS used the scapegoating response strategy to deny any responsibility for the two accidents and to shift the blame to Bombardier and the authorities. This is evident from a statement made by Dueholm even before the exact cause of the accidents was identified:

“It is not our responsibility that the two emergency landings happened. We have done everything the authorities and the aircraft manufacturer has told us to do”. (Ekstra Bladet 13/9-07).

When the preliminary reports from the Danish Accident Investigation Board and the Lithuanian Aircraft Accident and Incident Commission were released, which both established corrosion as the cause of the aircraft accidents, Dueholm employed the scapegoating response strategy by directly stating that:

“We have identified the cause of the accidents. There is no doubt that it is Bombardier’s responsibility. Therefore, we will now present our direct and indirect expenses, and ask for Bombardier’s suggestion for compensation”. (Jyllands-Posten 4/10-07).

Further Dueholm, in one statement, extends the “scapegoat” to comprise Goodrich, which is Bombardier’s supplier of landing gear, and even the Canadian authorities, in addition to Bombardier. He claims that:

“It is Bombardier that has chosen Goodrich as a supplier of the landing gears, and that has the safety- and control responsibility. We wonder that Goodrich, Bombardier and the Canadian authorities, who have approved the design and maintenance programs, have been so mistaken in regard to these components”. Further, he says *“We have confidence in the cooperation with Bombardier, but Bombardier have to acknowledge their responsibility in regard to the fact that the components that caused the two emergency landings, did not have the durability they told us”* (Nordjyske Stiftstidende 4/10-07).

Moreover, the president of SAS, Mats Jansson explains that:

“The accidents are due to corrosion in the landing gear, which is Bombardiers area of responsibility, and which we are not obliged to control. They have failed in their responsibility, and that resulted in

the two accidents and the grounding of the aircrafts, that has had a cost to us of 10-15 million Swedish kroner per day. We therefore expect to demand at least half a billion Swedish kroner in compensation, which amounts to the direct and indirect costs we have had” (Berlingske Tidende 4/10-07).

The previous statements from the top management in SAS, unambiguously show that the organization employed the deny crisis response strategy of scapegoating several times, by consistently claiming Bombardier to be responsible for the crisis. However, what more is evident from the two managers’ statements is their clear focus on telling that they will demand compensation from Bombardier. The implication being that SAS is a victim of the crisis too. The management of SAS tries to make the organization look like a crisis victim by emphasizing how Bombardier misinformed them of the corroded components’ durability, and how much money the manufacturer’s mistake has cost the company. Meaning, SAS used the bolstering crisis response strategy of victimization (Coombs 2007d: 170).

Another example of SAS management displaying the organization as a victim of the crisis is SAS’ technical director, Geir Steiro, commenting to Jyllands-Posten October 3:

“When the design of such a critical component does not fulfil expectations, it will clearly decrease the trust. We ask ourselves, if there can be other critical components too, that does not live up to Bombardiers’ standards. This is why we wish to gain access to Bombardier’s register of fault with the aircraft, so that we in the future can have a greater insight and knowledge of where there might be weaknesses in the aircraft. We have a dialogue with Bombardier concerning this at the moment”.

Scandinavian Airlines also employed the denial CRS in response to the prosecutor in Stockholm announcing a preliminary investigation of SAS. A press release issued September 19, quotes senior vice president of corporate communications at SAS, namely, Hans Ollongren, stating that:

“We reject the claim that there are grounds for the public prosecutor’s suspicions. We will naturally cooperate with the prosecutor and provide all necessary information”.

The same day, September 19, Hans Ollongren tells RB-Børsen that:

“We do not believe that there is any ground for suspicion about us, at any point in time, having created danger to other persons”.

Ollongren, obviously tries to create distance between the crisis and SAS. If SAS has not created danger to other persons, then it is not the airlines responsibility and thus no crisis exists (Coombs 2007d: 170).

In addition to the victimization response, Scandinavian Airlines frequently used the bolstering crisis response strategy of reminder, by telling stakeholders about the past good works of the organization (Coombs 2007d: 170). These include statements from different managers promoting SAS' great history of and focus on safety, and praises of SAS' own fast response to the crisis. Among other, John Dueholm claimed that:

“Safety comes before everything else in our company. That means that we do not compromise on the rules, and that we think things over all the time, and that nothing is too small or unimportant, when it comes to securing the safety of our customers and colleagues”. Further, Dueholm reminds stakeholders that SAS' grounding of the Dash 8 aircrafts was in fact: *“It was two hours before the authorities ordered us to ground them. It was seven hours before Bombardier said they should be grounded. I think that is a good example, of our systems, when we talk about safety, working unambiguously and completely above any discussion”* (Berlingske Tidende 16/9-07).

Another example of the reminder strategy is the president of SAS, Mats Jansson, stating:

“In regard to maintenance, SAS invests more in each aircraft than most other airlines. It is not true that the rationalisations during the crisis-years were at the expense of our work with safety. This is among other proven with us prioritising quality instead of short-term profit in SAS Technical Services” (Jyllands-Posten 27/9-07).

The director of Scandinavian Airlines Denmark, Susanne Larsen, also employs the reminder strategy in an article she has written for Jyllands-Posten, October 21:

“I also want to remind you that the safety and maintenance work in SAS is very extensive. SAS uses 2.5 hours on safety and maintenance for every hour an aircraft is in the air”.

All of these statements are examples of SAS' management attempting to use past good works to counterbalance the current negatives from the Dash 8 crisis.

Another of the secondary bolstering strategies, ingratiation (Coombs 2007d: 170), is also present in SAS' crisis response. Susanne Larsen, in her article in Jyllands-Posten praises the SAS' crews that were onboard the Dash 8 aircraft during the accidents:

“Thank God we had, in both situations, employees, that with great authority, calmly and professionally took hand of the passengers, landed and evacuated the aircrafts”.

SAS’ managers also relied on the diminish CRS, excuse and justification. John Dueholm, the vice president of SAS, employs the diminish crisis response strategy of excuse when he states that:

“In the aviation industry an accident is the worst that can happen. When two accidents with the same cause happens with 57 hours in between....it should not be possible- neither in theory nor in practice. My judgement is, that this will be the only time in the flight history, that an airline experiences two accidents with the same type of aircraft and with the same cause in such short timeframe” (Jyllands-Posten 4/10-07).

Dueholm is saying that the two accidents are something unusual, even impossible, which one will probably never see again. The implications are that SAS did not intend for the accidents to happen and probably could not have done anything to prevent this anomaly. Susanne Larsen presented SAS’ justification strategy:

“It is understandable that the press has put a critical focus on our Dash 8-Q400 aircraft, we have done that ourselves in SAS. But, apropos my introduction in this article, one might ask oneself, if the need for sensation overshadows reality and creates an unnecessary insecurity with passengers”.

The implications of Larsen’s statement is that SAS’ crisis might not be as bad as the media make it to look, and that the press might have exaggerated the crisis in order to create an exiting story.

Additionally, the rebuild crisis response strategy of compensation (Coombs 2007d: 170), was evident in SAS’ crisis communication in that the organization offered all victims of the Aalborg and Vilnius accidents 2000 euro and two tickets each for use in Europe (Nordjyske Stiftstidend 6/10-07).

6.2.3 Flight 2867: Copenhagen on October 27

When the third emergency landing occurred in Copenhagen on October 27, SAS responded by grounding the fleet of Dash 8-Q400 aircraft permanently. The organization continued to blame the aircraft, and thereby the aircrafts producer Bombardier, for the accidents. A press

release issued the day after the Copenhagen incident, October 28, quotes the deputy CEO of SAS, John Dueholm stating:

“The Dash 8-Q400 has given rise to repeated quality-related problems and we can now conclude that the aircraft does not match our passengers’ requirements concerning punctuality and regularity. SAS’s flight operations have always enjoyed an excellent reputation and there is a risk that the use of the Dash 8-Q400 could eventually damage the SAS brand” (SAS Press Release 28/10-07).

Moreover, the CEO of SAS, Mats Jansson, explained at a press conference October 28 that:

“There are three reasons why we choose to remove the Dash aircraft from our fleet. The first reason is that the customers do not have confidence in the aircraft and have been hugely affected by the aircrafts’ irregularity. Secondly, we want to secure our employees a proper working environment. And thirdly, we do it to protect our brand, which already have been subject to a great debate” (Berlingske Tidende 29/10-07). Further Jansson says, *“The decision is drastic. However, both the employees and the customers have lost confidence in the aircraft. We have to consider SAS as a brand”* (Jyllands-Posten 29/10-07).

Both Dueholm and Jansson employed the denial CRS of scapegoating (Coombs 2007d: 170), by claiming that the Dash 8-Q400 aircraft was responsible for the quality related problems and irregularities, and thus indirectly passing the blame to Bombardier. In addition, both Dueholm and Jansson recognize customers and employees importance to SAS, by emphasizing that the aircraft were removed from traffic out of consideration for the two stakeholder groups. Meaning they made use of the bolstering CRS of ingratiation by praising customers and employees (Coombs 2007d: 170). Furthermore, Dueholm emphasise the excellent reputation of SAS’ flight operations, thereby employing the bolstering strategy of reminder (Coombs 2007d: 170). In addition, by focusing on how the aircraft might damage the SAS brand, both managers also make use of the bolstering CRS of victimage (Coombs 2007d: 170). Bombardier’s aircraft had a negative impact on SAS and might damage the corporate brand, making SAS a victim of the crisis too.

The victimage CRS is also evident in John Dueholm’s comment to Politiken October 29, regarding how much money SAS’ will demand in compensation from Bombardier:

“The amount will of course increase after the latest incident, but it is too early to tell what our final loss will amount to. However, about the 500 million kroner, I can say that the negotiations with

Bombardier are going well. We are close to an agreement, and Bombardier has shown a good understanding of our demands”.

By stating that SAS will receive compensation from Bombardier from the two first accidents, and that SAS will increase the demand because of the third accident in Copenhagen, Dueholm makes SAS a crisis victim. Moreover, the focus on compensation from the third accident is a way of passing blame, which is the CRS of scapegoating (Coombs 2007d: 170). If Bombardier is to compensate SAS for the emergency landing this implies that the manufacturer is responsible for the crisis and not SAS.

The director of SAS Denmark, Susanne Larsen, also made use of bolstering CRS in her statement to Jyllands-Posten October 29:

“For 60 years we have had a brand, where our safety has never been questioned. It could be that there are rational arguments for why we should have waited with our decision until the cause of the last accident is known. However, it is not a rational decision we have made; it is based on the customers’ experiences and the employees’ experiences. We wish to preserve their belief in us”.

Larsen uses the reminder strategy by claiming that SAS’ has 60 years of spotless safety-works behind. Moreover, she employs the ingratiation strategy by recognizing the importance of customers and employees to the organization.

6.2.4 How SAS acted relative to Coombs’ recommendations

As the previous analysis of stakeholders’ responses established, the Dash 8-Q400 crisis represented a severe reputational threat to SAS. In such instances, where the perceived organizational responsibility for a crisis is high, the SCCT recommends employing CRS with high levels of responsibility acceptance. That is, the SCCT suggests the appropriate responses to be the accommodative rebuild CRS, because compensation or a full apology should work to improve the organization’s reputation. As supplements to the rebuild strategies, an organization might use the secondary bolstering strategies of reminder and ingratiation.

However, the first reaction of the management of SAS after the Aalborg incident was not to apologize for the emergency landing, but to attempt to downplay both the severity of the accident and the organization’s responsibility and control for it. That is, management used the diminish CRS of justification and excuse. For example, as illustrated by the passenger Villadsen’s perception, SAS framed the incident as a “security landing”, instead of an

“emergency landing”. This fits with Coomb’s diminish strategy, but also illustrates the use of terminological control during a crisis, in line with Hearit’s theory (Hearit and Courtright 2003: 88). SAS also tried to bolster its image in its messages by reminding stakeholders about the organization’s extensive work with safety maintenance. Even though the reminder strategy might be used as a supplement to the diminish CRS, the latter is suggested by the SCCT to be appropriate if an organization faces a moderate reputational threat (Coombs 2007d: 173; 2007c: 143).

After the occurrence of the second emergency landing in Vilnius, SAS also provided no apology. Even though the airline offered money and tickets in compensation to the passengers involved in the two emergency landings, the organization’s primary strategy was to make Bombardier the scapegoat, claiming that the manufacturer was responsible for the crisis. Therefore, SAS displayed itself as a victim of Bombardier’s mistakes and focused several of the organization’s messages on the compensation it would rightfully demand from the Dash 8 producer. Additionally, SAS management suggested the crisis to be an industry-wide problem, thereby attempting to reduce its own responsibility for the crisis. Further, they claimed that they acted on information from Bombardier, underscoring that they did not control the event. One representative from SAS also suggests the media to have blown the crisis out of proportions. Lastly, SAS continued to remind stakeholders of the organization’s solid history of safety works and praise the effort of the employees onboard the two accident aircraft. SAS made use of CRS from all three primary postures and the whole range of secondary strategies. SAS’ use of the rebuild strategy of compensation and the secondary bolstering strategies reminder and ingratiation are coherent with the SCCT recommendations for a severe reputational threat crisis. However, the deny CRS and the diminish CRS are only believed to be effective in crises that constitute minimal or mild reputational threats, respectively. Similarly, the SCCT suggests that the bolstering strategy victimage are only appropriate in rumor or challenge crises.

When the Dash 8-Q400 aircraft emergency landed in Copenhagen, SAS continued blaming Bombardier for the crisis and claimed to be a crisis victim too. The airline again emphasized its history of extensive safety procedures, acknowledged the customers and employees importance to the organization, and praised the employees’ effort during the three incidents.

Overall, SAS’ response to the Dash 8-Q400 crisis did not follow the prescriptions of the Situational Crisis Communication Theory. While the stakeholders’ perceptions classified the crisis as a severe reputational threat, the management of SAS for the most responded with

CRS appropriate for victim crises and accident crises without performance history. In addition, the organization, in contrast to what is recommended by the SCCT, was inconsistent in their responses to the crisis by mixing all three primary postures, which Coombs suggests will erode the effectiveness of the overall response (Coombs 2007d: 173).

Table 10 summarizes the reputational threat presented by the crisis situation, how SAS responded, and what CRS the SCCT recommends using in such a crisis.

Table 10. Reputational threat, SAS’ responses and SCCT recommendations summarized.

	Reputational threat of crisis situation	SAS’ responses	SCCT recommendations
<i>Flight 1209: Aalborg</i>	Strong attributions of crisis responsibility = severe reputational threat	<i>Diminish CRS:</i> Justification Excuse <i>Bolstering CRS:</i> Reminder	<i>Rebuild CRS:</i> Compensation Apology <i>Bolstering CRS:</i> Reminder Ingratiation
<i>Flight 2748: Vilnius</i>	Strong attributions of crisis responsibility = severe reputational threat	<i>Deny CRS:</i> Scapegoating Denial <i>Diminish CRS:</i> Justification Excuse <i>Rebuild CRS:</i> Compensation <i>Bolstering CRS:</i> Victimization Reminder Ingratiation	<i>Rebuild CRS:</i> Compensation Apology <i>Bolstering CRS:</i> Reminder Ingratiation
<i>Flight 2867: Copenhagen</i>	Strong attributions of crisis responsibility = severe reputational threat	<i>Deny CRS:</i> Scapegoating <i>Bolstering CRS:</i> Reminder Ingratiation Victimage	<i>Rebuild CRS:</i> Compensation Apology <i>Bolstering CRS:</i> Reminder Ingratiation

6.2.5 The impact of the crisis on SAS’ reputation

Even though SAS acted opposite to what the SCCT recommends in similar crises, certain information suggests that the airline’s reputation made it through the crisis. Naturally, there are restraints on the ability to explain the exact influences of the Dash 8–Q400 crisis on SAS’ reputation. The included data are from surveys, opinion measures and other information, which might suggest more about SAS’ image than reputation. Images concern the immediate impressions of individuals when confronted by a signal or message that comes from an organization, while reputations are more enduring general estimations established over time

(Cornelissen 2006: 84). Moreover, the perceptual construct of a reputation makes simple proxy measures of the assets, performance or output of a particular organization insufficient, as they fail to account for the subjective, perceptual nature of reputation and the longer period involved in its formation (Cornelissen 2006: 85). However, the discussion below relies on information thought to be useful indications of the crisis' eventual impact on SAS.

After the two first accidents with the Dash 8 aircraft, several opinion measures were conducted to assess the public's immediate impression of SAS and its handling of the crisis situation. The Danish company Wilke Markedsanalyse, asked approximately 1000 Danes from 15 to 62 years about their opinion of SAS. The results indicated that every third Dane felt insecure about flying with the airline, and half of the respondents believed that SAS consciously tried to hide or downplay the problems with the aircraft. Almost 80% of respondents answered that SAS had not been good enough to inform the public about the Dash 8 problems, and 75% believed that SAS should have removed the aircraft from traffic earlier (Politiken 26/9-07).

However, SAS conducted its own survey in September among 400 customers in Denmark and 400 customers in Sweden. The conclusion of the survey was, according to the magazine Inside SAS: "*Customers are prepared to fly and by all means with SAS, but are not as eager to travel on Q400 aircraft. Large jet aircraft are what customers want*". The perception of SAS as a reliable airline had decreased in Denmark, and the perception of quality had dropped the most among customers overall. However, the results of the study indicated that people did not intend to change the way they fly. In Denmark, 27% of business passengers said that they planned to fly more often than before, 69% believed they would fly about as often as before, and only 4% believed they would fly less often. Of business passengers, 58% were positive to flying with the Dash 8 aircraft. Leisure passengers in Denmark, on the other hand, were not so sure about flying with the aircraft. While 27% gave it their thumbs up, 46% said that they did not want to fly with the Dash 8. A clear majority of the 800 customers believed it is just as safe to fly with SAS as with other airlines (Lönqvist 2007b).

Results of a second survey conducted in November 2007, following SAS' decision to withdraw the Dash 8-Q400 aircraft, indicated that customers in Denmark and Norway perceived it to be as safe to fly with SAS as with other airlines. In Sweden, customers actually believed it to be safer to fly with SAS than with other companies. However, the results suggested negative reactions among customers in the Nordic countries following the Dash 8-Q400 incidents. In general, customers perceived the decision to remove the aircraft as wise,

but certain customers maintained that it came far too late. Further, the results indicated damage to the SAS brand in Denmark and Sweden relating to dimensions such as perceived quality, the image as a unique and popular company, and the core value “reliability”, which includes safety and punctuality (Lönqvist 2007a).

Although, the previous discussion suggests that SAS’ image was negatively affected by the crisis, a study conducted by the Reputation Institute (RI) indicates that SAS’ reputation in Denmark was not noticeably damaged. RI annually administers a global research program, which offers respondents’ general evaluation of companies’ reputation. Included in this study called RepTrak, is a reputation study of Denmark’s most visible companies (Reputation Institute 2008a). In addition to RepTrak, RI also conducts an annual study of companies’ workplace reputation among students, namely the WorkRep. Table 11 shows the results for the two studies from 2006-2008.

Table 11. RepTrak & WorkRep 2006-2008.

	RepTrak Pulse		WorkRep Students	
	<i>Rank (Total*)</i>	<i>Score (0-100 range)</i>	<i>Rank (Total*)</i>	<i>Score (0-100 range)</i>
2006	15 (30)	54.1	49 (96)	49.9
2007			48 (96)	48.2
2008	20 (34)	62.4	54 (89)	43.7

*Total number of organizations included in the study.

SAS was not included in RepTrak 2007, but the results from 2006 and 2008 indicate a slight improvement in SAS’ reputation the last couple of years, in spite of the 2007 Dash 8 crisis (Reputation Institute 2006; 2008a). The results of the WorkRep studies, however, indicate a decrease in SAS’ workplace reputation among students between 2006 and 2008. During a period of 2 years SAS’ score dropped by 6.2 points, and SAS was ranked significantly lower on the list in 2008 than in 2006. In 2006, SAS was among the bottom five companies concerning working conditions and performance and leadership in the WorkRep. However, that is not the case 2 years later, which might be an indication of a more balanced evaluation and improvement in certain of the measured categories (Reputation Institute 2007; 2008b). The results are not directly comparable though, as the criteria of nomination might differ from one year to the next. Moreover, whether these results are due to the Dash 8 crisis or other factors is not possible to ascertain.

Coombs suggests that the more negative the reputation, the less likely stakeholders are to report behavioural intentions that are supportive of an organization (Coombs 2007d: 169). In the case of SAS, the total number of passengers travelling with the airline actually increased during the first half of 2008 compared to 2006 and 2007. The number of passengers that flew with SAS Denmark decreased a little (SAS Group 2006; 2008b). Table 12 shows the passenger volume for the period January-June in 2008 and the same period during the two previous years.

Table 12. SAS’ passenger volume January-June 2006-2008.

	Number of passengers (000) January/June	
	<i>SAS</i>	<i>SAS Denmark</i>
2006	12, 389	4, 045
2007	12, 547	4, 011
2008	13, 205	3, 990
Change 07/08	+5.2%	-0.5%

The discussion above indicates that the Dash 8- crisis did not impact customers behavioural intentions, which again might indicate that the reputational damage was not that significant. On the other hand, SAS’ market position in Scandinavia and Denmark in particular, is very strong, and the customers may have little other choice of airlines, and may have to choose SAS or a Star Alliance partner.

6.3 Applicability of the SCCT

The purpose of the previous case study was to examine the SCCT’s applicability in a complex crisis case where there were multiple groups of stakeholders involved in the crisis. The SCCT was found to be applicable in the SAS Dash 8-Q400 crisis case study. The disparate views of multiple stakeholders did not limit the use of SCCT in deciding upon classifying the SAS crisis. Coombs treats stakeholders as a unitary actor, which worked in the SAS Dash 8 crisis because the stakeholders had similar attributions of crisis responsibility.

Though it was possible to categorize the stakeholders’ responses to crises in the SCCT, there was not always a perfect fit. Sometimes it was difficult to match the stakeholders’ perceived attributions of crisis responsibility with the appropriate crisis type or even crisis cluster, e.g. when the cause of each of the two first accidents was thought to be a

design error by Bombardier. Some of the stakeholders adopted this view and directly placed the responsibility for the accidents with the manufacturer. Coombs typology of crises does not include guidance for situations where an outside actor accidentally causes a crisis. Some might argue that stakeholders blaming Bombardier for the accidents could be described as a challenge crisis. However, there was no question of whether or not the accidents occurred with SAS' aircraft, and I found no other interpretation than to assume that the stakeholders' responses expressed their view of the crisis as a technical-error accident. Although Coombs has assured that "*most crises will fall easily into one of the crisis types*" (Coombs 2007c: 142), I found this was not always the case in this thesis.

Furthermore, Coombs' treats the crisis intensifiers, which are crisis history and relationship history, as something an organization either has or has not. However, the previous case analysis indicated that the perception of whether or not a history of previous crises exists might differ among different stakeholders. Additionally, the case study indicated that an organization does not necessarily need a history of crises to be perceived as more responsible for a particular crisis. In this case, SAS' crisis history was identified after the accidents occurred, in that minor safety violations and normal teething troubles experienced with most new aircraft suddenly was displayed as a great threat to flight safety. Even though previous research has investigated the impact of crisis history on organizational responsibility, it could be useful to identify how and what stakeholders actually perceive as a history of previous crises.

Another issue identified from the case analysis concerns the previous CRS of corrective action. Corrective action was removed from the list of CRS with the explanation that it was more appropriately viewed as adjusting information than as a reputation repair strategy (Coombs 2004d: 468). However, when SAS employed corrective action and grounded its entire fleet of Dash 8-Q400s permanently, the management consistently claimed that they removed the aircraft out of consideration for the organization's image and brand. It could be interesting to explore how other organizations use corrective action (adjusting information or reputation repair), and how stakeholders perceive it. Obviously, the crisis situation has been of primary research interest to Coombs. The list of CRS has been refined but has not been subjected to much empirical testing. Coombs relies mostly on external research when making changes to the CRS, and he does not always provide reasonable arguments for why he excludes or includes new responses.

Moreover, SAS did not follow the prescriptions of the SCCT for similar crises, but still managed to protect the corporate reputation. To adapt the stakeholders' frame and accept

responsibility for the accidents, as the SCCT proposes, would have been extremely costly to the airline and might have negatively influenced the organization's reputation. The fact that evidence supported SAS' claims that Bombardier was responsible for the corroded parts, and that the manufacturer accepted responsibility for the design error, suggests it was a wise strategy eventually resulting in a large compensation for SAS. The finding of the successful use of a mismatched response in this case analysis indicates that the choice of CRS might be more complex than the SCCT takes into consideration. Furthermore, SAS used strategies from the whole range of CRS in the SCCT. This shows that strategic crisis communication not necessarily is about making use of one or a few strategies.

6.4 Methodological issues and limitations

Some methodological issues should be discussed. This study was a case study examining one scenario (aircraft emergency landings) and one type of organization (profit-making organization). The case study approach enabled the researcher to undertake detailed in depth analysis and qualitative assessment of how Coombs' theory worked. However, such an approach clearly limits the generalizability of the results to organizational crises of different types, to different organizations or situations. Hence, this questions the external validity of the case study approach.

The analysis of the case is mainly based on articles from newspapers and press releases, and the author did not have access to internal documents from SAS or other organizations. Also it was not possible to interview key actors or conduct a survey. Analysing other stakeholders' opinions, and the responses SAS used in defence of the crisis, through the media can be problematic. The media have their own agenda, and the articles used in this case analysis may thus be coloured by the media's perceptions and account of the crisis. Consciously or unconsciously, journalists can leave out information that would have provided the reader a more nuanced picture. Journalists sometimes leave out small pieces of facts because such information would have made the news less exiting or "good" (Østlyngen and Øvrebø 2002: 83). Recently, much news coverage tends to use hysterical journalism when a crisis strikes, meaning over-hyped or over-dramatized coverage written in an extreme, frightened, angry or exiting style, and expressing the emotions or feelings of reporters. Such hysterical journalism, in turn, stimulates the psychological pulse and affects peoples perceptions more negatively toward actors concerned with the event (Cho and Gover 2006 :422). Therefore, media coverage can create its own bias and, thus have an impact on the analysis and conclusions.

Coombs has been critiqued for the research design employed in developing the SCCT (Johansen and Frandsen 2007). All experimental studies are limited because only a small set of variables can be tested. The SCCT-related research also relies on student data rather than the actual reactions of stakeholders. It has been claimed that to just pick a few variables from a theory, hypothesise some insulated causality between two or a few variables and test it with perceptual survey data using statistical techniques will only result in superficiality and emptiness (Gummeson 2006: 169). Schwarz (2008: 4) has critiqued Coombs, suggesting that it is problematic to assume that certain crisis types are linked to a determined degree of responsibility attribution. Although SCCT takes into account two additional variables in order to assess attributions, crisis situations are very complex and ambiguous events, which cannot easily be categorized in a few clusters of perceived responsibility.

Moreover, a particular type of crisis situation does not invariably necessitate the same strategies every time that it occurs. Some crises are predictable in their response and outcome, and hence fit in a generic approach, and others do not (Hearit and Courtright 2003: 85). Although it is important to recognize the genre(s) related to crisis situations and the variety of message strategies available to organizations, the discursive activities of multiple actors must also be taken into account (Hearit and Courtright 2003: 92). However, researchers often follow the positivistic temptation to treat the many components of crisis communication as objective choices, thus obscuring the distinctively communicative character of crises and their resolutions. Crises are dynamic, social constructions that are both created and resolved terminologically (Hearit and Courtright 2003: 79). It has been claimed that the reality of a crisis is socially constructed through language, a process whereby meaning is created and agreed upon. Thus, communication is not something that occurs by organizations in crises, but something that establishes the meaning that participants in that crisis come to hold (Hearit and Courtright 2003: 85).

Thus, the use of Coombs' SCCT as the theoretical framework for this thesis, impose limitations in that the genuine validity and relevance of the SCCT can be questioned. It could be that other theories would fit better or yield different results, though in this case study the SCCT seemed to be applicable as a tool for structuring the positions of stakeholders and the organization's actions.

The choice of theory for examination in this thesis furthers a brief debate of quantitative and qualitative approaches to research. A case study is qualitative research, referring to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things. In contrast, quantitative methods refer to counts and measures of

things. Clearly, numbers cannot meaningfully express certain experiences. Because qualitative research tends to assess the quality of things using words, images and descriptions, in contrast to quantitative research that relies chiefly on numbers, many people erroneously regard quantitative strategies as more scientific than those employed in qualitative research (Berg 2004: 2-3). Berg suggests that although various technologies are used by different researchers, it turns out that everyone is doing science, provided that science is defined as a specific and systematic way of discovering and understanding how social realities arise, operate, and impact on individuals and organizations of individuals (Berg 2004: 11).

6.5 Implications/Conclusions

This thesis has provided an in-depth explanation of the development of the SCCT and tested the theory using the SAS Dash 8-Q400 crisis as a case study. The SCCT has been subjected to extensive testing and refinement during the past 13 years and has been developed into a more coherent and comprehensive theory. Therefore, the SCCT has become more manageable in use, and Coombs' recent works indicate an increased understanding of the complexity and dynamics of crises.

The case analysis examined how multiple groups of stakeholders perceived the responsibility for the crisis and what CRS that SAS employed in response to the crisis. The SCCT was found to be applicable in this complex crisis involving multiple groups of stakeholders. Taking account of how several different groups of stakeholders viewed the crisis did not impose limitations in using the SCCT, because the stakeholders had similar attributions of crisis responsibility

Some limitations to the applicability of the SCCT were identified through the case analysis. The three crisis clusters in the SCCT only cover 12 types of crises, which sometimes proved difficult to match with the stakeholders' level of perceived responsibility for the crisis. Furthermore, the case analysis indicated that treatment of the crisis intensifiers as either present or not as in Coombs' theory, can be problematic. In the present case, whether SAS had a crisis history or not was a disputed issue among different stakeholders, and even between the stakeholders and the airline. Additionally, what was labelled SAS' crisis history was in fact a collection of previous minor incidents of which importance escalated after the first Dash 8 emergency landing, and not the organization's history of previous "real crises". Finally, the case analysis indicated differences in what Coombs and SAS perceive as reputation repair.

The case analysis also found that SAS did not follow the prescriptions from the SCCT, as the organization used a combination of strategies from all the CRS postures. Despite the organization's mismatched response, certain measures indicate that SAS' did not suffer noticeably damage to its corporate reputation, which confirms that in this crisis a mix of response strategies were successful.

In conclusion, this thesis has described the development of the SCCT over time and its application in a complex crisis with multiple stakeholders. In this special situation, the SCCT was applicable and useful for describing and structuring the positions of the various actors. This framework would also lead to firm recommendations for crisis managers, though in this case the SAS management partly chose different communication strategies.

7 REFERENCES

- Aasen, Svein O. 2008. *Skandinavisk Tilsynskontor (STK): History*. [Online]. Available from URL: <<http://aasen.se/history.html>>. [Accessed 2008 November 26]
- Allen, Myria Watkins and Rachel H. Caillouet. 1994. "Legitimation Endeavours: Impression Management Strategies Used by an Organization in Crisis". *Communication Monographs*, 61 (1): 44-62.
- Askheim, Ola Gaute and Tor Grenness. 2000. *Fra tall til ord: kvalitativ metode i markedsforskning*. Oslo: Universitetsforlaget.
- Aviation Safety Network. 2008. *Accident description*. [Online]. Available from URL: <<http://aviation-safety.net/database/record.php?id=20011008-0>>. [Accessed 2008 November 26].
- Barton, Laurence. 2001. *Crisis in Organizations II*. Cincinnati, OH: College Divisions South-Western.
- Benoit, William L. 2004. Image restoration discourse and crisis communication. In *Responding to crisis: a rhetorical approach to crisis communication*, edited by Millar, D. P. and Heath, R. L.. Mahwah, NJ, USA: Lawrence Erlbaum Associates, Inc.
- Berg, Bruce L. 2004. *Qualitative research methods for the social sciences*. 5th ed. Boston: Pearson education, Inc.
- Clarkson, Max E. 1995. "A stakeholder framework for analysing and evaluating corporate social performance". *Academy of Management Review*, 20 (1): 92-117.
- Chizema, Amon and Trevor Buck. 2006. "Neo-institutional theory and institutional change: Towards empirical tests on the "Americanization" of German executive pay". *International Business Review*, 15: 488-504.

Cho, Seung Ho and Karla K. Gover. 2006. "Framing effect on the public's response to crisis: Human interest frame and crisis type influencing responsibility and blame". *Public Relations Review*, 32: 420-422.

Coombs, W. T. 1995. "Choosing the right words: The development of guidelines for the selection of the "appropriate" crisis response strategies". *Management Communication Quarterly*, 8: 447-476.

Coombs, W. T. 1998. "An Analytic Framework for Crisis Situations: Better Responses From a Better Understanding of the Situation". *Journal of Public Relations Research*, 10(3): 177-191.

Coombs, W. T. 1999a. "Information and Compassion in Crisis Responses: A Test of Their Effects". *Journal of Public Relations Research*, 11(2): 125-142.

Coombs, W. T. 1999b. *Ongoing crisis communication: Planning, managing, and responding*. Thousand Oaks, CA: Sage.

Coombs, W. T. 2000a. Crisis Management: Advantages of a Relational Perspective. In Ledingham, J. A. & Bruning, S. D. (red.). *Public Relations as Relationship Management*. Mahwah, NJ: Lawrence Erlbaum.

Coombs, W. T. 2000b. "Designing Post-Crisis Messages: Lessons for Crisis Response Strategies". *Review of Business*, 21 (3-4): 37-42.

Coombs, W. T. 2001. Interpersonal Communication and Public Relations. In Heath, R. L. (red). *Handbook of Public Relations*. Thousand Oaks: SAGE Publications.

Coombs, W. T. 2002. "Deep and surface threats: conceptual and practical implications for "crisis" vs. "problem". *Public Relations Review*, 28: 339-345.

Coombs, W. T. 2004a. A theoretical frame for post-crisis communication: Situational crisis communication theory. In Martinko, M. J. (Ed.), *Attribution theory in the organizational*

sciences: Theoretical and empirical contributions (pp. 275-296). Greenwich, CT: Information Age Publishing.

Coombs, W. T. 2004b. "Impact of past crisis on current crisis communications: Insights from situational crisis communication theory". *Journal of Business Communication*, 41: 265-289.

Coombs, W. T. 2004c. "West Pharmaceutical's explosion: structuring crisis discourse knowledge". *Public Relations Review*, 30: 467-473.

Coombs, W. T. 2005a. Crisis and crisis management. In Heath, R. L. (Ed.), *Encyclopedia of public relations* (pp. 217-221). Thousand Oaks, CA: Sage.

Coombs, W. T. 2005b. Crisis communication. In Heath, R. L. (Ed.), *Encyclopedia of public relations* (pp. 221-224). Thousand Oaks, CA: Sage.

Coombs, W. T. 2006a. *Code red in the boardroom: Crisis management as organizational DNA*. Westport, CT: Praeger.

Coombs, W. T. 2006b. Crisis Management: A Communicative Approach. In Botan, C. H. & Hazleton, V. (Eds.). *Public Relations Theory II*. Mahwah, NJ: Lawrence Erlbaum.

Coombs, W. T. 2006c. "The Protective Powers of Crisis Response Strategies: Managing Reputational Assets During a Crisis". *Journal of Promotion Management*, 12(3/4): 241-260.

Coombs, W. T. 2007a. "Attribution Theory as a guide for post-crisis communication research". *Public Relations Review*, 33: 135-139.

Coombs, W. T. 2007b. "Crisis Management and Communications". Published by the Institute for Public Relations. Available from URL: http://www.instituteforpr.org/files/uploads/Coombs_Crisis2.pdf. [Accessed 2008 November 27]

Coombs, W. T. 2007c. *Ongoing crisis communication: Planning, managing, and responding*. Thousand Oaks, CA: Sage.

Coombs, W. T. 2007d. "Protecting Organization Reputations During a Crisis: The Development and Application of Situational Crisis Communication Theory". *Corporate Reputations Review*, 10(3): 163-176.

Coombs, W. T., & Holladay, S. J. 1996. "Communication and attributions in a crisis: An experimental study of crisis communication". *Journal of Public Relations Research*, 8(4): 279-295.

Coombs, W. T., & Holladay, S. J. 2001. "An extended examination of the crisis situation: A fusion of the relational management and symbolic approaches". *Journal of Public Relations Research*, 13: 321-340.

Coombs, W. T., & Holladay, S. J. 2002. "Helping crisis managers protect reputational assets: Initial tests of the situational crisis communication theory". *Management Communication Quarterly*, 16: 165-186.

Coombs, W. T., & Holladay, S. J. 2004. Reasoned action in crisis communication: An attribution Theory-Based approach to crisis management. In Millar, D. P. & Heath, R. L. (Eds.), *Responding to crisis: A rhetorical approach to crisis communication* (pp. 95-115). Mahwah, NJ: Lawrence Erlbaum.

Coombs, W. T., & Holladay, S. J. 2005. Exploratory study of stakeholder emotions: Affect and crisis. In Ashkanasy, N. M., Zerbe, W. J. & Hartel, C. E. J. (Eds.), *Research on emotion in organizations: Vol. 1: The effect of affect in organizational settings* (pp. 271-288). New York: Elsevier.

Coombs, W. T., & Holladay, S. J. 2006. "Unpacking the Halo Effect: Reputation and crisis management". *Journal of Communication Management*, 10(2): 123-137.

Coombs, W. T., & Holladay, S. J. 2007. "The negative communication dynamic: Exploring the impact of stakeholder affect on behavioural intentions". *Journal of Communication Management*, 11 (4): 300-312.

Coombs, W. T., & Holladay, S. J. 2008. "Comparing apology to equivalent crisis response strategies: Clarifying apology's role and value in crisis communication". *Public Relations Review*, 34: 252-257.

Coombs, W. T., & Schmidt, L. 2000. "An empirical analysis of image restoration: Texaco's racism crisis". *Journal of Public Relations Research*, 12(2): 163-178.

Cornelissen, Joep. 2006. *Corporate Communications: Theory and Practice*. 3th ed. London: SAGE Publications Ltd.

Cutlip, Scott M., Center, Allen H. and Glen M. Broom. 2006. *Effective Public Relations*. Upper Saddle River, NJ: Prentice Hall International. 9th. ed.

Davies, Gary., Chun, Rosa., da Silva, Rui Vinhas and Stuart Roper. 2003. *Corporate Reputation and Competitiveness*. New York: Routledge.

Dilenschneider, Robert L. 2000. *The Corporate Communications Bible: Everything You Need to Know to Become a Public Relations Expert*. Beverly Hills: New Millennium Press

Dunn, D., and Cody, M. J. 2000. "Account credibility and public image: Excuses, justifications, denials, and sexual harassment". *Communication Monographs*, 67(4): 372-391.

Dutton, Jane E. 1986. "The Processing of Crisis and Non-Crisis Strategic Issues". *Journal of Management Studies*, 23(5): 501-517.

EASA. 2008. *What we do*. [Online]. Available from URL: http://www.easa.eu.int/ws_prod/g/g_whatwedo.php. [Accessed 2008 November 26]

Fagerli, Hans Petter and Bjørn Richard Johansen. 2003. "Crisis Management". In *Corporate Communication: A Strategic Approach to Building Reputation*, edited by Peggy Simcic Brønn and Roberta Wiig. Oslo: Gyldendal Akademisk.

Fearn-Banks, Kathleen. 1996. *Crisis Communications : A Casebook Approach*. Mahwah, NJ, USA: Lawrence Erlbaum Associates, Inc.

Fearn-Banks, Kathleen. 2001. "Crisis Communication: A Review of Some Best Practices". In Heath, R. L. (ed). *Handbook of Public Relations*. Thousand Oaks: Sage Publications. 479-485.

Fearn-Banks, Kathleen. 2002. *Crisis Communications : A Casebook Approach*. Mahwah, NJ, USA: Lawrence Erlbaum Associates, Inc.

Gonzales – Herrero, Alfonso and Cornelius B. Pratt. 1995. "How to Manage a Crisis Before- or Whenever – It Hits". *Public Relations Quarterly*, Spring: 25-29.

Heath, R. L. (red). 2001. *Handbook of Public Relations*. Thousand Oaks: SAGE Publications.

Gummesson, Evert. 2006. "Qualitative research in management: addressing complexity, context and persona". *Management Decision*, 44(2): 167-179.

Havarikommissionen for Civil Luftfart. 2007a. *Preliminary report 13/9-07*. [Online].

Available from URL:

<<http://www.hcl.dk/graphics/Synkron-Library/hcl/dokumenter/Redegorelser/2007/510-000433%20LN-RDK%20Preliminary%20Report%20med%20header.pdf>>. [Accessed 2008 November 27]

Havarikommissionen for Civil Luftfart. 2007b. *Preliminary report 29/10-07*. [Online].

Available from URL:

<http://www.hcl.dk/graphics/Synkron-Library/hcl/dokumenter/Redegorelser/2007/510-000449%20LN-RDI%20Preliminary%20Report%20UK_29102007.pdf>. [Accessed 2008 November 27]

Hearit, Keith Michael and Jeffrey L. Courtright. 2003. "A social constructionist approach to crisis management: Allegations of sudden acceleration in the Audi 5000". *Communication Studies*, 54(1): 79-95.

Heath, Robert L. and W. Timothy Coombs. (2006g). *Today's Public Relations: An Introduction*. Sage Publications, Inc.

Johansen, Winni and Finn Frandsen. 2007. *Krisekommunikation: når virksomhedens image og omdømme er truet..* Frederiksberg: Forlaget Samfundslitteratur.

Ledingham, John A. 2006. Relationship Management: A general theory of public relations. In Botan, C. H. & Hazleton, V. (Eds.). *Public Relations Theory II*. Mahwah, NJ: Lawrence Erlbaum.

Ledingham, John A. and Stephen D. Bruning. 1998. "Relationship Management in Public Relations: Dimensions of an Organization-Public Relationship". *Public Relations Review*, 24(1): 55-65.

Lee, Kayman Betty. 2004. "Audience-Oriented Approach to Crisis Communication: A Study of Hong Kong Consumers' Evaluation of an Organizational Crisis". *Communication Research*, 31: 600-618.

Lee, Kayman Betty. 2005. "Hong Kong Consumers' Evaluation in an Airline Crash: A Path Model Analysis". *Journal of Public Relations Research*, 17(4): 363-391.

Lönqvist, Stefan. 2007a. "Q400: SAS brand has taken a blow". *Inside SAS* [Online], 11: 6. <http://www.bildhotellet.biz/fotoweb/sas%20group%20images/Inside%20SAS.fwx?year=2007&nr=11&node=NODE_0_11>. [Accessed 2008 November 24]

Lönqvist, Stefan. 2007b. "Yes to flying, yes with SAS and preferably by jet". *Inside SAS* [Online], 10: 2. Available from URL: <http://www.bildhotellet.biz/fotoweb/sas%20group%20images/Inside%20SAS.fwx?year=2007&nr=10&node=NODE_0_10>. [Accessed 2008 November 24]

Marcus, A.A., and Goodman, R.S. 1991. "Victims and shareholders: The dilemmas of presenting corporate policy during a crisis". *Academy of Management Journal*, 34: 281-305.

Massey, Joseph Eric. 2001. "Managing Organizational Legitimacy: Communications Strategies for Organizations in Crisis". *Journal of Business Communication*, 38: 153-183.

McLaughlin, J. C., Cody, M. J., and O'Hair, H. D. 1983. "The management of failure events: Some contextual determinants of accounting behaviour". *Human Communication Research*, 9(3): 208-224.

Mitroff, I. I. 1994. "Crisis Management and Environmentalism: A Natural Fit". *California Management Review*, 36(2): 101-113.

Mitroff, I. I. and G. Anagnos. 2001. *Managing Crisis Before They Happen: What Every Executive and Manager Needs to Know About Crisis Management*. New York: Amacom.

Mitroff, Ian I., Shrivastava, Paul., and Firdaus E. Udwardia. 1987. "Effective Crisis Management". *The Academy of Management Executive*, 1(3): 283-292.

Pearson, Christine M. 2002. "A Blueprint for Crisis Management". *Ivey Business Journal*, January/February: 69-73.

Pearson, Christine M., and Ian I. Mitroff. 1993. "From crisis prone to crisis prepared: a framework for crisis management". *Academy of Management Executive*, 7(1): 49-59.

Pearson, Christine M., and Judith A. Clair. 1998. "Reframing Crisis Management". *Academy of Management Review*, 23(1): 59-76.

Regester, Michael and Judy Larkin. 2005. *Risk issues and crisis management: A casebook of best practice*. London: Kogan Page. 3rd. ed.

Reputation Institute. 2006. Velkommen. [Online]. Available from URL: http://www.reputationinstitute.com/international/denmark_files/6Juni06_sem_pres.pdf. [Accessed 2008 November 27]

Reputation Institute. 2007. *Måling av virksomheders omdømme som arbejdsplads. WorkRep Students Danmark 2007- ranking*. [Online]. Available from URL: <http://www.so.dk/content/Resultater%20WorkRep%20Students%202007.ppt#1049,1,Lysbilde1>. [Accessed 2008 November 24]

Reputation Institute. 2008a. *Omdømme I den danske befolkning: RepTrak 2008 resultater*.

[Online]. Available from URL:

http://reputationinstitute.com/events/Reputation_in_the_Danish_population_Global_Pulse_results_2008.pdf. [Accessed 2008 November 24]

Reputation Institute. 2008b. *WorkRep Students Denmark- 89 virksomheders omdømme som arbejdsplads blandt studerende på videregående uddannelser*. [Online]. Available from URL:

http://reputationinstitute.com/events/WorkRep_Students_2008_hovedresultater.pdf.

[Accessed 2008 November 24]

SAS Group. 2001. *Annual report*. [Online]. Available from URL:

<http://www.sasgroup.net/SASGROUP_IR/CMSForeignContent/2001eng.pdf>. [Accessed 2008 November 26]

SAS Group. 2004. *Milestones*. [Online]. Available from URL:

<<http://www.sasgroup.net/SASGroup/default.asp>>. [Accessed 2008 November 27]

SAS Group. 2005. *Annual report*. [Online]. Available from URL:

<http://www.sasgroup.net/SASGROUP_IR/CMSForeignContent/2005eng.pdf>. [Accessed 2008 November 26]

SAS Group. 2006. *Annual report*. [Online]. Available from URL:

<http://www.sasgroup.net/SASGROUP_IR/CMSForeignContent/2006eng.pdf>. [Accessed 2008 November 26]

SAS Group. 2008a. *Focus on the SAS Group 2008*. [Online]. Available from URL:

<http://www.sasgroup.net/SASGROUP_FACTS/CMSForeignContent/Focus%20on%20the%20SAS%20Group%202008_light.pdf>. [Accessed 2008 November 22]

SAS Group. 2008b. *Interim Report January-June*. [Online]. Available from URL:

<http://www.sasgroup.net/SASGROUP_IR/CMSForeignContent/2q08eng.pdf>. [Accessed 2008 November 27]

Scholes, Eileen and David James. 1997. "Planning stakeholder communication". *Journal of communication management*, 2(3): 277-285.

Seeger, Matthew W., Sellnow, Tomothy L., and Robert R. Ulmer. 2001. Public Relations and Crisis Communication: Organizing and Chaos. In Heath, R. L. (ed), *Handbook of Public Relations*. Thousand Oaks: SAGE Publications. 155-165.

Shrivastava, Paul and Ian I. Mitroff. 1987. "Strategic Management of Corporate Crises". *Colombia Journal of World Business*, spring: 5-11.

Sturges, David L. 1994. "Communicating through crisis: A Strategy for Organizational Survival". *Management Communication Quarterly*, 7(3): 297-316.

Schwarz, Andreas. 2007. Covariation-based causal attributions during organizational crisis: Suggestions for extending Situational Crisis Communication Theory (SCCT). Paper presented at the annual meeting of the International Communication Association, TBA, San Fransisco, CA, May 23.

Tucker, Laura and T.C. Melewar. 2005. "Corporate Reputation and Crisis Management: The Threat and Manageability of Anti-corporatism". *Corporate Reputations Review*, 7(4): 377-388.

Ulmer, Robert R. 2001. "Effective Crisis Management through Established Stakeholder Relationships: Malden Mills as a Case Study". *Management Communication Quarterly*, 14(4): 590-615.

Ulmer, Robert R., and Timothy L. Sellnow. 2000. "Consistent Questions of Ambiguity in Organizational Crisis Communication: Jack in the Box as a Case Study". *Journal of Business Ethics*, 25: 143-155.

Weiner, B. 1986. *An attributional theory of motivation and emotion*. New York: Springer Verlag.

Weiner, B. 1985. "An attributional theory of achievement motivation and emotion". *Psychology Review*, 92: 548-573.

Wilson, Steven R, Cruz, Michael G, Marshall, Linda J and Rao Nagesh. 1993. "An Attributional Analysis of Compliance-Gaining Interactions". *Communication Monographs*, 60: 352-372.

Winston, Tellis. 1997. "Introduction to Case Study". *The Qualitative Report*, 3(2).

Zyglidopoulos, Stelios C. 2001. "The Impact of Accidents on Firm's Reputation for Social Performance". *Business Society*, 40(4): 416-441.

Østlyngen, Trine and Turid Øvrebø. 2002. *Journalistikk: Metode og fag*. 3rd ed. Oslo: Gyldendal Norsk Forlag AS.

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