Chapter 9
Disaster Consequence Management: An Integrated Approach for Fostering Human Continuity in the Workplace

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SUMMARY. The critical element in a workplace approach to consequence management for disaster, terrorism and other critical incidents is the integrated planning and response across numerous workplace functions including human resources, employee assistance, security and facilities, medical, occupational health, wellness and work-life. These corporate functions ensure the performance, health, safety and human continuity of the workplace. In this model, workplace professionals charged with the human capital and continuity of their organizations play new crucial roles that require an understanding of (1) the integration of mental health into a public health approach for managing the psychological and behavioral implications of terrorism; (2) the integration of operational continuity planning with human continuity resources; and (3) the integration of workplace preparedness into the larger sphere of population health interventions for the 21st century. This new role of workplace health and productivity professionals is necessary to the
INTRODUCTION

The events of 9/11 and the anthrax attacks that followed constituted a wake up call in the United States—across government (federal, state and local), public health, the health care industry and academia. Some 76% of Americans, two years after 9/11, are concerned about terrorism in the United States (NCDP, 2003). However, most do not believe that the U.S. health system can respond effectively to a biological, chemical or nuclear attack. The most prevalent concern of Americans (66%) is the need to account for the whereabouts and safety of family members yet less than one in four families (23%) actually have a basic emergency plan (NCDP, 2003). The integration of previously separate and often unrelated functions, services and resources are needed to address the unprecedented impact of terrorism.

As a primary target, the workplace was no exception to this call. The importance of human capital—individual employees and their collective needs—took on new meaning to corporate America. Employers from diverse corporations and industries recognized anew the value of their people and their wellness and resiliency (Coutu & Hyman, 2002; Greenberg, 2002; Mankin & Perry, 2004). In the words of Ray O’Rourke, managing director for global corporate affairs at Morgan Stanley, “We knew within the first day that, even though we are a financial services company, we didn’t have a financial crisis on our hands; we had a human crisis. After that point, everything was focused on our people” (Argenti, 2002).

While workplaces differ in size, industry and employee populations, the human impact of terrorism is predictable, expectable and requires organization-wide preparedness that includes both general and worksite specific interventions. Responsibilities for employee health and productivity also vary within corporations, but these functions (human re-
sources, employee assistance programs, security and facilities, medical, occupational health, wellness and work-life) can play an essential role in equipping workers and organizations to prepare for and respond to the threat and/or actuality of terrorism.

The critical element in this workplace approach to preparing for and responding to the threat of terrorism is integrated planning and response across the above-mentioned functions. These corporate functions ensure the performance, health, safety and human continuity of the workplace. In order to effectively address critical behavioral preparedness needs, the integration and coordination of these activities is necessary. Such an approach can better protect corporate security, employees and the citizens of the nation.

This article addresses an integrated workplace terrorism, disaster and critical incident response plan. In this model, workplace professionals charged with the human capital and continuity of their organizations play new crucial roles in preparedness and consequence management for disaster, terrorism and other critical incidents. This perspective requires an understanding of: (1) the integration of mental health into a population public health approach for managing the psychological and behavioral implications of terrorism in communities, including vertical communities of the corporate world; (2) the integration of operational continuity planning with human continuity resources; (3) the integration of workplace preparedness into the larger sphere of population health interventions for the 21st century. This new role of workplace health and productivity professionals is necessary to the health and resiliency of our global community and its citizens in the workplace and at home.

**THE PREPAREDNESS ROLE OF THE WORKPLACE**

The most prestigious science organization of the USA and one of the most prestigious in the world, the National Academies of Science, Institute of Medicine (IOM), recently issued a timely and essential report for workplace planning. *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy* (IOM, 2003a) identifies “... the workplace as a new and important area in which to address public health planning for the psychological consequences of terrorism.” Because most acts of terrorism in the U.S. have occurred where and when people work, it is essential that interventions for preparedness, response and recovery occur in occupational settings. Sustaining the workforce—its or-
ganizational health and the well-being of workers—is central to protecting the economic and social capabilities of a nation. In addition, the workplace provides one of the most important avenues to go “from the employee to the citizen” to provide community knowledge and resources.

The public is generally not knowledgeable about preparedness within their own workplace (NCDP, 2003). Only 36% of citizens report being familiar with emergency plans in their workplace (Council for Excellence in Government, 2004). Nearly half of U.S. workers feel their employer is not prepared for a terrorist attack (Comp Psych Survey, 2004). In addition, although 70% of people working in companies mandated to have an emergency evacuation plan were aware of such plans, only 42% were familiar with the details (NCDP, 2003).

The work of organizations must continue after terrorist, disaster or other critical incidents despite high levels of anxiety and possible future attacks. Banks, groceries, schools as well as government workplaces of military (e.g., the Pentagon) and services (e.g., the U.S. Postal Service) must continue regardless of the risk of new attack whether that is an explosive or a bioterrorist event such as the anthrax attacks. The IOM report also recognizes that preparing for the psychological consequences of terrorism will have important benefits for dealing with other violent events and critical incidents in the workplace.

A population level approach (rather than individual care, treatment and services) is the core of the public health approach recommended for workplace communities. In this model, screening, early detection, health education, service access, and health promotion and prevention are central. Likening terrorism and the fear it propagates to a disease transmission model, the IOM report points to the need for pre-event, event and post-event interventions to protect the health and sustain the performance capacity of individuals and groups, including the workplace.

‘Population health,’ a perspective familiar to all workplace services directed to helping employees as a whole, is a term that refers to ‘the health of the population’ or ‘the population’s health’ (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999 as referenced in IOM, 2003b). Perhaps one of the most universal examples of a population health intervention is automobile seat belts. Seat belts modify the risk of automobile accidents and therefore reduce the risk of injury and psychological disease due to injury after accidents. Similarly, fluoride in drinking water is a population level intervention to modify the risk of tooth decay, and influenza vaccination is a population intervention to reduce the incidence and spread of influenza. Workplace interventions that are to prepare as well as respond to terrorism may use
a population health perspective to prevent and/or modify the risk of injury and morbidity from exposure to terrorism. From practicing fire drills to planning for leave policies, emergency hires and depression screening and ensuring adequate health benefits for mental health care for trauma exposure, the population health perspective prompts thinking on the large scale for needed services, behaviors and interventions before, during and after a terrorist or disaster event.

Many workplace professionals, however, lack training in the services and program needs for mental health interventions for the pre-event, event and post-event phases of disaster including terrorism. With training, workplace health and service professionals can make significant contributions to sustaining, protecting and restoring the mental health of employees and the operational continuity of the workplace after terrorist and disaster events (IOM, 2003a; Ursano, Fullerton, & Norwood, 2003). They can also complement the disaster response role of the federal government that is geared to immediate needs at the directly affected site, rather than pre-event planning and longer-term responses that may occur in areas (workplaces or communities) not directly involved but nonetheless affected.

**PSYCHOLOGICAL AND BEHAVIORAL IMPLICATIONS OF TERRORISM FOR THE WORKFORCE**

It is important to realize that the primary goal of terrorism is to spread terror around a nation and in this way to destabilize trust in public institutions, to change peoples’ beliefs, sense of safety, and behaviors (Holloway et al., 1997). The deaths that may occur in the process are, sad to say, only the mechanism for the spread of terror. These psychological effects are especially deleterious in the workplace. They can undermine the economic, intellectual and social capital of a nation, its industries, as well as the health and routine of its citizens, their families and communities.

While not the first terrorism on American soil, the events of 9/11 were the first to have such a profound and pervasive impact on the nation (Silver et al., 2002; Vlahov et al., 2002; Stein et al., 2003). One longitudinal study (Stein et al., 2003) documented that amongst those Americans (16%) who experienced persistent stress two months after 9/11, this distress disrupted their work (65% reported accomplishing less), their social life (24% avoided public places) and led to increased
health risks (38% using alcohol, medication or other drugs to relax, sleep and reduce terrorism-related worries).

At a 2003 global symposium on workplace mental health held at the International Labour Organization in Geneva, Switzerland, attendees, including medical directors from multinational corporations, EAP providers and ministers of health, expressed concern about terrorism as an extreme form of workplace violence with global consequences. Recommendations included preparing employees through workplace drills in evacuation, shelter-in-place, as well as training for employee health and productivity professionals in disaster mental health (Vineburgh, 2003).

Immediate responses to disasters and terrorism involve knowledge about “disaster behavior,” a term and concept that may be unfamiliar, but can be extremely useful in communicating the value of preparedness to employers, management and employees. Renowned Norwegian disaster psychiatrist Lars Weisaeth (1989) was one of the first to use the term, which refers to behaviors in the face of disaster such as spontaneous reactions like fear and panic, or planned reactions such as evacuation, shelter-in-place and quarantine. These reactions are of critical importance in the workplace (Hall et al., 2003; Ursano & Norwood, 2003). During the 1993 World Trade Center explosion, 32% of individuals had not begun to evacuate by over one hour, 30% decided not to evacuate and only 36% had participated in a previous emergency evacuation (Aguirre et al., 1998). Importantly, large groups (greater than 20 people) took 6.7 minutes longer to initiate evacuation, a time frame of life or death in many disasters. In addition, the higher the location, the greater the delay in initiating evacuation, and the more people were known to one another, the longer the group took to initiate evacuation (Aguirre et al., 1998). These findings may be familiar to anyone who has taken part in a fire drill in the workplace during which often one hears: “Are you going?,” “Maybe,” “Shall we ask Mary?,” “Sure, want to do lunch?,” “We better bring our umbrellas,” etc. Our wish to affiliate, to join is a danger in these settings because such behaviors delay critical decisions to protect our safety and health. For workplaces, this behavior can be life threatening.

Similar findings from a recent study emphasize the importance of addressing the behavioral issues of preparedness. The study of a representative sample of the United States found that 90% of Americans say they will not evacuate immediately if directed to do so by officials citing concern by 66% of those to account for the whereabouts of family and loved ones (NCDP, 2003). Whether human resource planning includes
adequate personnel locator planning for disasters and terrorist events, and “meet up stations” after evacuation to allow for counting heads, may make the difference between knowing who is injured and appropriately notifying families, and minimizing the anxiety that accompanies hours or days of delay in knowing the whereabouts of loved ones. The implications and knowledge of these disaster behaviors is critical to inform interventions around terrorism, bioterrorism and infectious diseases like SARS that pose risks in vertical communities (the workplace) as well as global industries where travel, travel policies and sick leaves are critical to the continuity of infrastructure and people.

Disaster mental health care must address both the psychological and behavioral responses to the traumatic events (Ursano et al., 2004a). These may be evident in distress responses such as changes in perceived safety or the willingness to fly in airplanes or altered behaviors such as increased smoking or alcohol consumption (Fullerton et al., 2003; North et al., 1999; North et al., 2002) or the more traditional illnesses and diseases that may result from trauma exposure including post-traumatic stress disorder and depression (Galea et al., 2002; North et al., 1999; Pfefferbaum & Doughty, 2001; Ursano et al., 2003; Vlahov et al., 2002).

Disasters are either naturally occurring (earthquakes, hurricanes, floods) or human made (industrial and environmental accidents). Terrorism is a human made disaster. Human made disasters, similar to intentional traumatic events such as robbery or rape, carry a potentially greater mental health impact than other disasters because of their malicious intent. Like other human made disasters, terrorism generates a loss of trust in the world, an altered sense of safety and belief in the just world, and disbelief, anger, and feelings of lack of control. In addition, terrorism can open the “fault lines” that are always present in groups of individuals related to differences in ethnicity, race, religion and socioeconomic status. Such fault lines can become major divides that separate labor and management or may result in scapegoating and stigmatization of fellow employees (Ursano, 2002; Ursano, Fullerton, & Norwood, 2003). These behaviors and disorders can be costly in the workplace in terms of safety, productivity and morale, all factors that affect the health and productivity of a corporation.
INTEGRATION:
ADDRESSING WORKPLACE BARRIERS
AND OPPORTUNITIES FOR ORGANIZATIONAL
AND EMPLOYEE PREPAREDNESS

In the USA, the events of 9/11 and the anthrax attacks that followed reinforced in the minds of employers the value of an organization’s people and the importance of sustaining their well-being (Argenti, 2002; Coutu & Hyman, 2002; Greenberg, 2002; Mankin & Perry, 2004; Schouten et al., 2004). Addressing the psychological and behavioral effects of terrorism to protect workplace employees and business continuity requires integration across a number of areas previously unaccustomed to collaborating. A number of barriers to preparedness exist within the workplace: (1) a corporate focus on operational versus human continuity (Mankin & Perry, 2004; Ursano, Vineburgh, & Fullerton, 2004; Ursano & Vineburgh, 2004a); (2) corporate silos that prevent the collaboration and coordination essential in facilitating employee preparedness (Vineburgh, 2004; Ursano & Vineburgh, 2004a; Ursano & Vineburgh, 2004b); (3) employer and employee resistance to engaging in preparedness activities; (4) a need for professional training of workplace health and service providers in disaster mental health and service needs for disaster response and recovery (IOM, 2003a); (5) a common language to communicate the conceptual and practical implications of disaster mental health, preparedness and response (Holloway & Waldrep, 2004).

The first three barriers to preparedness deserve special attention (consult Table 1). Workplace professionals must address these to begin the process of equipping organizations and workers to deal with the psychological impact of terrorism.

Regarding the first barrier another way to view corporate continuity is through ‘3 R’s’: redundancy, reliability and resiliency (Ursano, Fullerton, & Vineburgh, 2004). Redundancy refers to a corporation’s

TABLE 1. Organizational Barriers to Workplace Preparedness for Terrorism

| 1. Corporate focus on operational rather than human continuity. |
| 2. Corporate silos that prevent the collaboration and coordination essential to facilitating employee preparedness. |
| 3. Employer and employee resistance to engage in preparedness due to attitudes and/or emotions ranging from complacency, fear to denial. |

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physical back-up as in alternate sites and bench strength in terms of leadership roles. Reliability refers to a corporation’s hardware as in its IT systems and operations. Resiliency represents the human capital of the organization—its people. It took 9/11 to demonstrate the first priority in the face of disaster is an organization’s people who are also the most resilient element (Greenberg, 2002; Argenti, 2002; Coutu & Hyman, 2002).

The second major barrier to workplace preparedness is the effect of corporate silos that prevent important collaborations for employee preparedness. Corporate security is an excellent example of this silo effect. The traditional role of corporate security in the United States has been operational—guarding the perimeter. At a national Conference Board meeting (2003) of senior level security professionals, there was an expressed interest in expanding that role to prepare employees for terrorism. The security professionals present communicated their desire to play a more human role in protecting employees and were seeking creative ways to collaborate with the health and productivity functions within their organization. Partnering with their company’s EAP program was of great interest.

The third organizational barrier to workplace preparedness is employer and employee attitudes about such activities that range from complacency, to fear, to lack of fitness! An interesting, newly reported phenomenon amongst employers who have tried to institute evacuation drills since 9/11 is employee resistance due to lack of fitness (Ursano & Vineburgh, 2003). A woman who experienced the burning of the Twin Towers and works in New York City remarked that her workplace subsequently engaged employees to practice evacuation from the 42nd floor. She commented that, “employees are not conditioned for terrorism, and most colleagues reported feeling the effects of this drill for an entire weekend” (L. Hall, personal communication, December 2003).

Not taking drills seriously or not wanting to participate because drills take too much time are attitudes that impede employee preparedness for terrorism. Several young attorneys in an urban law firm in a high-rise building reported that their boss told them not to participate in such drills, as they do not constitute billable hours! The attorneys said they would most likely participate if these drills were conducted in the context of an employee preparedness campaign that would educate them about the significance of disaster behaviors including evacuation, shelter-in-place and family communication plans. If such a campaign were to be national in scope, employees would feel part of a larger commu-
nity in which everyone—employers, schools, community institutions—were joined in a united effort (Vineburgh, 2004).

Fear is a particular barrier to preparedness. A number of employee assistance and occupational health professionals of Fortune 500, multi-national corporations interested in workplace preparedness expressed their primary concern as a question: how to raise awareness of this topic without raising undue anxiety in their workplace (Bender, 2003).

A Workplace Resiliency Model (consult Table 2) offers a framework around which to organize the workplace response to prepare, respond and recover from terrorist events and address these barriers to preparedness and response through integration and a focus on resiliency. This approach is both a strategy for moving organizations in the direction of terrorism planning, as well as a health promotion vehicle to educate leadership, management and employees about disaster preparedness. With an aim to establishing an integral and integrated role for the workplace health and productivity professional in this process and practice, this article advances a framework derived from a public health model that views terrorism as a threat to the health of an entire nation and its communities including workplace communities.

PREPARING AND RESPONDING THROUGH AN INTEGRATED WORKPLACE APPROACH TO TERRORISM PREPAREDNESS

Employers are important population health partners (IOM, 2003b) with resources and established relationships that can foster terrorism and disaster preparedness (IOM, 2003a). Workplace health and productivity professionals (employee assistance professionals, human resource professionals, corporate medical directors, and occupational health, wellness and work-life professionals) are ideally positioned for an important role in disaster preparedness, and must be at the table as corporations develop or expand their disaster plans to address 21st century issues around terrorism and bioterrorism.

The events of 9/11 dramatically raised the visibility of EAPs (Coutu & Hyman, 2002; Greenberg, 2002; Mankin & Perry, 2004). EAP providers (internal and external) of affected corporations were called upon to set up off-site family assistance centers, contract with grief counselors and provide direct counseling services throughout their corporations, in the immediate aftermath and overtime, including planning for workplace anniversaries of 9/11. Because EAPs deal on a day-to-day basis
with many of the psychological and behavioral risk issues that can result from disaster exposure, their involvement in disaster preparedness and behavioral and mental health response is logical, and can provide seamless resources and services.

Employee assistance programs and providers deal with a broad range of psychological and behavioral disorders. In the United States, work-
place mental health programs began after WWII to address problem drinking in the workplace, expanding in the 1970s and 1980s to encompass the emotional health and distress of employees (Davidson & Herlihy, 1999). Most EAP programs were ‘internal’ featuring mental health counselors as employees working within the corporation. With the advent of managed care in the 1980s, behavioral health carve-outs (private companies that offer mental health benefits and services) began offering EAP services, and many corporations chose to outsource their mental health and substance abuse assessment and treatment to these large networks. Such programs are referred to as ‘external EAP’ programs. Some companies have both ‘internal’ and ‘external EAPs’ called a mixed model.

Although EAP programs vary, most conduct employee health promotion and education activities, mental health assessment and referral, and sometimes treatment including alcohol and drug or mental health counseling. Many EAPs conduct national mental health awareness programs like National Depression Screening Day and National Alcohol Screening Day, and offer confidential and interactive screening resources (800 numbers and online programs) that encourage self-identification and help-seeking for depression, anxiety, post-traumatic stress disorder, and a range of alcohol problems from risky drinking to alcohol dependence (Raskin & Williams, 2003). The majority of American employers offer EAP services (Roman & Blum, 2002), as do a growing number of employers worldwide (Masi, 2000; Reddy, 2003).

The events of 9/11 also gave rise to new roles and collaborations among many workplace health and productivity professionals that must be further developed and sustained to achieve organizational and employee preparedness. The role and relationship between employee assistance and human resources in response to terrorism provides an interesting example of new and needed collaborations and opportunities for integration of health and productivity with security functions to protect health and sustain the workforce.

To manage the human consequences of 9/11, EAPs worked hand-in-hand with human resource departments whose staff was present at off-site family assistance centers addressing the needs, immediate and long-term, of victims’ families including benefits and services (Greenberg, 2002). Despite the leadership role of human resources during and after 9/11, and despite major workplace terrorist events (1993 World Trade Center attack and Oklahoma City bombing), no articles addressing employee consequences of terrorism were published in human resource journals between January 2001 and March 2003 (Mankin & Perry, 2004). Human resource departments are a logical locus for terrorism preparedness because most
employee health and benefits activities reside in human resources, including EAP programs that provide direct psychological services.

Human resources and employee assistance can be formidable partners in equipping organizations and workers for the impact of terrorism. Because most EAP programs (internal and external) report to their corporation’s human resources department, it is incumbent upon human resources to seek organizational buy-in for disaster preparedness planning, especially around terrorism; to advocate for the integration of a human continuity focus; and to include their organization’s employee assistance and/or related occupational health, work-life and medical services in the process and planning. Presently, many human resource departments have been reluctant to collaborate with their employee assistance programs or bring the human focus of disaster response into alignment with operational planning. The reasons for this resistance remain unexplained.

The partnership between human resources and employee assistance can facilitate the creation of family communication plans, an essential aspect of preparedness for terrorism. The workplace is an excellent place to encourage families to have family/work and family communications plans, and to be knowledgeable about disaster policies and plans in settings where their children and loved ones reside when not at home such as schools, day care and elder care communities. On the morning of 9/11, the first concern amongst employees everywhere was for the safety and whereabouts of their families. EAPs joining with human resources can advance a new approach in population health: citizen preparedness through workplace preparedness.

A corporate trend to outsource critical incident planning and response to specialty firms or for a corporation’s external provider to subcontract to such specialty providers runs the risk of undermining essential integration of internal health and productivity functions (human resources, occupational health, work-life, etc.) into corporate disaster planning. This trend also undermines the important work of employee preparedness that many specialty firms might not find profitable nor within their scope of work.

INTEGRATED WORKPLACE RESILIENCY MODEL: ADDRESSING AND OVERCOMING BARRIERS TO WORKPLACE PREPAREDNESS

A focus on integration and resiliency can reframe tasks and foster necessary collaborations for health and corporate operational continu-
ity. Resiliency is a growing topic of interest in mental health and mental health promotion (American Psychological Association Help Center, 2004; Vineburgh, 2004). It is important to recognize that resiliency is the expected outcome in all studies of disaster (North, 2003; Ursano et al., 2003). Resiliency is also a growing topic of interest in the workplace as it bridges the health and continuity of the organization and its people (Coutu, 2002; Vineburgh, 2004). There is an interest amongst EAP programs such as Chevron/Texaco (Blair Consulting Group, 2003) and Dupont, as well as EAP professional associations (EASNA, 2004) to use resiliency as a health promotion vehicle and way to integrate mental health into other productivity functions and outcomes. A workplace strategy that reframes disaster preparedness as a means of fostering organizational and employee resiliency can be an effective way to communicate about and motivate preparedness.

The cornerstone of an Integrated Workplace Resiliency Model is its focus on resiliency as an outcome of preparedness planning, an approach that might be viewed as beneficial by organizations and workers rather than threatening. Resiliency has a positive connotation and can provide a positive framework for engaging reluctant corporations and employees to participate in terrorism preparedness. Resiliency is a meaningful disaster metaphor for workplace preparedness and response to disaster (Vineburgh et al., 2004; Vineburgh, 2004). Resiliency involves two perspectives that have workplace specific implications. From a clinical perspective, resiliency is the expected outcome of disaster and terrorism (North, 2003; Ursano, 2002), and aligns with workplace health and productivity. From an organizational perspective, resiliency is integral to corporate continuity, especially human capital continuity (see three R’s).

**PRE-EVENT PHASE: EDUCATE**

In the pre-event phase, workplace health professionals must educate the workplace—senior management, management and employees—about the importance of preparedness including practical interventions. It is important to educate senior management in order to achieve executive level buy-in and participation. Educating senior management to integrate human continuity functions (employee assistance, medical, occupational health) within their business continuity planning is an essential first step to organizational preparedness for terrorism.
Workplace health providers must also educate employees about preparedness, both its psychological and behavioral implications. Working in collaboration with other functions like human resources or corporate security, EAPs can provide information on important disaster behaviors such as evacuation, shelter-in-place and the creation of family communication plans. Disaster behaviors can be taught in conjunction with corporate security that can facilitate the actual practicing of the drills. Existing health awareness events or a dedicated day on workplace preparedness can provide the vehicle for this activity (Vineburgh, 2004). Such a campaign on workplace resiliency incorporating terrorism preparedness could even be conducted as a global workplace initiative.

**Make the Case**

The 9/11 response of Morgan Stanley, a global corporation, is an excellent example of a collaborative approach involving operational and human continuity planning that greatly enhanced the resiliency of the business and its people. Soon after the 1993 WTC bombings, Morgan Stanley launched a preparedness program of serious evacuation drills directed by its corporate security department. On the morning of 9/11, one minute after the North Tower was struck, Rick Rescorla, security Vice President, instructed Morgan Stanley’s employees to evacuate the South Tower immediately, to stay calm and follow their well-practiced drills. This resulted in a loss of only seven of its 2,700 employees. Tragically, Rescorla was among them, but this example represents the successful integration of security, facilities, human health and behavior and employee preparedness. Moreover, Morgan Stanley exhibited a trait attributable to corporations that are resilient: an ability to ‘stare down reality’ and plan for the worst having recognized after 1993, they could again be a target of terrorism (Coutu, 2002). This kind of planning amongst senior leadership, management and employees sends message of a strong and responsive organization, which creates social cohesion and shared values, two important components of organizational and individual resiliency.

**EVENT PHASE: COMMUNICATE**

In the event phase, the immediate, actual response to the terrorist event, workplace health professionals must *communicate* on behalf of
and in sync with corporate leadership. It is essential to stay on the corporate message to reinforce information on employee safety, workplace resumption and schedules, and employee resources for information and help seeking. Employee assistance programs can integrate the corporate communication message into existing EAP 800 numbers and websites, and provide valuable support to human resources and corporate communications to alleviate anxiety by ongoing information as well as the important task of getting employees back to work around which there will be anxiety. An important role in this phase is provision of psychological first aid: promoting personal care, sleep, exercise and return to normal routine.

**Make the Case**

Corporate leadership of affected corporations as a result of 9/11 recognized that second to and intertwined with a priority on employee well-being was the ability to communicate with clarity, compassion and an expectation of resiliency (Argenti, 2002; Greenberg, 2002). Strong, consistent communication fosters a sense of community and corporate continuity from which emerge resilient organizations and resilient employees (Argenti, 2002). Many corporations post 9/11 have brought together human resources, employee assistance, medical and corporate communications to mount integrated planning for phone trees, updating of employee contact information that is required on a frequent and regular basis. Another way in which communication has been stepped up is through corporate security reporting internally on PA systems and company intranet sites about any issues that might raise employee safety concerns. This kind of planning and this corporate security communication for human continuity builds and fosters a resilient workforce and business plan.

**POST-EVENT PHASE: EVALUATE**

In the post-event phase, workplace health and productivity professionals must evaluate the impact of the event and provide necessary resources to aid in the recovery. EAPs can provide health promotion materials on normal distress reactions of trauma and how to distinguish between normal distress and more serious psychiatric problems requiring evaluation and treatment. They can provide information on escalation of health risks such as increased smoking, alcohol, and even family violence. EAPs can promote use of existing, anonymous and interactive screening resources for case finding.
Human resource professionals must stay alert to the opening of fault lines from terrorist events. Terrorism opens the fault lines of a society revealing its vulnerabilities and divisive tendencies along racial, ethnic and religious lines (Ursano, 2002) that can result in scapegoating, discrimination against ethnicities perceived akin to the terrorist agent, as well as fallout around perceived inequities in treatment responses.

In the aftermath of the anthrax attacks of 2001, U.S. postal workers became disgruntled perceiving their medical treatment inferior to that given to employees on Capitol Hill despite the fact that theirs may have been a technically more effective protocol. This perception has historical roots around the fault lines of race and ethnicity in the United States. It resulted in serious and persistent mistrust that undermined the cohesion of the postal service workplace including legal ramifications (Steury et al., 2004; Holloway & Waldrep, 2004). These behavioral consequences of terrorism have important implications for the human capital and continuity of organizations about which human resource personnel must be knowledgeable.

Employee assistance programs and human resources departments must reach out to vulnerable populations. Specific groups may require special interventions. These include identified cultural groups whose perception of the disaster may be markedly different because of past experiences with disasters (i.e., refugees, individuals recently exposed to traumas, ethnic groups). The number of refugees worldwide is growing, and many are relocated in the United States, as well as in workplaces throughout the world. The unique characteristics of refugees groups, including cultural, ethnic and language considerations, torture or trauma experiences, multiple losses, minimal resources, and an uncertain future need to be considered in developing mental health services (Gerrity & Steinglass 2003).

Make the Case

The events of 9/11 constituted a tipping point in which many corporations realized the importance of mental health issues, their link to employee health and productivity and the importance of functions that support this work—EAPs, occupational health, work-life—across a continuum from pre-event, event, post-event outreach (Mankin & Perry, 2004). While resiliency is the expected outcome of disaster, attention to the psychological and behavioral implications of trauma including vigilance and response to the opening of fault lines as described above can enhance the recovery and resiliency of organizations and workers (Ursano, 2002; Coutu & Hyman, 2002).
INTEGRATION AND RESILIENCY AS THE WORKPLACE PREPAREDNESS MODEL FOR TERRORISM IN THE 21ST CENTURY

The workplace is an important disaster preparedness setting for managing the organizational and human consequences of terrorism. Workplace health and productivity providers can play an important role in equipping organizations and employees to deal with the impact of such trauma. Because terrorism continues to be a global threat and one that frequently targets, disrupts and in some instances destroys the workplace, this role will be increasingly important worldwide.

Workplace preparedness for terrorism is an important dimension of and vehicle for population health in the 21st century. Employed individuals spend more than a third of their day at work (IOM, 2003b), and work is most often the source of one’s health benefits. In addition, employees are avid health consumers for themselves and their families (Vineburgh, 2002). Interestingly enough, more than two times as many individuals experiencing persistent distress after 9/11 accessed information at work rather than from a medical practitioner, and over three times as many sought information and counseling at work rather than from a mental health provider assumedly in a community setting (Stein et al., 2003). There is increasing evidence that workplace health promotion activities and programs can change behavior and psychosocial risk factors for individual employees and the collective risk profile of the employee population (IOM, 2003b).

This is very encouraging for workplace health professionals seeking to play a proactive role in equipping organizations and workers to deal with the impact of terrorism. As corporations begin to develop and/or expand their capacity to respond to disaster and terrorism, outsourcing to firms that specialize in critical incident stress management may become a common practice. If so, workplace health professionals that reside inside the workplace must make an extra effort to make their voices heard that they can collaborate with operational functions like human resources, security and corporate communications to oversee employee preparedness education and activities.

Similarly, workplace health professionals affiliated with outsourced critical incident services should either provide human continuity information (evacuation, shelter-in-place, work/family communication plans) and/or recommend to employers or external employee assistance companies with whom they contract the importance of this human continu-
ity aspect of disaster response and the importance of *its integration* with operational preparedness.

Workplace health and productivity professionals can provide the health promotion context and health promotion content to educate management, employees and even families on preparedness for terrorism. Organizational planning for terrorism must address and incorporate the human element of disasters in order to manage the human consequences. Because many corporations are multinational and/or engage in global trade, employee preparedness for terrorism must extend across organizations and geographical boundaries and encompass culturally sensitive and culturally relevant preparedness information and response interventions to terrorist events.

Language is an important element in motivating systems and attitudi-
nal change organizing society, culture and organizations and certainly critical to preparing for, responding to and recovering from the effects of disastrous events (Holloway & Waldrep, 2004). The language of terrorism is frightening conjuring up images and events that provoke anxiety amongst large populations that can be a barrier to preparedness. Therefore the language used by health promotion professionals and public education campaigns aimed at preparedness for terrorism must strike a chord that engages organizations and individuals to take action in a way that does not provoke unnecessary anxiety.

New language (see Table 3) to communicate the significance of preparedness based on “positive affect messages” is needed to more effectively engage the public than traditional health communication strategies that have often used fear-based appeals or straightforward presentation of fact (Monahan, 1995; Vineburgh, 2004). In using language that engages the attention of our intended audience, in this case employers, management and employees, we join with them to respect and integrate their concerns, needs and objectives into a greater vision for the common good.

Employers and workplace health and productivity professionals can play a vital role in fostering the resiliency of their organization and its people in the face of terrorism and disaster. Such efforts will require cooperation among global workplace colleagues that can benefit the health of their communities and nation. Workplace preparedness for terrorism advances population health in the 21st century and highlights the valued role of employee health professionals in an integrated response to disaster consequence management and their contribution to homeland and global security.
TABLE 3. New Language to Promote Workplace Preparedness for Terrorism and Population Health—Partnerships for the 21st Century

- **Disaster Behaviors:** Human responses to disaster that can be reactive, chaotic and injurious such as mass panic and flight, or proactive and planned with the intention of preventing, mitigating and fostering recovery from its injurious consequences. Proactive disaster behaviors include evacuation, shelter-in-place and creation of family disaster communication plans.

- **Human Continuity:** That which applies to and maximizes the health, productivity, morale, social cohesion and shared values of a community.

- **Population Health:** A term that refers to ‘the health of the population’ or ‘the population’s health’ for which public health and public health interventions are developed. Employers and employee health and productivity providers are important partners in population health who can provide disaster education to enhance the health of their workplace, their community and their nation.

- **Organizational Continuity:** That which applies to or ensures the continuance of a corporation’s operations and its business.

- **Preparedness:** Education about disasters including terrorism and bioterrorism, as well as actions taken to prevent, mitigate and foster recovery from disaster. This includes knowledge of proper evacuation techniques; understanding and voluntary compliance with life-saving disaster behaviors including shelter-in-place, quarantine; the creation of family communication plans and disaster kits.

- **Resiliency:** In its most general sense, bouncing back from adversity. In the context of disaster mental health, resiliency is the expected, clinical outcome of disaster. In an organizational context, resiliency applies to the human element of the organization, in addition to its operational components (redundancy and reliability). The human element is the most resilient component of an organization.

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REFERENCES


