

Please cite the Published Version

Drake, HM, Fielden, Sandra, Crozier, S and Hunt, Carianne (2019) A Longitudinal Investigation of the Glass Ceiling in Nursing. *Journal of Managerial Psychology*, 34 (2). pp. 96-109. ISSN 0268-3946

DOI: <https://doi.org/10.1108/JMP-02-2018-0093>

Publisher: Emerald

Version: Accepted Version

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Structured Abstract

Purpose: This paper presents a longitudinal, qualitative study exploring changes in the attributional constructions of sense-making in the perceptions and lived experiences of the glass-ceiling among a cohort of female mental health nurses in the National Health Service (NHS) who participated in a 12-month multi-faceted career and leadership development pilot programme compared to a matched control group.

Design/methodology/approach: The authors interviewed 27 female mental health nurses in the UK who participated in a multi-faceted development programme specifically designed to support female nurses secure career advancement and 27 members of a matched control group who did not experience the programme. Participants engaged in semi-structured telephone interviews at three separate time points (six months apart) over a 12-month period.

Findings: Programme participants differed in their attributional constructions of sense-making in relation to the glass-ceiling over time compared to the matched control group. e.g. triggering understandings and awakenings and re-evaluating the glass-ceiling above when promoted. Findings are used to theorise about the glass-ceiling as a concept that shifts and changes over time as a function of experience.

Practical implications: Practical implications include important organisational outcomes in relation to fostering the career advancement and retention of talented female leaders at all career stages.

Originality/value: The authors present the first known longitudinal, qualitative study to explore changes in attributional constructions of sense-making in perceptions and experiences of the glass-ceiling among female nurses over time compared to a matched control group.

Introduction

Nurses and midwives constitute a significant proportion of the UK workforce, a workforce which is predominantly female in the UK and across the globe (Alghamdi *et al.*, 2018; Nursing and Midwifery Council, 2016; World Health Organisation [WHO], 2017). Despite their predominance, female nurses are proportionately more likely than men to be concentrated in lower-status roles and excluded from managerial and decision-making positions (Burke and Singh, 2014; Newman, 2015). An array of barriers to leadership progression for women have been identified by researchers, which have been shown to influence recruitment, retention and pay (Alghamdi *et al.*, 2018; WHO, 2017). Specifically, it has been proposed that female nurses face a glass-ceiling in their efforts to achieve senior roles (Andrews *et al.*, 2012; Woolnough and Fielden, 2017).

This paper presents a longitudinal, qualitative study exploring changes in the attributional constructions of sense-making in the perceptions and lived experiences of the glass-ceiling among a cohort of female mental health nurses in the NHS who participated in a 12-month multi-faceted career and leadership development pilot programme. Distinctively, the study included a matched control group recruited from the same NHS Trusts to capture similarities and differences in the experiences of those who encountered the intervention and those who did not.

The year 2018 marked 40 years since the term *glass-ceiling* was first coined, yet despite progress across occupational sectors including nursing, the glass-ceiling phenomenon continues to permeate women's managerial careers (Broadbridge and Fielden, 2018; Loden, 2017). There is a dearth of research on female nurses attempting to navigate career barriers

and the experiences of female mental health nurses in particular have been overlooked. The limited research base tends to focus on career barriers faced by female nurses (Andrews *et al.*, 2012; Tracey, 2006), with little understanding of *how* female nurses interpret and explain their lived encounters. Notably absent is the paucity of longitudinal research on the experiences and perceptions of female nurses as they navigate and make sense of the glass-ceiling. This nuanced understanding over time is crucial if the career development of female nurses is to be addressed given previous research findings, which suggest that the glass-ceiling discourages women from striving for career advancement and contributes to valued and experienced women leaving the workforce (Guillame *et al.*, 2013; Smith, Caputi and Crittenden, 2012).

In the highly pressured context of the NHS there is a need to nurture and retain talented nursing staff, along with a requirement to address this gap in knowledge and provide more effective support to female nurse leaders (Alghamdi *et al.*, 2018; Newman, 2015). This study responds to calls for robust longitudinal, qualitative research to advance knowledge of the intricacies of the glass-ceiling (Elaqua *et al.*, 2009; Jackson, *et al.*, 2014). It addresses this gap by drawing on attribution theory as an overarching framework, to qualitatively capture areas of sense-making related to participants' specific experiences of the glass-ceiling over time (Martinko *et al.*, 2011; Wyatt and Silvester, 2015). We also explore practical implications for managers and business leaders beyond the clinical context within which this study is set.

The glass-ceiling

Discourse around the glass-ceiling has permeated the management literature since the 1970s and describes a subtle, invisible barrier which prevents women and minorities from progressing into higher managerial positions in organisations (Powell and Butterfield, 2015; Watkins and Smith, 2014). Empirical work shows that the glass-ceiling exists even in occupations where women predominate, including nursing, teaching and social work (Powell and Butterfield, 2015; Randstad, 2016). In 2017 the Royal College of Nursing (RCN) reported that just 10.8% of registered nurses in the UK were men and that nursing is one of the most gender-segregated jobs in the UK (RCN, 2018). In addition to vertical segregation, there is evidence of horizontal segregation within the nursing profession with men gravitating towards certain types of nursing, chiefly mental health nursing, where 28% of registered male nurses are employed (NMC, 2016). Research has found that the mental health discipline is preferred by male nurses as the roles, activities and culture associated with the sector allows men to express their masculinity in a profession dominated by women (Harding, 2007).

Explanations for the existence and persistence of the glass-ceiling are complex and interrelated including factors at societal, organisational and individual levels, which interact and converge to block women's progression into top management positions (Guerro and Posthuma, 2014; Powell and Butterfield, 2015). Consequently, considerable evidence attests that organisations are missing out on women's leadership talent (Chung and Van der Horst, 2017). Although seventy-seven per cent of the NHS workforce is female, only 37 per cent of senior Board level roles are held by women, reflecting the lack of women in leadership roles (Davies and Welfare, 2015). To capture the intricacy of workplace discrimination, Eagly and

Carli (2007) refer to the 'labyrinth' which women must navigate on their leadership journeys and further research exploring these complexities is required (Bruckmuller *et al.*, 2014).

Making sense of the glass-ceiling

To enable women to navigate a gendered organisational context which is less favourable to them than men, organisations have invested in forms of training and support specifically designed for women, including career and leadership development programmes (Broadbridge and Fielden, 2018; Kassotakis, 2017). Such programmes can be beneficial by providing aspiring women leaders with space to claim and enact credible leadership identities, in an environment away from the dominant masculine status quo (Ely *et al.*, 2011; Ibarra, *et al.*, 2010). However, few of these programmes offer rigorous, longitudinal research addressing the impact of programmes on participant's experiences and perceptions of the glass-ceiling.

This work builds on previous research utilising attribution theory to make sense of career events in leadership journeys (Wyatt and Silvester, 2015). Attribution theory asserts that individuals exhibit a tendency to engage in a process of sense-making when they encounter new, surprising or destabilising events (e.g. when encountering the glass-ceiling) in their attempts to understand and control their environment (Martinko *et al.*, 2011). This sense-making enables individuals to cognitively create meaning and understanding in order to construct a coherent account of their organisational world, and decide how to react (Maitlis and Christianson, 2014). Specifically, this cognitive work is an attempt to manage such new, surprising or destabilising events by making them more predictable. The way in which individuals make sense of events (e.g. the glass-ceiling) influences subsequent emotional and

behavioural responses, which can positively or negatively affect job satisfaction, motivation and performance (Martinko *et al*, 2011; Welbourne *et al.*, 2007).

This framework is offered as a valuable lens through which to examine events that have initiated sense-making in relation to the glass-ceiling, specifically, how these events are experienced, and responses to them as a result of their sense-making (Maitlis and Christianson, 2014). Previous research has tended to adopt a positivist approach, despite evidence that spoken attributions occur spontaneously in regular discourse and this study builds on prior research utilising qualitative enquiry to addresses this omission (Silvester *et. al.*, 2004; Wyatt and Silvester, 2015). Hence, spoken attributions can provide rich, qualitative insights into how study participants make sense of and respond to, career episodes encountered relating to the glass-ceiling, further enhancing our understanding of the intricacies of the glass-ceiling.

The aim of this longitudinal study was to identify episodes of participants' sense-making related to specific experiences of the glass-ceiling over the course of a pilot 12-month multi-faceted career and leadership development programme, which was designed to support female mental health nurses to secure career advancement and enhance their leadership potential. Uniquely this study also explored similarities and differences in the sense-making of programme participants compared to a matched control group over time. Our specific research questions were:

- (i) what are the trends and changes in the attributional constructions of sense-making in the perceptions and lived experiences of the glass-ceiling among a cohort of female mental health nurses in the NHS who participated in a 12-month multi-faceted career and leadership development pilot programme?
- (ii) in what ways are these similar to, or different from the matched control group over the same 12-month period?

Methodology

Study design and sample

This study focussed on the glass-ceiling element of a wider investigation into the impact of the programme on the career and leadership development of participants. The study participants were female mental health nurses selected from six NHS mental health Trusts in England.

The programme

The programme was designed by a development team including academics and practitioners, in collaboration with the six NHS Trusts and contained an array of training and development events. It began with a 3-day residential career development and leadership course incorporating training sessions on leadership development; gender awareness (including an

exploration of the glass-ceiling in the workplace and healthcare in particular); role modelling; career and action planning. This was followed by work-shadowing line managers; four facilitated action learning sets with other programme participants; and a 12-month matched mentoring relationship with a male or female mentor. Mentors were senior managers from within the respective NHS Trust.

The programme was open to female mental health nurse participants engaged in ward or non-ward-based management positions from six NHS mental health Trusts across England, interested in furthering their career. This particular level of nurse had been identified by senior health executives guiding the development of the programme, as the level at which female nurses were most likely to encounter a glass-ceiling. This was corroborated by (confidential) data collected from numerous NHS mental health Trusts across the UK, which isolated the disproportionate gender ratio of nurses at senior levels.

Potential participants were invited to apply for the programme by submitting a written application outlining: their reasons for applying for the programme; past work experience and their vision for their future career. Initially, 100 female mental health nurses from a wide variety of areas of mental health practice across the large NHS Trusts involved applied (e.g. both ward and community nursing) and from these 60 were selected as potential programme participants. This selection was undertaken by a panel consisting of members of the programme development team based on predetermined criteria in applications to the programme i.e. each of the aforementioned elements. At this stage, each mental health nurse had an equal chance of participating in the programme or forming part of the control group

(Richie *et al.*, 2013). Random allocation (stratified by NHS Trust) was achieved by using sealed envelopes containing randomly allocated numbers, which had been generated by an academic external to the research. Five participants from each NHS Trust were selected to participate in the programme ($n = 30$). The five others were invited to take part as members of the control group ($n = 30$) and subject to the same research measures as participants.

Incorporating a control group was designed to support programme appraisal and address the extent to which exposure to the programme influenced attributional constructions of sense-making in relation to the glass-ceiling among participants compared to the control group who did not experience the programme intervention. Despite the diversity in area of mental health practice and geographical location within Trusts from which participants and members of the control group were recruited, it was necessary to be cognisant of the fact that participants and members of the control group may have interacted during their working roles across the 12-month study period. To uphold study validity, programme participants were asked to refrain from disclosing and discussing programme content and experiences in detail with colleagues external to the programme whilst participating in the intervention.

Although 30 female participants were recruited only 27 participants and members of the control group completed the full 12-month programme, this relatively small attrition rate was due to increased work demands and personal issues (Hassett and Paavilainen-Mäntymäki 2013). Table I presents the career demographics of both programme and control group participants. As can be seen from Table 1, the demographics of both groups were similar across all measures including occupational positions, which had elements of ward and community nursing, such as technicians, specialists, therapists and managers.

Insert Table 1 about here

Interviews

The study was positioned ontologically within a realist research paradigm, which sees reality as ‘only imperfectly and probabilistically apprehensible’ (Healy and Perry, 2000: 119). An interpretive epistemological approach was adopted in line with calls for more robust qualitative research to advance knowledge regarding the intricacies of the glass-ceiling as a function of lived experiences over time (Duberley, *et al.*, 2012). Interviews focussed on themes derived from an in-depth literature review, as semi-structured interviews focussing on key themes have been shown to be useful in longitudinal studies seeking to reconstruct changes in perceptions and experiences over time (Hassett and Paavilainen-Mäntymäki 2013; Ruspini, 2002). Interviews were conducted with the programme participants and control group at six-month intervals over a 12-month period. Research questions are presented in Table 2.

Insert Table 2 about here

Data were collected prior to the programme (baseline, time point one), half way through the programme (six months, time point two) and at the end of the programme (12 months, time point three). Interviews were conducted over the telephone due to time and geographical constraints and lasted approximately 40 minutes with programme participants and 25 minutes

with members of the control group. Interviews were audio recorded (with permission) and transcribed verbatim and materials were piloted at each time point, although few amendments were required. All programme participants engaged in interviews at each of the three time points, however a common limitation of longitudinal research is attrition and this study was no exception (Hassett and Paavilainen-Mäntymäki 2013; Neuendorf, 2002). While the entire control group engaged in interviews at time points one and two, the authors were unable to reach two participants from the control group at time point 3, despite repeated attempts.

Data analysis

Qualitative interview data were analysed using thematic content analysis and a human based coding system (Braun and Clarke, 2006). Analysis focussed on the content of attributions made during sense-making episodes in relation to the glass-ceiling at each time point (Martinko *et al*, 2011; Silvester, 2004; Wyatt and Silvester, 2015). Our aim was to uncover a richer, nuanced understanding of the similarities and differences in the narratives of participants compared to the control group through qualitative data. An emergent process of coding was adopted, involving a combination of induction and deduction to avoid constraining the analysis to established findings (Neuendorf, 2002) and, while coding schemes utilised at each time point initially remained the same, additions and amendments were made as the study progressed. Internal validity was realised by each interview being coded independently by two members of the research team, who then met to discuss coding decisions made (Denzin and Lincoln, 2011; Whittemore *et al.*, 2001). Discrepancies were discussed across the whole team. In this way, coding was rigorously examined by the research team in a process of triangulation to ensure accurate coding before final

categorisation was agreed (Ritchie *et al*, 2013). Furthermore, to increase reliability, the authors fostered reflexivity by scrutinising coding decisions and engaging in member checks with a number of participants at each time point (both programme participants and members of the control group) to explore the credibility of data collated (Ritchie *et al.*, 2013; Neuendorf, 2002).

Pre-analysis of the interview materials began with the process of familiarisation and immersion in the data to reflect on overall meaning (Denzin and Lincoln, 2011). Transcripts were then read through again and general themes were noted as they began to emerge. As data analysis progressed, themes were divided into main themes or sub themes and headings were developed to represent the data. Further codes were attached to words and phrases and grouped into these themes and sub themes (Braun and Clarke, 2006). Interviews were analysed at each time point and every attempt was made to view each transcript in isolation so as not to omit and disregard any useful and relevant data (Ritchie *et al*, 2013).

Findings

Findings reflecting trends and changes in the perceptions and lived experiences of the glass-ceiling among programme participants compared to the control group are presented below and reflected in Figure 1, which offers a conceptual model to illustrate the main themes in relation to the research questions revealed through data analysis. Specifically, the model captures the fluid and dynamic nature of events that for programme participants triggered attributional constructions of sense-making in relation to the glass-ceiling compared to the matched control group. The model shows that at time point 1 (baseline), both programme

participants and the control group shared common experiences and perceptions across a range of glass-ceiling sub-themes. Subsequently, the model showcases the divergence in the lived experiences of the glass-ceiling for programme participants compared to the control group at time points 2 (six months) and 3 (12-months), where further distinct trends and changes arise alongside programme participation and career advancement. Key themes are presented below and quotations are utilised to illustrate findings.

Common ground: baseline

Our findings highlighted that prior to the programme (baseline – time point one), most participants (n=20, 74.0 per cent) perceived a glass-ceiling to exist in mental health nursing. This is not surprising given participants had applied to participate in a development programme to facilitate career advancement. Rather than disclosing first-hand experiences of the glass-ceiling, interviewees tended to use sense-making to express their awareness of the disproportionate number of men at senior levels and the gendered context in which they operate:

“It (the glass-ceiling) does exist. In my speciality, there has always been a very macho culture encouraging male members. It’s unwritten and unsaid but it’s definitely there.” (21)

A small number of participants (n=7; 25.9 per cent) appeared more questioning with regards to the existence of a glass-ceiling. Interestingly, this group of interviewees were from two particular NHS Trusts with a higher proportion of female senior managers compared to other

Trusts and, while they did not expressly dismiss the existence of a glass-ceiling, they tended to consider that access to influential people was key to career progression, thereby illustrating wider inherent inequality:

“I’m not sure that a glass-ceiling exists in my organisation although maybe it does in other Trusts. I think opportunities are pretty much equal here. I think it’s more about knowing the right people, not your gender.” (15)

Similarly, our findings highlighted that members of the control group perceived a glass-ceiling to exist in mental health nursing (n=22, 81.4 per cent) prior to programme commencement:

“If I was male with the same career history and with the same experience, I’d have progressed further by now.” (31)

Correspondingly, prior to the programme, a small number of members of the control group (n= 5; 18.5 per cent) appeared to question the existence of a glass-ceiling for women in mental health nursing. Again, this group of interviewees were from two particular NHS Trusts with a higher proportion of female senior managers:

“There are a number of senior women in this Trust, so the glass-ceiling is less apparent here. It’s who you know that influences whether you’ll get on or not.” (43)

Overall, both programme participants and members of the control group perceived a glass-ceiling to exist at time point 1 (baseline), thereby illustrating identification of systemic barriers to women's progress into senior roles among both study groups.

Understandings and awakenings: changing perceptions and experiences over time

Despite similarities between programme participants and members of the control group at baseline (time point 1), our findings revealed differences as the study progressed and this divergence became apparent at time point two (6 months), (see Figure 1). Interviewees on the development programme who had by this time point experienced an array of training and development opportunities (including a training session exploring the glass-ceiling in the workplace) reported an increased awareness of the glass-ceiling as the study progressed. Ten programme participants (37.0 per cent) commented on their heightened understanding and awareness of the glass-ceiling at time point two and an additional five interviewees (18.5 per cent) reported this at time point three.

“I can see how subtle the glass-ceiling is in a way I don't think I really noticed before. It's the way in which male members of staff seem to progress in a way female nurses don't. No-one's overt about it – but it definitely knocks women off track.” (03)

Additionally, findings highlight that programme participants at time point one who had been more questioning with regards to the existence of the glass-ceiling, tended to report an increased awareness of the prevalence of a glass-ceiling by time point three. In other words,

the extent to which they considered a glass-ceiling to impact on their career trajectory changed over time as a function of their involvement with the development initiative:

“I feel very strongly that a glass-ceiling exists in mental health nursing. I’m much more aware of it now. I used to think that well, we had women in senior roles here, so it wasn’t that bad. I now understand it’s not as simple as that. For most women in the NHS you get to a certain level then that’s your lot.” (15)

In contrast, no members of the control group elaborated on episodes of sense-making in relation to their deeper understanding or awareness of the glass-ceiling at subsequent time points:

“I don’t think the way in which I see the glass-ceiling has changed. If your face fits, you will progress.” (50)

This highlights that for programme participants, sense-making in relation to increased understandings and awakenings occurred as a function of programme participation.

Promotion: navigating the ceiling above

Over the course of the programme, 11 programme participants (40.7 per cent) from across the six NHS Trusts were promoted, of those, three (11.1 per cent) were promoted by time point two and a further eight (29.6 per cent) were promoted by time point three. This is a highly

successful outcome in terms of meeting programme aims, i.e. to aid participants in their attempts to advance. To highlight this further, the percentage of promoted participants and the percentage of the control group promoted were converted to estimates of conditional probabilities (programme participants = 0.4074, control group participants = 0.1481). These figures were used to compute a chi-square test which supported a statistically significant difference between the two groups ($\chi^2(1) = 4.523$, $p = .033$. Phi coefficient (ϕ) .289) where programme participation resulted in increased instances of promotion. This finding provides converging evidence of the programme's success in terms of meeting its aims and objectives. Quotations in this section are from promoted programme participants and members of the control group.

Analysis of the qualitative interview materials among promoted programme participants revealed that this event triggered episodes of sense-making, in that most programme participants who experienced promotion over the course of the programme expressed an increased awareness of the glass-ceiling after promotion.

“I’ve been promoted, and it’s made me more aware of what’s going on above me further up the Trust. It’s very male dominated. I didn’t see that so much in my previous role.” (08)

Whilst promoted programme participants generally did not report first-hand experience of the glass-ceiling before the programme started (time point one), three interviewees (11.1 per cent) at time point three reported first-hand experience of the glass-ceiling arising from their changing experience post promotion. For example:

“Definitely! I’m aware of it (the glass-ceiling) now – full throttle! I suppose when I first started on the programme I maybe didn’t think there was such a thing that was very evident but now I know that there is. It’s definitely affected me recently.” (14)

These findings make visible the increased awareness of and frustration with the glass-ceiling that accompanied the otherwise largely positive outcome of promotion. Although promotion was interpreted by programme participants as evidence of disturbing the glass-ceiling, career advancement also served to illuminate further career barriers and gender imbalance.

“I’ve been promoted so I’m knocking on that glass-ceiling but it’s frustrating really because I can see more barriers ahead, it’s going to be a challenge. I don’t feel that female nurses with good ideas are always listened to.” (02)

Four members of the control group (14.8 per cent) were also promoted, all occurring between time points two and three. In contrast to most programme participants who expressed an increased awareness of the glass-ceiling after promotion, promoted members of the control group did not report any changes.

“Yes, I’ve been promoted since we last spoke. No, I don’t think my views on the glass-ceiling have changed.” (36)

Queen bees: Disrupting anticipated female solidarity

Programme participants revealed a perceived existence of female misogyny in mental health nursing, which was first expressed at time point two (n=4; 14.8 per cent) and

reported by a further seven programme participants at time point three (29.6 per cent). Such respondents considered senior women to be acting in ways to prevent the future promotion of talented junior female nurses and was interpreted as a key factor in the persistent nature of the glass-ceiling. At time point two, this perception appeared to manifest itself in the form of backlash from female peers and colleagues:

“It’s been a bit difficult back at the unit because some (female) colleagues are jealous that I’m on this course and they’re not and I’m much more visible and am doing additional stuff.” (03)

By time point three, the notion of senior women inhibiting the career advancement of more junior women was reported by more programme participants (n=5; 18.5 per cent) and this was represented in the data through reference to ‘queen bees.’ Interestingly, this was not something reviewed in programme training materials and their sense-making reveals the unexpected nature of encountering perceived resistance from fellow women. The analysis showed that programme participants who highlighted the existence of ‘queen bees’ tended to be those who experienced promotion, specifically, comparatively rapid promotion, i.e. those promoted between time points one (baseline) and two (six months). In the words of one promoted programme participant:

“There are a few women, they’re very much like ‘queen bees’, who try to keep you down where you are. I think they feel very threatened by anybody else who’s up and coming and wants to develop themselves. It’s almost like they are protecting their role.” (26)

Members of the control group did not refer to unexpected resistance from female colleagues, which could be explained by the comparative lack of organisational investment in their career progression during the 12-month study period. Even those who had been promoted made no reference in their discourse to ‘queen bees.’ As control group participants were all promoted towards the end of the 12-month study period, this may not have afforded them sufficient time to encounter such apparently negative attitudes in their new positions. For programme participants (particularly those promoted), the unexpected nature of this perceived resistance may have required more investment in cognitive effort to understand these tensions in order to navigate them.

External Opportunities: challenges and checking out

Against a backdrop of unrelenting pressure regarding recruitment, retention and resource allocation in the NHS, programme participants referred to a diminishing pool of senior roles to progress into. Seven programme participants (29.6 per cent) highlighted this at time point two and it was raised by a further six programme participants (22.2 per cent) at time point three.

“I want a new job and I’d like to stay here but the opportunities just aren’t there for me.” (01)

Interestingly, six programme participants found promotion outside of their original NHS Trusts, whereas only one of the control group members was similarly promoted. Analysis of

the baseline materials highlighted that no programme participant (or indeed member of the control group) initially considered the possibility of moving to a different Trust, or alternative area of mental health practice, to further their career. This suggests that programme participants garnered an awareness of external possibilities as a result of networking with others from alternative Trusts.

“Meeting other women on the course from other Trusts made me realise that actually there was more than my Trust out there in the world.” (04)

Faced with the challenge of accessing scarce promotional roles, programme participants responded by looking externally. This sense-making response has implications for the retention of female nurse leaders within individual Trusts, yet arguably contributes to the career acceleration and retention of talented female leaders across the wider NHS. Similarly, members of the control group highlighted the absence of senior roles within their Trust. This was reported by nine members of the control group (33.3 per cent) at time point two and six members of the control group (22.2 per cent) at time point three.

“There’s no hope of a promotion. I’m not even sure if I’ll have a job. I probably wouldn’t want to stay in the Trust anyway.” (41)

In contrast, members of the control group did not look externally for career openings. Potentially, this was a consequence of their comparative lack of external networks when compared to programme participants over the 12 months study period.

“There aren’t any opportunities for promotion here. I want to stay here, my friends are here, it’s what I know.” (28)

Discussion and conclusion

Utilising attribution theory as an overarching framework, the study illuminated constructions of realities and identified areas of sense-making related to specific lived experiences of the glass-ceiling over time, comparing female mental health nurses in the UK NHS (n=27) participating in a pilot 12-month multi-faceted career and leadership development programme, to a matched control group (n=27), (Maitlis and Christianson, 2014; Ruspini, 2002; Wyatt and Silvester, 2015). Findings indicate that for programme participants, the content of attributions made during sense-making episodes at each time point were shaped and sculpted as a process of their interactions with the glass-ceiling further to encountering the development programme, particularly in comparison to the control group who did not express such nuanced interpretations.

Arguably, our results reveal a double-edged sword for programme participants, in that their heightened awareness of the glass-ceiling and the unexpected and destabilising events they encountered present as a challenge *and* a success. Programme participants came to make-sense of the complexities of their position in relation to navigating the glass-ceiling over the course of the 12-month study period and results revealed this caused some tension. However, perhaps it is precisely this deeper appreciation of the complex and insidious nature of the glass-ceiling that acts as a catalyst for organizational learning to evoke challenge to gendered

organisational contexts (Broadbridge and Fielden, 2018). According to attribution theory, the way in which individuals interpret sense-making influences their subsequent actions (Martinko *et al.*, 2011; Welbourne *et al.*, 2007). This suggests that sense-making in relation to the glass-ceiling has the potential to engender apathy and diminish women's promotional aspirations, *or*, empower action to disrupt the glass-ceiling. Future longitudinal research is required here.

Specifically, our analysis revealed that more programme participants were promoted (40.7%) over the course of the programme compared to the control group (14.8%) and this indicates programme success in terms of participants securing career advancement. Yet, when compared to the control group, programme participants expressed an increased awareness of, or an awakening towards the existence and persistence of the glass-ceiling and for some programme participants, promotion appeared to exacerbate perceived career barriers. A number of programme participants promoted over the course of the 12-months highlighted their frustration with fellow female mental health nurses whose anticipated solidarity was not always realised. The extent to which these underlying assumptions of fellow women as 'natural allies' is helpful has been challenged in previous conjecture and suggests that exploring the gendered contexts in which these assumptions are constructed and how they interact with sense-making warrants further consideration (Mavin, 2008). Furthermore, the importance of unlocking barriers through the availability of attractive opportunities to progress into was expressed by both programme participants and members of the control group and study results revealed support for prior research highlighting the significance of networking in women's career progression (Ibarra, *et al.*, 2010; Watkins and Smith, 2014). This is particularly pertinent given structural changes and flattening hierarchies in the NHS

(Ham, 2014) and the extent to which these emerging changes affect the availability of senior roles and by implication the glass-ceiling, warrants further investigation.

We make several theoretical contributions. Firstly, we extend the managerial psychology literature by presenting the insights of female mental health nurses in relation to the glass-ceiling. Secondly, we add to the glass-ceiling literature by highlighting the potential twists and turns in perceptions and experiences of the glass-ceiling over time (Eagly and Carli, 2007; Patton and Haynes, 2014). Unlike previous cross-sectional research, we offer insights into the extent to which sense-making is adapted and altered longitudinally (Neurendorf, 2002; Ruspini, 2002). Thirdly, we extend work relating to the professional workplace by drawing attention to the process-oriented nature of the glass-ceiling. This is further illustrated in our conceptual model (Figure 1), which encourages the interpretation of the glass-ceiling as an ongoing layered phenomenon that is re-evaluated and re-appraised relative to one's leadership trajectory.

We assert the need for managers and business leaders to recognise the potentially daunting nature of the glass-ceiling and be cognisant of the need to provide organisational support for women crafting leadership pathways as being predicated upon an understanding of contextually specific evolving experiences and perceptions of the glass-ceiling that emerge and re-emerge at differing stages of an overall leadership journey. For example, as women progress in their leadership pathways, new barriers occur. Promotion may initially be viewed positively, yet arguably it brings accompanying challenges. We advocate the adoption of

multi-faceted approaches in organisational practice during specific career episodes, thereby providing an array of tailored support to women navigating a raft of gendered conditions.

This study was limited to mental health nurses within the NHS in the England and in keeping with our ontological position and qualitative epistemological approach, generalisability was not an overall research goal (Denzin and Lincoln, 2011). Future longitudinal studies may be conducted in different contexts and occupational sectors to progress understanding.

Additionally, longitudinal research on the perceptions and lived experiences of the glass-ceiling through the lens of intersectionality to elevate understanding in relation to the diversity of women's experiences would further enrich debate (Atewologun and Sealey, 2014). Given the persistent damaging nature of the glass-ceiling for women's careers, even over 40 years on from the inception of the term, we assert the importance of pursuing this research agenda.

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Table 1: Demographic details of participants and the control group

		Percentage (n = 27)	
		Participants	Control
Age	Mean	36	38
	Range	26-51	26-56
Ethnic Background	British – White	85.1 (23)	96.2 (26)
	British –Afro Caribbean	3.7 (01)	-
	Mixed Race	3.7 (01)	3.7 (01)
	Indian	7.4 (02)	-
Children under 18 living with participants	Yes	74.0 (20)	77.7 (21)
	No	25.9 (07)	22.2 (06)
Highest Educational Level/Attainment	Diploma	14.8 (04)	18.5 (05)
	Advanced Diploma	14.8 (04)	14.8 (04)
	Degree	55.5 (15)	48.1 (13)
	Masters	11.1 (03)	18.5 (05)
	MPhil	3.7 (01)	-
Nursing Band	6	18.5 (05)	22.2 (06)
	7	59.2 (16)	51.8 (14)
	8	18.5 (05)	14.8 (04)
	9	3.7 (01)	11.1 (03)
Length in Role	Less than 1 year	48.1 (13)	29.6 (08)
	1-5 years	37.0 (10)	55.5 (15)
	6-10 years	7.4 (02)	7.4 (02)
	11-15 years	3.7 (01)	3.7 (01)
	16-20 years	3.7 (01)	3.7 (01)

Table 2: Research Questions

Time Point(s) Questions asked	Semi-structured Interview Schedule
T1-T3	What does the glass-ceiling mean to you?
T1-T3	To what extent do you feel a glass-ceiling exists in mental health nursing in the NHS? In your opinion, why do you think this is the case?
T1-T3	To what extent do you feel a glass-ceiling exists in mental health nursing in your Trust? In your opinion, why do you think this is the case?
T2-T3	Do you think your understanding of and/or perception of the glass-ceiling has changed since we last spoke? If so, please explain.
T2-T3	Has your role changed in the last six months? If so, please explain. <i>If appropriate for programme participants</i> - To what extent do you consider this to be a result of participating in the programme?
T2-T3	Do you consider that you have experienced any barriers to your career advancement since we last spoke? If so, please explain.
T1-T3	In your opinion, what can NHS Trusts do to support female mental health nurses navigate the glass-ceiling?
T1-T3	Any other comments/views you think may be relevant?