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The emotional sequelae of whistleblowing: findings from a qualitative study

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Aims and objectives. To highlight and illuminate the emotional sequelae of whistleblowing from whistleblowers and subjects of whistleblowing complaints.

Background. Whistleblowing has the potential to have a negative impact on individuals' physical and emotional well-being. However, few empirical studies have been conducted using qualitative methods to provide an in-depth exploration of the emotional consequences for those involved in whistleblowing incidents.

Design. Qualitative narrative inquiry design.

Method. Purposive sampling was used to recruit participants who had been involved in whistleblowing incidents. During interviews participants' accounts were digitally recorded and then transcribed verbatim. Data were then analysed by two researchers until consensus was reached.

Results. Findings revealed that participants' emotional health was considerably compromised as a result of the whistleblowing incident. Analysis of the data revealed the following dominant themes: 'I felt sad and depressed': overwhelming and persistent distress; 'I was having panic attacks and hyperventilating': acute anxiety; and, 'I had all this playing on my mind': nightmares, flashbacks and intrusive thoughts.

Conclusions. While it has been previously acknowledged that whistleblowing has the potential to have a negative impact on all aspects of an individual's life, this study notably highlights the intensity of emotional symptoms suffered by participants as well as the extended duration of time these symptoms were apparent.

Relevance to clinical practice. As professionals, nurses, as well as organisations, have a responsibility to identify those who may be suffering the emotional trauma of whistleblowing and ensure they have access to appropriate resources.

Key words: narrative inquiry, nurses, nursing, whistleblowing, whistle blower, workplace emotion

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Introduction

Although whistleblowing is commonly framed as an aberrant (Vardi & Weitz 2004) or treacherous (Burrows 2001) act, it has emerged as a significant factor in large scale inquiries that have led to improvements in health care safety and quality (Faunce 2004, Firtko & Jackson 2005). Whistleblowing can be defined as a situation where 'a party or parties take matters that would normally be held as confidential to an organisation, outside that organisation despite the personal risk and potentially negative sequelae associated with the act' (Firtko & Jackson 2005, p. 51). While it is known that whistleblowing is associated with a range of negative sequelae (Jackson 2008), few empirical studies have been conducted using qualitative methods to provide an in-depth exploration of the emotional consequences for those involved in whistleblowing incidents.

Background

When a nurse undertakes to 'blow the whistle' they may be unprepared for the aftermath on their personal physical, emotional and professional well-being. Whistleblowing by its very nature may lead institutions to adopt a defensive stance to protect their own interests and frame those who blow the whistle as troublemakers (Johnstone 2004). This can generate a hostile work environment and so whistleblowers may have negative feelings or may not be able to return to the workplace which has been the subject of their complaint and while some return, others leave (Bolsin 1998, McDonald & Ahern 2002, Ohnishi *et al.* 2008, Jackson *et al.* 2010b). Workplace based retaliation directed at whistleblowers has been reported in the form of victimisation, ostracism, exclusionary behaviour, hostility and bullying (Lennane 1993, LaVan & Martin 2008, Jackson *et al.* 2010a).

The literature suggests several negative personal consequences for people involved in whistleblowing incidents and their families. Effects on families can include reduced income, poor child outcomes, disputes, relationship breakdown, separation and divorce (Lennane 1993, Bolsin 1998, McDonald & Ahern 2002). Sleep disturbances, increased smoking, mental illness and suicidal thoughts have been identified as issues for people involved in whistleblowing (Lennane 1993, McDonald & Ahern 2002, Faunce *et al.* 2004). According to McDonald and Ahern (2002) nurses have reported distressing feelings of anger, anxiety and disillusionment suspiciousness, cynicism, irritability and bitterness associated with whistleblowing. Lesser reported various sequelae include reliving the experience, fear, panic attacks and feelings of unworthiness (McDonald & Ahern 2002).

In one of the few qualitative studies of whistleblowers, Ohnishi *et al.* (2008), used a modified grounded theory approach and found that the initial emotional upheaval subsided to relief and emotional stability for two whistleblowers. Though the literature provides valuable insights into the emotional sequelae of whistleblowing, there is much that remains poorly understood. The Ohnishi *et al.* (2008) study involved a single whistleblowing incident, where the whistleblowers ($n = 2$) acted only after leaving their jobs and therefore were not exposed to ongoing workplace hostility. Furthermore, the emotional sequelae experienced by the two informants are only briefly dealt with. Little is known about the extent and intensity of emotional symptoms and about the duration of emotional distress experienced as a result of whistleblowing events. Furthermore, those accounts that do exist are all based on whistleblowers or non-whistle blowers. The experiences of subjects of whistleblowing events remain invisible in the literature.

Aim of this paper

This paper is drawn from a larger study that sought to gain deep firsthand understandings of the experience of being directly involved in a whistleblowing event, from the perspectives of key stakeholders, that is, the whistleblowers themselves and subjects of whistleblowing complaints. We have previously published findings related to reasons for whistleblowing (Jackson *et al.* 2010a), effects of whistleblowing on collegial relationships (Jackson *et al.* 2010b) and experiences of confidentiality in the context of whistleblowing and organisational wrongdoing (Jackson *et al.* 2011).

The aim of this paper is to present detailed accounts to highlight and illuminate the emotional sequelae of whistleblowing for those directly involved – whistleblowers and subjects of whistleblowing complaints.

Methods

The study employed a narrative inquiry research design. Narrative inquiry was chosen because subjectively constructed meanings and experiences, embedded in language and the social world, could be captured (Holloway & Freshwater 2007) and as Carr (2008) notes, narratives afford us with the opportunity to provide descriptions of an original act in a larger story; that is in this case, whistleblowing and nursing. Narrative methods provide a voice for participants and as whistleblowing can be a negative experience for all involved the telling of stories is often cathartic for research participants (East *et al.* 2010). Additionally, listening to and allowing participants to convey their contextualised

construction of their stories, 'values the teller' (Frank 1995, p. 18) and provides deep insights into an event or phenomena as a whole experience.

Participants

Following ethics approval, advertisements were placed in Australian professional magazines and the local media so nurses who were interested in participating could contact the research team. Nurses who had the experience of being a whistleblower (W), the subject of a whistleblowing episode (S), or a bystander in a whistleblowing incident (B) met the inclusion criteria for the larger study. Following purposive sampling, 18 nurses from several states across Australia consented to participate. This paper, however, explores the emotional aftermath of the fourteen participants who were W and S. These narratives consistently described the high emotional cost of their experiences. The W and S nurses were all female and had 2–40 years of nursing experience.

Data collection and analysis

Data were collected in 2009. A skilled, experienced member of the research team undertook 40 minute to two hours, face-to-face or telephone interviews with the participants. Prior to the commencement of the interviews participants were advised that they could cease the interview at any time, withdraw from the study without consequence and were given contact details of free relevant independent counselling services in the event that they became distressed. Because the interviews were facilitated by a researcher skilled in narrative inquiry, the participants' contextual, subjective stories were accessed through conversations (Duffy 2007). Following the essence of narrative inquiry subscribed by Frank (1995) and Holloway and Freshwater (2007), questioning throughout interviews was phrased in such a way that the participants controlled the story they conveyed and therefore their own agenda was recorded. The question asked of participants to trigger the narrative was 'Tell me your story about your experience of whistleblowing' and during the conversation, further clarifying questions were used to ensure context without reducing the autonomy of the participants. Narratives were digitally recorded and transcribed verbatim. Throughout the interview, notes were taken to assist in the contextualisation of the narratives. To ensure accuracy further, the interviewer listened to the recordings whilst reading the transcripts. The transcripts were then anonymised and the interviewing researcher and another member of the team, undertook data analysis. Following data immersion, data were iteratively de-contextualised (reduced) and coded

until final themes were developed (Tesch 1990, Silverman 2005). This uncovered the meanings of the experience for the participants. As suggested by Polkinghorne (1995) for the purpose of this research thematic analysis was appropriate as the focus of the research encompassed several stories from different characters in an explored event, namely whistleblowers, subjects of whistleblowing episodes, or bystanders in whistleblowing incidents. Pseudonyms are used in the presentation of findings to protect participant identities.

Rigour

The researcher has an impact on participants' recall, feelings and expression (Silverman 2005), therefore, reflexivity was used to ensure the interviewer authentically captured participants' stories. Reflexivity included the interviewer's self-awareness of their pre-understandings, an awareness of the positioning of the participants and constant reflection on the dynamic in the researcher/participant relationship. The interviewer kept a reflexive journal and regularly debriefed with co-researchers to reflect on aspects that could influence and shape the recorded narratives. This added to the credibility of the study (Koch 2006). Further, confirmability is evidenced by two members of the team independently immersing themselves in the data and developing codes and themes. These two team members engaged with the data until consensus was reached. Member checking was not used as the researchers perceived, (as found by authors of previous research on sensitive topics, for example, Throsby (2004), returning transcripts to participants for member checking to be an unnecessary burden. Strategies such as using an experienced interviewer and independent data analysis in combination substantiate the trustworthiness of the study.

Findings

These qualitative findings reveal the extent and range of the emotional distress experienced by participants following the whistleblowing event. Three themes capturing the emotional experiences of these participants are identified and discussed in detail below. These are: 'I felt sad and depressed': overwhelming and persistent distress; 'I was having panic attacks and hyperventilating': acute anxiety; and, 'I had all this playing on my mind': nightmares, flashbacks and intrusive thoughts.

'I felt sad and depressed': overwhelming and persistent distress

Participants described distress that was overwhelming. This distress was manifest in various ways, including episodes of

tearfulness, avoidance of social occasions, loss of confidence and insomnia. Rosie describes taking up an unhealthy pattern of alcohol use to try to cope with her distress and this seemed to exacerbate her difficulties with sleep:

I started drinking, I would go to bed at six o'clock at night... waking up at two o'clock in the morning and staying awake. (Rosie – whistleblower)

Despite their distress, participants did initially try to go about their lives appearing happy to friends, colleagues and other observers. However, this mask of normality was difficult to sustain and was not able to be maintained in the safety of their homes:

Whenever I did go to work I was trying to be happy, trying to you know do the right thing there but at home you can be yourself and so I was myself at home. Friends were worried about me, they'd ring and say I haven't seen you in about a month. I'd say oh yeah, we'll get together, yeah, yeah, yeah we'll get together. Always putting it off... I felt sad and depressed. (Rosie – whistleblower)

The extent of their sadness and distress was overwhelming and the depth of it was such that it was likened to previous episodes of grief associated with the deaths of loved family members:

The only feeling that I can compare it to is the grief that I had when my grandfather died when I was quite young and I just went into a black space and had to stay in bed with the blankets over my head for a week and that's what I did. (Evelyn – whistleblower)

The persistent nature of their distress eventually resulted in development of ongoing depressive symptoms that for some participants, required medical management:

Through this period I developed depression. At one stage my GP treated me for depression but for me, it wasn't an endogenous depression. So the treatment is actually to fix the cause, so taking the pills really doesn't help. I don't know, I think it [anti-depressant medication] flattens your affect and I don't think it allows you to think clearly, maybe for a short time. I must confess that I persuaded him to take me off them after a while. I was much more appreciative of the things [medications] that helped me sleep. (Carolyn – subject)

As with Carolyn, several other participants reported seeking assistance from general practitioners (GP). However, in two of the cases, both of which had involved nurse whistleblowing against medical wrong-doing, participants felt less than fully supported by their GPs. Moira had blown the whistle about a medical colleague who was in a sexual relationship with a mentally impaired patient. Subsequently, Moira experienced considerable distress and eventually became depressed requiring medical assistance:

I got depressed. I actually went to a doctor. I mustn't have done the depression thing very well because he wasn't very sympathetic and he just said you know, just take some pills and he didn't really want to give me any time off. I said look I'm finding it really hard to cope at work. (Moira – whistleblower)

Mary had blown the whistle about an aspect of the clinical practice of a medical practitioner. Her action in drawing attention to this had grave repercussions, which included the medical practitioner's suspension, a police investigation and widespread media scrutiny. Though she had initially remained in the workforce, Mary herself had suffered enormous emotional distress and reached the point where she was not able to work for a period of time:

My doctor said to me 'I'll give you off until the end of March and then you can go back to work. You're right to go back to work then aren't you?' and I said, yep alright. I was sort of thinking, god I hope so. But at the moment I just feel like, if something is to go wrong at work, I'm just going to walk out. I'm just going to throw the keys and say I'm not doing this and I can't, I just can't emotionally do this to myself. I can't put myself through this anymore. (Mary – whistleblower)

Even with the passage of time, with months and years elapsing since the traumatic events, the ramifications of the whistleblowing event continued to be felt. For these participants, the whistleblowing had life and career changing ramifications and culminated in major changes, including having to take new jobs, sometimes in new cities and in new specialty areas. Rita described an on-going constant low level feeling of depression that was associated with her changed circumstances:

To this day, not a day goes by that I just have this constant dull depressed sort of feeling but I'm not a depressed sort of person. It's like a deadness about you that this is not what I planned and I'm only here [in current position] because of what happened. This is not what I wanted to do even though I don't mind what I'm doing. It's not that bad but this is not what I wanted to do. (Rita – subject)

'I was having panic attacks and hyperventilating': acute anxiety

Accompanying the distress was anxiety and participants described ongoing states of anxiety that arose from the whistleblowing event. It was associated with their work and interfered with their previous normal enjoyment of life. This anxiety manifested in various ways. Valerie described feelings of anxiety that became more acute as the time drew nearer for her to attend work:

Even when I was on days off, I'd sort of get the anxiety a day or two before I was supposed to go back to work. Before I was due to go to work I'd be starting to get worried about it. It would be on my mind when normally on my days off I'd just enjoy myself. (Valerie – whistleblower)

Anna had been the subject of a whistleblowing accusation and as a result of this, had developed anxiety that caused her to become stressed and agitated and interfered with her ability to effectively seek help for her difficulties:

I was having panic attacks and hyperventilating and pacing like an absolute lunatic...I spent hours and hours and hours on the phone trying to ring around, trying to get somebody to listen to me and I sounded mad because I was mostly crying all the time. (Anna – subject)

For Anna the anxiety was severe and persistent, rendering her unable to function efficiently on a day-to-day basis. She eventually sought help from her GP and was hospitalised for a short period:

And then the enquiry started. I was starting to get really anxious, so I went to my doctor and he put me on some medication and I had a reaction to it and I ended up in hospital, in the psych admission section for a while. [participant tearful]. And I slept for three weeks after that. And I had three months off work and again I nearly lost my home. (Anna – subject)

For other participants, the anxiety manifested as hyper-vigilance, where participants were constantly watchful and alert, looking for and anticipating possible danger in previously unproblematic activities. Moira described the strain that she experienced as a result of this constant state of watchfulness:

I was hyper vigilant, I was on the alerts. I tried to look at every possible way how I might be set up for something in terms of making a mistake whether it was with drugs or with something, you know, covering your arse. Like for instance if I took an order for medication I made sure I got it checked, you know, that sort of stuff because these people would not protect, if something went wrong...I think that was the strain when I came back that led to me feeling like I don't want to go to work. I got quite depressed. Like first of all I got quite anxious about the workplace and then I ended up getting a bit of a depression. (Moira – whistleblower)

As the subject of a serious whistleblowing allegation in her previous situation, Diana had a heightened sense of her own vulnerability in her workplace. She became hyper-vigilant and began to take copious detailed records of all her actions and encounters with others. This was very time intensive and became very tiring and wearing for Diana:

I practiced defensive management from the day I walked in that door. I wrote everything down, I kept a log of every conversation and it was exhausting. (Diana – subject)

Participants described this stress and anxiety as being inextricably associated with being in the workplace and for some participants, was episodic in nature. Rosie described being able to function very well at times, while on other occasions, even when feeling relatively normal and positive about going to work, would become acutely anxious and not be able to leave her car to enter the workplace:

Some days I was fine, I walked in, I had a great day. Other days I just, I'd feel fine, I'd roll up at the front door, park the car, burst into tears, ring up and say I can't come in. (Rosie – whistleblower)

'I had all this playing on my mind': nightmares, flashbacks and intrusive thoughts

The whistleblowing experience was all consuming for these participants, who reported being troubled with intrusive thoughts and nightmares. Large parts of their days and nights were spent thinking about and ruminating on the events surrounding their involvement in the whistleblowing episode:

Probably for the first, almost a year, it was the last thing in my head before I went to sleep and it was the first thing in my head when I woke up and probably after a year I had to make a concentrated effort to try and stop that because it was wearing me out but over the last couple of months it's back again. (Diana – subject)

The trauma surrounding the events was such that even in the presence of many other potential diversions, thoughts of the whistleblowing episode were never far away. They often led to other distressing and uncomfortable thoughts. Rita felt she had been unjustly accused and could not understand why she had been targeted as the subject of a complaint:

It was difficult just to be yourself because it's just constantly in the back of your mind, why did they do this to me? But that's gone, you know, a lot of tears. (Rita – subject)

Participants found it difficult to find any respite from their thoughts, or peace from the distress that their association with the whistleblowing events caused them. These thoughts were experienced as unpleasant, distressing and intrusive. They were circular, meaning that the same thoughts repeated again and again, with little new insights gained or solutions developed:

I had all this playing on my mind, I was wondering what effect it would have on me...it was constantly on my mind and I was constantly figuring out ways of dealing with the problem. (Valerie – whistleblower)

These thoughts were burdensome and participants had no way of relieving or off-loading them. Rita was concerned about the possible long-term mental health outcomes of having continual distressing thoughts over long periods:

It plays on me and plays on me that [partner]'s mother had someone, a relative, take all her money and she was just haunted by it and she was obsessed by it. She eventually developed Alzheimer's disease and you sort of wonder, is this going to drive me mad? (Rita – subject)

In reflecting on this aspect of her experience, Diana commented on the difficulty in finding an appropriate and accepting milieu where it would be safe to give voice to some of her thoughts:

I've nursed my mother to her death. I've worked in health for 30 years and nothing, nothing prepares you for this and there aren't people, like there's not a group where you can go and offload. You can go and talk to a psychiatrist or a psychologist, but what I've found with psychiatrists and psychologists over the years is that you talk and yes it feels a bit better at the end because you actually verbalise stuff, but they don't give you anything and I said to this woman down here, she's been great, but I said to her a lot of people would, if they'd gone through this, they'd be medicated by now or had some really adverse outcome, you know, been an absolute alcoholic or turned to drugs because this is how horrendous it is. (Diana – subject)

In addition to intrusive unwelcome thoughts and images, Mary was troubled by nightmares and flashbacks, which were associated with a particular traumatic outcome involving a patient:

You know then I just had nightmares all the time, when it was at it's worst I would just see this man continually, as soon as I closed my eyes or if I was daydreaming or like I would be just washing my hair with the shampoo, have my eyes closed and just these eyes, this face, this man's face – I have never been able to get rid of it. This has been since 2005 and it's just been a constant on my thoughts. (Mary – whistleblower)

Discussion

Analysis of participant accounts highlights the severity of adverse effects attributed to the experience of whistleblowing. In particular, we draw attention to the extensive and enduring nature of the resultant emotional harm. All participants reported experiencing a level of emotional distress that negatively influenced their health, ability to work and private lives. Similar to studies of workplace bullying, participants described their experience as an extremely distressing

(Mikkelsen & Einarsen 2002) and critical life event (Hutchinson *et al.* 2006). An important finding, not previously reported in the nursing literature, was the duration of emotional symptoms. For several participants, more than a year after the event they continued to experience flashbacks, intrusive thoughts and disabling emotional responses. This emotional state significantly affected their capacity to work and engage in family life. This finding suggests that whistleblowing may have long-term disabling consequences that continue long after the event.

The narratives of our respondents draw attention to whistleblowing as a hidden conflict in health care, one which potentially undermines public accountability and access to justice (Faunce 2004). Whistleblowing positioned participants in open contradiction to accepted workplace norms, creating a rupture that brought forward hostile reactions from colleagues. Framed as deviant and stripped of their respectability, nurse whistleblowers and subjects of whistleblowing complaints detailed their fight to survive.

As a flow on from whistleblowing, participants experienced a spiral of negative emotions that often commenced with self-doubt and over time, escalated to an increasing loss of self-confidence and sense of coherence. In this context, participants reported feelings of reduced dignity and self-worth, which was further exacerbated through denial of support. In the face of increasing emotional fragility, participant's well being began to deteriorate under the pressure. It has been postulated that denial of support is a secondary process of victimisation (Mikkelsen & Einarsen 2002) which serves to further shatter an individual's assumptions about benevolence and justice (Lewis & Orford 2005). In the face of diminishing social support, respondents withdrew and became increasingly isolated, marginalised and vulnerable. Sensing themselves as alone in the face of adversity and under increasing attack they withdrew further as a coping strategy. Withdrawal was associated with avoidance of social interaction, loss of confidence and alcohol abuse to cope with the distress. This response resonates with the experience of sexual harassment (Fitzgerald *et al.* 1997) and workplace bullying (Hutchinson *et al.* 2008) where individuals have been reported to engage in withdrawal as a strategy to reduce the stress associated with the experience while remaining employed in an abusive environment. As this negative spiral continued, it rippled into participants' private lives, compromising their relationships and further eroding their sources of support.

Echoing studies on workplace bullying where clinical symptoms of post-traumatic stress have been reported (Leymann 2004, Tehrani 2004), this study draws attention to experiences that created a chain of events which challenged

individuals' sense of coherence and the fundamental assumptions they held about their world. It is known that permanent psychological harm can result from ongoing exposure to abuse and trauma (Ancharoff *et al.* 1998, Hirigoyen 2000). While not clinically assessed in this study, symptoms of anxiety, depression, hyper vigilance and flashbacks were commonplace and are consistent with definitions of post-traumatic stress disorder (Leymann 2004, Palmeri & Fitzgerald 2005) and the experience of injustice and psychiatric morbidity (Ferrie *et al.* 2006). The prolonged period of stress and sense of inescapability and being captive to the situation (Bonafons *et al.* 2009) may account for these symptoms in our participants.

Conclusion

This paper has revealed the impact on the emotional health of all involved in whistleblowing events. While it is known that whistleblowing can result in negative emotional outcomes for all involved, a notable aspect in the narratives of these participants was the severity and ongoing nature of their emotional symptoms. The lack of recognition of potentially debilitating emotional symptoms and the absence of the provision of appropriate support by colleagues and managers in health care facilities, may compound the emotional sequelae associated with whistleblowing incidents. Interestingly, the very organisations that avow to uphold principles

to promote good health, seemingly either could not recognise ill health in their own employees or ignored this aspect of health 'care'.

Relevance to clinical practice

This study has evidenced that management in the health arena have a significant responsibility to provide ongoing care and support for their employees who are whistleblowers or are affected by a whistleblowing event. While they need to consider organisational status and reputation, health sector employers also need to have independent mechanisms to assist nurses and others affected by such episodes. Nurses as professional colleagues have a responsibility to be vigilant and assess the needs of those who may be suffering the emotional trauma associated with whistleblowing events and direct them to appropriate resources.

Contributions

Study design: DJ, KP, SA, LL; data collection and analysis: KP, DJ and manuscript preparation: KP, DJ, LL, MH, LW, SA.

Conflicts of interest

There are no conflicts of interest to declare.

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