Received: 29 March 2021 | Revised: 15 November 2021 | Accepted: 21 December 2021

DOI: 10.1111/1748-8583.12434

Human Resource Management Journal WILEY

RESEARCH ARTICLE

Maternal (perinatal) mental health and employment: An agenda for research and practice

Krystal Wilkinson

Department of People and Performance, Centre for Decent Work and Productivity, Manchester Metropolitan University, Manchester, UK

Correspondence
Krystal Wilkinson, Department of People and Performance, Centre for Decent Work and Productivity, Manchester Metropolitan University, Business School, All Saints, Manchester M15 6BH, UK.
Email: k.wilkinson@mmu.ac.uk

Abstract

Whilst there is a rich literature on maternity and employment, and an emerging literature on mental health and employment, which inform policy and human resources (HR) practice, there is a lack of consideration of the intersection of these issues—the two-way relationship between maternal (specifically 'perinatal') mental health and employment. To understand individual employee perinatal mental health and employment experiences and pathways, and also trends in workplace experience in different contexts, researchers should consider the interaction of four elements: the body; the socio-cultural context; individual agency and time. Drawing on existing transdisciplinary literature and illustrative examples from the UK context, a series of issues for exploration are identified at different levels of a bio-ecological systems framework. The article concludes with implications for HR management practice.

KEYWORDS
equal opportunities, gender, maternity, mental health, qualitative research methods, wellbeing

1 | INTRODUCTION

Whilst there is a rich literature on maternity and employment (see Gatrell, 2011a; Stumbitz et al., 2018, for reviews), and emerging literature on mental health and employment (see Follmer & Jones, 2018, for review), which inform

Abbreviations: HR, human resources; HRM, human resource management; KIT, Keeping in Touch; NHS, National Health Service; PMI, perinatal mental illness; PTSD, post-traumatic stress disorder.

Practitioner notes

What is currently known?

- There is a lack of academic and practitioner literature on the intersection of maternal (perinatal) mental health and employment.

What this paper adds?

- This paper uses bio-ecological systems theory, informed by rhythmanalysis, as a robust theoretical framework for researching this issue.
- This framework considers the intersection of biology, socio-cultural context, agency and time.
- The paper proposes an agenda for research and practice.

Implications for practice

- Human resource (HR) practitioners can use this framework to audit their context, policies and practices in terms of maternal (perinatal) mental health support.
- A range of recommendations are made to improve support for perinatal mental health at work.
- HR should consider including specialist health professionals where appropriate in individual employee case management.

policy and human resources (HR) practice, there is omission of consideration of the intersection of these issues in both research and practice—the two-way relationship between maternal (specifically 'perinatal') mental illness and employment. The aim of this article is to develop a robust theoretical framework for exploring this intersection, and an agenda for research and practice, akin to Atkinson et al. (2021) paper on menopause and employment. The paper draws on existing transdisciplinary literature, and illustrative examples from the UK context.

In this article, the term perinatal mental illness (PMI) is used to refer to mental illness occurring during pregnancy and/or up to 1-year post-birth, the definition used by the UK's National Health Service (NHS). It is acknowledged, however, that many PMI episodes last longer (Vliegen et al., 2014, p. 14). Whilst postnatal depression is the most well-known, a range of mental illnesses can occur at this time including anxiety, obsessive compulsive, and post-traumatic stress disorders (PTSD) (O'Hara & Wisner, 2014), elaborated below.

It is extremely important that scholars and HR practitioners consider the intersection of PMI and work. From a social responsibility perspective, maternal and mental health are international public policy goals (WHO). PMI affects up to 20% of expectant/new mothers (NHS), often goes unrecognised, undiagnosed and untreated (Law et al., 2021), and can have significant consequences for mothers, infants and families (NHS). A large proportion of women experience the issue whilst employed, and yet the author is aware of few empirical studies or theoretical papers that address this issue. From a business case perspective, supportive management of PMI is likely to positively impact employee attendance, performance and retention, and yet the issue appears largely absent from HR radars.

The contributions of this paper are as follows: The first is bringing PMI to the attention of organisation scholars and the HR community. The second contribution is the development of a robust theoretical framework for exploring the intersection of PMI and employment, and pathways of experience, based on ecological systems theory (Bronfenbrenner, 1979), informed by rhythmanalysis (Lefebvre, 2004; Toyoki et al., 2006). This framework takes account of four key factors: biology, socio-cultural context (micro- through to macro-level), individual agency and time. The third contribution is the development of a research agenda for perinatal mental health and employment, developed from the framework and existing transdisciplinary literature. The final contribution is a set of recommendations for HR practitioners, which include auditing current context, policies and practice, and then improving the PMI 'rhythm intelligence' (Rouse et al., 2021) of their organisation and key stakeholders. Practitioners are encouraged to consider including specialist health professionals where appropriate in individual employee case management.

The next section provides the rationale for a theoretical framework accounting for biology, environment, agency and time. Bio-ecological systems theory is introduced, with some additions from rhythmanalysis, which is useful for theorising the 'arrhythmia' likely in PMI and employment pathways of experience. A table then summarises the framework and associated research agenda, before key elements are discussed in turn, with reference to insights from transdisciplinary literature. The paper concludes with implications for human resource management (HRM).

2 | PMI AND EMPLOYMENT: ACKNOWLEDGING BIOLOGY, ENVIRONMENT, AGENCY AND TIME

PMI is classed as a 'significant complication' of pregnancy/the postpartum period (O'Hara & Wisner, 2014), whilst maternity itself presents significant bodily changes. Both affect different women in different ways, and specific women in different ways over time (at different stages of maternity/course of mental illness). As such, any theoretical framework for understanding the intersection of PMI and employment should consider biological experience. Symptoms and severity are likely to impact a woman's ability to do her job, attend work and remain in work/return to work after maternity leave. The body is also embedded within a specific socio-cultural context, and a range of structural/cultural factors will influence how pregnancy and PMI are conceptualised, experienced, and intersect with work for any individual woman.

Ecological systems approaches accept holistic conceptions that consider biological, psychological, sociocultural and physical environmental elements (Stokols, 2000). Originally designed to theorise early childhood development, bio-ecological systems theory (Bronfenbrenner, 1979) addresses an individual's relationships in and within particular contexts. It has been used by researchers with various disciplinary interests, including wellbeing at work (Bone, 2015), employee relations and the work–life interface (Pocock et al., 2012; Voydanoff, 2008); mental health recovery (Kelly & Coughlan, 2019) and inclusive organisations (Doughty & Moore, 2021).

Bio-ecological systems theory can be used to map how an individual (bodily experience) interacts with a multi-layered socio-cultural context, in a temporal way. The theory divides a person's environment into five ecological levels: microsystem (micro-settings of interest), which has the strongest level of influence; mesosystem (how micro-settings interact); exosystem (indirect environments); macrosystem (society) and chronosystem (space through time) (Bronfenbrenner, 1999, p. 20). The five systems are interrelated, and ecological systems can be either positive or hostile for an individual (Bone, 2015).

Applied to PMI and employment, key micro-settings are the workplace, healthcare system (the individual's interactions with medical professionals) and home, as well as possibly the community, including peer support. Roles, relationships and safety within each domain are crucial (Bronfenbrenner, 1979) as are how domains interact with each other (mesosystem) and with the body. In relation to the latter, specific job or home contexts might make PMI more likely or symptoms more severe, and healthcare context will influence diagnosis and treatment. Each of the micro-settings and the mesosystem are in turn informed by the next levels. The exosystem incorporates formal and informal social structures which do not themselves contain the individual as an active participant, 'but in which events occur that affect, or are affected by, what happens in the [micro] setting' (Bronfenbrenner, 1979, p. 25). This level contains employment regulation, healthcare and welfare systems, as well as cultural norms around motherhood and mental health. The macro-system refers to 'consistencies, in the form and content of lower-order systems (micro-, meso- and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems' (Bronfenbrenner, 1979, p. 26). Capitalism, pro-masculine gender orders (Acker, 1990; Bradley, 2012) and 'ablism' (Alvesson & Karreman, 2000) are likely the most important forces shaping PMI and employment experience, although other forces may be influential for specific women based on their intersectional positioning.

The chronosystem recognises that for particular interactions to be effective, they must occur regularly over extended periods (Bronfenbrenner, 2000), but also that chaos can 'interrupt and undermine the formation and stability of relationships and activities' (Bronfenbrenner, 2000, p. 133). The chronosystem takes account of both historical

time (changes to the socio-cultural environment) and biographical time, which in our case includes biological changes over time; relationship changes over time; and skills development over time (affecting 'bargaining power' in the employment relationship; and problem-solving abilities in relation to new family demands). The notion of the chronosystem, and disruptions to stable relationships and activities has parallels to the notion of 'arrhythmia' within rhythmanalysis (Lefebvre, 2004; Toyoki et al., 2006). It is likely that the rhythms of a woman's body and the rhythms of her employment will be disrupted by pregnancy and PMI, causing arrhythmia (see Rouse et al., 2021). The conceptualisation of agency in rhythmanalysis is useful in theorising possible responses.

In rhythmanalysis, agency has a specific temporal orientation, being predominantly past-focused repetitive/routine (acting to preserve existing rhythms); practical-evaluative (creating a new solution in the moment) or projective (with reference to future rhythm concerns). (Toyoki et al., 2006, p. 104) state that actors may have 'more or less conscious knowledge of the various temporal and spatial forces that are in play in any given situation', but tend *not* to innovate rhythms, performing practices that comply with *cultural schemas* (generalized notions of appropriate patterns of action/norms), *governance regimes* (institutionalised sets of recurring and systematic connections between social roles) and *resource* distributions handed on from the past. These additional rhythmanalysis concepts are used in the framework to categorise influencing factors at the micro- and exo-system levels.

Literature on maternity and employment, and also mental health and employment, seems to support the notion that key stakeholders tend to preserve existing work rhythms, rather than demanding change to governance regimes, cultural schemas and resource distributions to accommodate arrhythmia. Silence at work about mental illness is a common employee strategy (King & Botsford, 2009), as conditions can remain invisible (Ragins, 2008) unless behavioural change is extreme. Presenteeism is also common in this population (Elraz, 2018). Such strategies prohibit work(place) accommodations being made/offered, even where potentially available. Silence at work is also common in early pregnancy, with women employing other strategies over time (as disclosure becomes inevitable) to manage the pregnant body as 'controllable [and] linear' at work, even when personally experienced as 'messy and unpredictable' (Gatrell, 2011a). Routine and practical-evaluative strategies to downplay arrhythmia include pregnant presenteeism (remaining present at work despite nausea, exhaustion and other symptoms) (Gatrell, 2011c; Haynes, 2008); 'supra-performance' (Gatrell, 2011b) defined as performing above expected standards; and 'maternal stoicism' (Gatrell, 2013; van Amsterdam, 2014)—coping with competing physical demands and tolerating discrimination/sidelining. Interestingly, Gatrell primarily researched UK professionals, suggesting even relatively privileged women—in terms of governance regimes (maternity rights), cultural schemas (working motherhood norm) and resources (qualifications and bargaining power)—resorted to agency that maintained, rather than challenged, existing work rhythms that were 'unfriendly' to their maternal bodies. Even when formally requesting a change to work rhythms, via flexible working applications upon return from maternity leave, women have been found to engage in 'edited disclosure' (Rouse et al., 2021), attempting to resolve most arrhythmia themselves.

Employers/managers appear to act in a similar way. Formal requests for flexible working following maternity leave are often refused, or inadequate accommodations made to enable success (Rouse et al., 2021), even where this causes managers problems personally. This results in a feedback loop incorrectly reinforcing beliefs that work and maternity rhythms are incompatible, which then justifies continued rejecting and under-accommodating. More broadly, we have ongoing reports of discrimination against, and negative treatment of, maternal and ill bodies at work, in the United Kingdom and beyond, despite years of employment legislation (i.e., CIPD, 2016; Stevenson & Farmer, 2017; Martin et al., 2018). Consciously or unconsciously, key stakeholders appear unlikely to adjust work rhythms, despite the potential of maternal and ill bodies, given appropriate support.

Scholars such as Rouse and Sappleton (2009) have called for interventions to help managers and employees develop practical-evaluative and projective skills to better negotiate supportive maternity management. Research has yet to consider the actions and decision-making of both managers and employees when it comes to PMI and employment, and the support both might need in determining and actioning workplace adjustments. Because PMI is a dual physical/mental condition, there may be more opportunity for it to be revealed as a workplace issue and framed as a management/HR responsibility to resolve.

Bio-ecological systems theory, informed by concepts from rhythmanalysis, is proposed as a fruitful framework for exploring individual PMI and employment experiences; pathways of experience; and accumulation of insights and comparison across contexts.

3 | THE FRAMEWORK APPLIED AND AGENDA FOR RESEARCH

Table 1 sets out the conceptual framework by level, mapped to research focus for organisational/HRM scholars. This is followed by a discussion of each level of the system.

4 | THE BODY EXPERIENCING PMI

The biological experiences of relevance to our enquiry are maternity and mental illness. A woman's body goes through many changes in the perinatal period: a 'novel rhythm of conception, gestation, and childbirth' (Rouse et al., 2021, p. 5). A woman may experience a range of different physical and mental symptoms, to varying levels of severity, at different times. These disrupt normal bodily rhythms, and how they intersect with other rhythms such as employment.

PMI includes a range of conditions. Depression and anxiety disorders (pre- and/or post-natal) are the most common and range from mild to severe (O'Hara & Wisner, 2014). A lesser known, but extremely serious condition is post-partum psychosis, which presents rapidly after birth, with mood fluctuation, confusion, and marked cognitive impairment (bizarre behaviour, hallucinations) (O'Hara & Wisner, 2014). There is also perinatal obsessive–compulsive disorder (OCD) and perinatal eating disorders. Individuals may experience PTSD triggered by birth or Neonatal Intensive Care Unit experience (Shaw et al., 2009). Pre-natal illnesses are unlikely to stop at birth (Vliegen et al., 2014, p. 14), co-morbidity is common (i.e., depression and anxiety experienced together) (O'Hara & Wisner, 2014), and there is a high risk (around 40%) of subsequent perinatal and non-perinatal (not linked to pregnancy) relapse (NICE, 2014).

Available literature (O'Hara & Wisner, 2014) suggests certain PMI experiences may affect rhythms/pathways differently. An episode of mental illness starting in the perinatal period may be the first experience of mental illness for a woman, arising due to a mixture of genetics, biological change and psychosocial change (NHS, 2017). This might come as a significant 'shock' to a woman, and she might be unaware of sources of support, including at work. Alternatively, PMI might occur after prior mental health issues. Pre-existing diagnoses place a woman at higher risk of developing PMI (O'Hara & Wisner, 2014), and certain occupational contexts make this more likely, such as PTSD frequency in the police/military (Martin et al., 2009). A complex fertility history might also have an impact. It is well established that infertility, fertility treatment and miscarriage are linked to adverse mental health, including anxiety, depression, and suicidal thoughts (American Pregnancy Association, 2019; Griel et al., 2010; Verhaak et al., 2007). Miscarriage or ectopic pregnancy might also invoke PTSD (Farren et al., 2020). A history of fertility/pregnancy problems might also foreground potential complications in an expectant mother's mind, increasing anxiety (Gaudet et al., 2010). Prior mental health or fertility-related struggles might improve a woman's ability to identify new psychological symptoms, but potentially impede her ability to manage/overcome them. The rhythm pathways of these different experiences, in terms of the intersection with work, may be quite different (elaborated below).

Mental health rhythms are affected not only by triggers, symptoms and severity, but also by diagnosis (or not) and treatment, as informed by other levels of the bio-ecological system. Treatments for PMI vary and include psychological counselling, medication, and hospitalisation for extreme cases (O'Hara & Wisner, 2014)—each with their own temporal pathway. Taking the example of medication for depression, these often take weeks before showing full effect, can make an individual feel worse initially, and can induce a range of side effects (NHS, 2021). Furthermore, an individual may try several medications before finding the best one, with each change requiring a period to wean off the last one (NHS, 2021). These issues need to be factored into support for PMI in the workplace.

TABLE 1 Conceptual framework and research agenda

Level	Focus	Indicative factors	Indicative research interests for HRM/organisation studies
Individual	Biology	Stage of maternity; body changes; mental illness episode(s); symptoms; reaction to medications (side effects); behaviours	- Responses to symptoms/side effects
		Embodied knowing and agency	- Impact of symptoms/side effects on capabilities (performance, attendance, maternity management strategies)
		Other biological intersections, i.e. age, ethnicity	- Employee identity
			- Employee sense of control and predictability over their body (at work)
Microsystem	Work micro-setting	Governance regimes: Such as, working hours; leave entitlements; policies (maternity, absence, flexible Working, etc.); working environment; reporting lines and spans of management control; communication channels	- Nature of arrhythmia
		Cultural schemas: Such as, leadership styles; attitudes; norms	- Impact of workplace on ability to access treatment (attend appointments/insurance)
		Resources: Such as, skills; salary; autonomy; length of service; friendships; competence/experience of managers and HR; wellbeing provisions; benefits; access to childcare	- Employee strategies re. Arrhythmia
		Agency: Employee; manager; colleagues, HR	- Manager strategies re. Arrhythmia
			- HR strategies re. Arrhythmia
			- Employee bargaining power and sense of entitlement to support
			- Discrimination
			- Level of support from colleagues
	Medical micro-setting	Governance regimes: Maternity and mental health provisions, criteria, funding, and resourcing; staffing levels/workloads; opening hours and operations	- Impact of healthcare experience on workplace experience (linked to diagnosis and treatment)
		Cultural schemas: Assumptions about need (who is screened, etc.); attitudes towards different treatments	
		Resources: Medical professional competence/experience	
		Agency: Individual; health professionals	
	Home/family	Family role; household finances; partner/family support with childcare; emotional and physical safety in home; involvement of extended family	- Impact of home experience on mental health and work experience
	Community	Peer support for pregnancy, new motherhood, PMI	- Impact of community experience on mental health and work experience

TABLE 1 (Continued)

Level	Focus	Indicative factors	Indicative research interests for HRM/organisation studies
Mesosystem	Interactions between micro-settings	Relationships; communications; and alignment of goals	- The extent to which medical professionals and home dynamics input into work experience
Exosystem	Other social structures	Governance regimes: Such as, labour markets; employment legislation; social policy; healthcare systems and funding; trade unions; tribunal system rules	- Analysis of national policy and legislation
		Cultural schemas: Such as, narratives around working motherhood and maternal mental health; industry work cultures; power of trade unions; presence of mothers in leadership roles	- Patterns of experience (i.e., discrimination or disclosure) in different workplaces/industries
		Resources: Specialist charities	- Patterns in tribunal claims - Influence of stigma, but also social 'narratives of support' (i.e., mental health campaigning) - Influence of third sector institutions on individual agency and workplace experience
Macrosystem	Society/culture	Neoliberalism; gender orders; ablism; geography	- International/comparative research
Chronosystem	Temporality (past, present and future)	Historical time	- Impact of biography (including job history) on conditions/symptoms
		Biographical time	- Impact of biography on agency
		Relationships over time	- Impact of projective-thinking in decision-making of key actors - Impact of changes to policy and cultures - Individual pathway experiences over time - Employee–line manager relationships over time, and the impact on agency and pathway experiences - Employee–colleague relationships over time, and the impact on agency and pathway experiences - Reinforcement or elaboration of work rhythms

Abbreviations: HR, human resources; PMI, perinatal mental illness.

There is a two-directional relationship between mental health and work. Engagement with work can impact mental health and recovery either positively or negatively (Martin & Fisher, 2014; Stevenson & Farmer, 2017), with the nature of the work being key. Stressful work, precarious employment and discrimination have been linked to PMI (Kachi et al., 2021; Karl et al., 2020). Mental illness also impacts upon work, limiting ability to engage in or fully meet the requirements of certain jobs (Follmer & Jones, 2018).

Material feminism (Alaimo & Hekman, 2008) is useful in conceptualising how the body relates to other levels of the framework and informs pathway experiences. The movement is key in advancing theoretical insights into the materiality of bodies, and registers the interplay of biology, agency and society, via the 'inextricable entanglements of bodies in time and space, with histories, the socio-political and the material (see Grosz, 2004)' (Warin, 2015, p. 52). This is sometimes lacking in management/organisation studies (Fotaki et al., 2014). Material feminism acknowledges that women experiencing PMI have some degree of agency—via constantly acquiring capabilities and capacities (Grosz, 2004)—in how they view and react to their bodies, symptoms and side effects, as well as these bodies, symptoms and side effects limiting certain capacities. Embodied 'knowing' and agency will be informed by the woman's history; other bodies and non-human material she encounters; as well as discourse/socio-political contexts (see Katila, 2019). She has some degree of choice over whether/the extent to which/and how she interacts with other bodies, material and discourse in the different micro-settings (health services; workplace; home and community).

5 | THE MACRO- AND EXOSYSTEM: SETTING THE SCENE FOR WORKPLACE EXPERIENCE

As noted above, the macro-system is said to refer to ideology/beliefs at the level of culture or subculture, that impact all other levels of the bio-ecological system. Capitalism, gender orders, and ablism have long been identified as dominant, global forces. These forces, especially working together, position maternal and 'ill' bodies as 'problematic' in the labour market and workplace—contrasted to the 'ideal worker' who can work full time, long hours, unencumbered and constantly visible (Acker, 1990; Bradley, 2012). They also inform cultural schemas around 'good motherhood', and how a mother is supposed to feel about pregnancy and her new baby (Law et al., 2021).

Experiencing something that sits at odds with dominant narratives can invoke stigma, and self-stigma. Stigma is defined as an attribute or 'mark' considered abnormal, flawed or deviant and that is apparent to others (Goffman, 1963). Individuals who share a given stigma are categorised as similar and assumed to exhibit (often negative) attributes/behaviours, resulting in stereotyping and discrimination. The degree of stigma connected to an identity varies along multiple dimensions, including course, disruptiveness, aesthetic qualities, origin and peril (Jones et al., 1984). Maternity can be considered 'disruptive' and problematic 'aesthetically', especially in the workplace (Gatrell, 2011a). Mental illness is similarly disruptive and may be linked to peril (dangerousness) (see Corrigan et al., 2007), unpredictable course (fluctuation in symptoms) and confusion about origin (perceptions that an individual can 'snap out of' a mental illness episode). These features were observed by Follmer and Jones (2018), who concluded that mental health stigma is more significant and problematic than stigma around other concealable identities/disabilities (see also Stevenson & Farmer, 2017). Maternity and mental illness together is likely to result in compound stigma, considered even more disruptive and unpredictable (Dolman et al., 2013). Stigma, along with the 'ideal worker' and 'good mother' narratives from which they derive, inevitably infiltrate the micro-system and influence relationships and attitudes (Follmer & Jones, 2018; Gatrell, 2011b; Haynes, 2008). The contrast between PMI and good mother norms has been found to invoke stigma even among some healthcare professionals (Dolman et al., 2013).

Acknowledging the chronosystem, whilst capitalism, gender orders and ablism have proved resilient forces over time, international research and activism highlighting employment discrimination has resulted in exosystem (i.e., government and legislative) protections. Taking the UK context, 'pregnancy and maternity', and 'disability' (which includes mental illness), are classed as 'protected characteristics'[1] within the Equality Act 2010. It is unlawful to discriminate against someone at work because of a protected characteristic, and the Act provides a legal obligation for organisations to make 'reasonable adjustments'[2] to accommodate disability—thus to adapt work rhythms to an appropriate degree. Maternity entitlements are also relatively generous for many employed women—with leave entitlements of up to 1 year, and payments for 9 months. There are also options around 'shared parental leave', the 'right to request flexible working' and Keeping in Touch (KIT) days[3]—all designed to provide greater flexibility between the work and home micro-settings. Organisations are required to carry out maternity risk assessments to audit the job/work envi-

ronment and make changes or provide paid leave where appropriate. Maternity- and disability-related absence are also recorded differently to other absence, to minimise negative consequences. If employers fail to follow legislation, there is an employment tribunal system for individuals to seek recompense.

Unfortunately, such legislation neglects PMI. Postnatal maternity-related absence is not recorded in the same ways as absence in pregnancy or disability. There is nothing in maternity risk assessments to pick up on mental illness, and KIT days are not about wellbeing or planning for required adjustments upon return to work. Furthermore, PMI is unlikely to qualify as disability, as the latter is 'long-term' (equating to a year or more), when PMI durations vary (O'Hara & Wisner, 2014) and a woman may not recognise that the problem may persist. Furthermore, where women experience discrimination on the grounds of maternity, they are unlikely to pursue employment tribunal due to the 'prohibitively short' (Baska, 2019) time limit (3 months) for bringing a claim. This limit may be especially problematic when a woman experiences PMI as she may not recognise an employer's actions as discrimination and/or have energy to raise a challenge. HR professionals can seek to understand their specific exosystem and mitigate gaps in legislative provisions within organisational policies.

International and comparative research is important at the macro level. Stumbitz et al. (2018) note that most countries provide *some* women with maternity leave rights, although many women internationally have no right to leave and receive no pay. Different countries also have different perinatal mental health services, based on funding and other factors. The United Kingdom is world-leading in this respect, with specialist community services in all 44 local NHS areas in England, 14 dedicated mother and baby units, and plans for the extension of perinatal services to 2-year post-birth by 2023/2024 (NHS). Cultural schemas also vary by geographic location, including those around mental health (i.e., Choudhry et al., 2016), maternity (i.e., Danziger, 2012) and wellbeing/psychosocial safety at work.

6 | THE MICRO- AND CHRONOSYSTEM: WORKPLACE SUPPORT OVER TIME

The microsystem is defined as 'a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting' (Bronfenbrenner, 1979, p. 22). It is composed of two or more 'micro-settings', which have a key influence on specific experience. These settings are places that the individual directly engages with and are therefore experiential spaces where they form perceptions. Micro-settings thus have both objective and perceived properties (Bronfenbrenner, 1979) which can inform action.

Due to space constraints, the main discussion here relates to the workplace micro-setting. I will add, however, some worrying information regarding the health micro-setting. A recent Guardian article drew on findings from a UK National Childcare Trust survey to state that much PMI goes undetected because many new mothers are given as little as three minutes to discuss feelings and mental health at the 6-week postnatal check-up, with a sixth given no time at all (Campbell, 2019). Furthermore, women may worry about telling healthcare professionals how they feel, fearing judgement, or that their child will be taken away (Royal College of Psychiatrists, 2018). Such issues impact disclosure at work, and availability of evidence to support disclosure.

Workplace roles, relationships and safety, as experienced by an individual, are informed by the interaction of various governance regimes, cultural schemas, resources and agency (see Table 1). It is here that exosystem factors are mediated and translated into policy, practice and workplace norms. Maternity and wellbeing policies thus have the potential to go above and beyond regulatory protections, or on the other hand, cultural norms and workloads could lead managers to block access to entitlements or send messages that take-up would be frowned upon (see Kossek et al., 2011). This is where agency (especially routine) may impede policies from meaningfully changing workplace rhythms.

When it comes to line managers, numerous issues can prevent supportive responses in relation to PMI, alongside ignorance or hostility. These include confidence (Shann et al., 2014); lack of procedural knowledge (Martin et al., 2015); and/or fears of awkwardness, of offending, or of handling the situation badly (Martin et al., 2018)—especially in relation to personal characteristics that carry special legislative protection. Such challenges are exacerbat-

ed where organisational support and guidance around appropriate action is lacking (Martin et al., 2018), which seems likely with PMI. Managers must also balance the needs of the affected employee with co-workers (especially those taking on additional workload) to avoid team-level animosity (Ladegaard et al., 2019), and with their own wellbeing (Martin et al., 2018). Appropriate training interventions and support for managers can help to mitigate such issues.

Relationships are temporally informed, and it is important to consider how workplace support for PMI may vary over time. First, there are issues to consider relating to the temporality of maternity itself, and how this relates to exosystem governance regimes. Let us start with disclosure. If mental illness coincides with the pregnancy stage of maternity, a woman in the United Kingdom may be more likely to disclose this to their manager than if it occurs postnatally, especially during maternity leave. During pregnancy, UK legislation mandates a maternity risk assessment, and there are likely to be other discussions between manager and employee around maternity planning (i.e., maternity leave timing and duration). This provides an opportunity for PMI disclosure, especially where the relationship is positive. Where the relationship is negative, silence seems more likely (see Brouwers et al., 2020, for discussion of temporality and relationships in mental health disclosure decisions). Here, silence may well be enabled by the protections around sickness-absence reporting during pregnancy. A woman could give a physical health reason for PMI-related issues/absence if she perceived this to be less stigmatising, knowing it would be reported non-punitively. If PMI occurs during maternity leave, however, a woman may be more reluctant to disclose, even where the relationship with the manager is positive. She may hope/believe the condition will have improved by the return-to-work date, and there may be less opportunities to raise the issue (less interactions). As time passes and the expected return date looms closer, she may become more anxious, feeling bad for the lack of disclosure earlier, and so avoid communicating or taking up KIT days. Where illness is ongoing at the point of expected return, she may choose to resign and/or exit the labour market entirely, with her manager unaware of the reason. Maternity policies that include information on PMI may be beneficial here, giving women a reference document for raising concerns about their mental health at whatever point they occur.

The timing of PMI within maternity may also impact manager reaction, if disclosed. If occurring during pregnancy, a manager may feel obligated to engage in discussion with the employee about reasonable adjustments. This fits with expectations around maternity risk assessments. Where postnatal, however, the manager may be less inclined to act. The exosystem governance regime of maternity leave, designed as a benefit to women, may act against a new mother here, when combined with neoliberal and masculine management cultures. Employees on maternity leave are often considered outside of business operations and so not a legitimate concern (Rouse et al., 2021). Even supportive managers may consider it inappropriate to contact women during maternity leave, as well as ill equipped to plan an appropriate return to work should PMI be disclosed. Clear requirements within maternity policies for regular wellbeing checks, including throughout maternity leave, would increase manager sense of responsibility. This intervention will also provide an opportunity for women to speak up, helping to mitigate the issue raised in the last paragraph.

Relationships are temporally informed beyond the maternity timeline—by the history of the relationship, and of each actor. How PMI is managed will depend on whether this is the first experience of acute arrhythmia within the relationship, and how each party has previously experienced/managed arrhythmia. If the employee had a pre-existing mental illness, complex fertility journey or similar, that affected their work, the employee and manager might have negotiated rhythm adjustments to minimise disruption (practical evaluative agency). In such cases, past skills and practices can be drawn upon (see Martin et al., 2018), although this instance may prove more unique. If the individual had recently changed manager, however, this joint history (resource) would be absent. Each individual has their own history, however, and so a manager with extensive experience managing other employees through arrhythmia of different types might have accrued sufficient 'rhythm intelligence' (Rouse et al., 2021) to apply their learning to this context. To avoid the handling of PMI being 'luck of the draw' in terms of management competence, management development interventions around wellbeing at work (Mellor & Webster, 2013) are needed, which might include coaching, case studies and role plays, as well as information on policies and procedures.

A history of mental illness or other arryhthmia may cause its own problems, however, in terms of PMI disclosure and support available. If an employer/manager has made accommodations in the past, and/or colleagues have picked

up additional work, an employee may worry about the 'balance sheet' of credits on which adjustment relies (Dex & Scheibl, 2001), and feel unable to make another request. On the other hand, if prior instances of mental illness/arrhythmia have been handled badly, and the employee felt unsupported (see research on psychological contact breach, i.e., Zhao et al., 2007) and unable to satisfactorily perform their job duties, then a new episode, with the compound stigma associated with PMI and potentially additional responsibilities around infant care, may push a woman to take action. She may feel the work-life situation is untenable and so quit the job/labour market. To mitigate such perceptions, communications campaigns may be important, to show that positive handling of maternity/mental health at work is possible and in the business interest. It is also important to show that there are alternative avenues to access support if the line manager is deemed unsupportive (including HR). The actions of employees and management, where visible to others, will have an influence on evolving cultural schemas—signalling to others whether work–life arrhythmia will be supportively handled (Law et al., 2011).

7 | OPPORTUNITIES FROM THE MESOSYSTEM

As stated above, the mesosystem refers to the interactions between different micro-settings. Following Doughty and Moore (2021), communications, relationships and alignment of goals are important here. When it comes to knowing how best to support a specific employee experiencing PMI in the workplace, HR should consider how best to communicate, and build relationships with, key actors in the healthcare and home micro-settings who have the same goal—helping the woman navigate her new polyrhythmic assemblage, including maternity and the rhythms of mental illness and treatment. It is important for work and healthcare settings to be aware of supports and safety at home, in terms of whether the woman has access to a safe partner, or other support system, who offers logistical and emotional support, and a safe living environment. If the woman is under specialist perinatal mental health services, she may have a key worker well placed to understand her condition; home situation; how her condition and supports might affect ability to attend/perform at work; and what work adjustments might be helpful. Depending on maternity stage and mental health history, the key worker might be a specialist midwife, specialist health visitor or psychiatric nurse. If the woman is not under specialist services, her doctor, midwife or health visitor may be appropriate. Such professionals could be invited to contribute to meetings or asked to provide letters/reports to aid in maternity planning. In all instances, however, the ability (linked to skills, but also time pressures) and willingness of the health professional will have an impact on the success of such strategy. This leads to potential action points for decision-makers within health care that are beyond the remit of this paper.

8 | IMPLICATIONS FOR HRM

The literature reviewed, applied via a bio-ecological systems framework, suggests there is still some way to go to accommodate the rhythms of maternity and mental health within the rhythms of work, even in the United Kingdom, where maternity entitlements are relatively generous; there is legislative protection around maternity and mental health at work; and health services are world leading. When it comes to PMI and employment, arrhythmia unfortunately seems likely. So what is the role of HR?

Whilst HR professionals do not have control over the macro and exosystem forces that inform their organisational contexts, they do have some influence over governance regimes and cultural schemas relevant to maternity management, wellbeing at work, and the nature of relationships between employees and their managers. HR professionals should start by auditing their ecological system and considering the impact of macro and exosystem factors on their culture, governance regimes and the likely resources of differently positioned employees. This will help inform a picture of how supportive their workplace is likely to be for those experiencing PMI and highlight opportunities for improvement.

In terms of governance regimes, amendments can be made to maternity policies, disability policies, maternity risk assessments and absence management processes. As there are likely to be many unknowns in the management of PMI, dialogue and flexibility appear important. As noted above, policies should require managers to have regular discussions with an employee throughout the maternity journey and involve specialist health professionals wherever possible. Reasonable adjustments should be considered, including phased returns from maternity leave, and should be regularly reviewed. If a worker reports a collaborative partner or childcare support person in the home micro-setting, and desires their involvement, managers/HR could offer to include that person in developing or refining adjustments. An example might be discussing working hours adjustments to navigate around partner's work demands or a nanny's available hours, to reduce arrhythmia and stress. Sometimes, trial and error may be the strategy required. Teams should be consulted, where workload reallocation decisions affect them, where this would not breach confidentiality. For this to work well, broader governance regimes may need attention. Managers need the autonomy, time and resources to act. They also need to be held accountable, with employee wellbeing included in performance management requirements.

Cultural schemas can be influenced by building narratives of support around various forms of work–life arrhythmia, including maternity and mental illness, although the power of HR in creating culture change remains contested (Ogbonna, 2019). Any reports of discrimination on the grounds of maternity and/or mental illness should be investigated, and any wrongdoing addressed. Cultures of presenteeism should be discouraged, with senior leaders co-opted wherever possible to role-model responsible attitudes towards taking leave when needed, including 'mental health days' (Lamont et al., 2017). There can be specific awareness-raising around PMI, via the promotion of awareness weeks, adding resources to staff intranets, encouraging sharing of stories (including supportive management stories) and peer support mechanisms. Line manager competence can be increased via specific learning and development interventions, with integrated stigma-reduction training (Hamann et al., 2016).

9 | CONCLUSION

Follmer and Jones (2018) note that missing from most studies on mental health and work was a strong theoretical rationale to guide the research questions and hypotheses. Stumbitz et al. (2018) state that there is an urgent need for research on maternity management to consider the complex and embodied transitions from pregnancy to maternity leave and then paid work. They also call for theorising that incorporates positionality and intersectionality. Bioecological systems theory, with additions from rhythmanalysis, is presented as a conceptual framework to encourage a global programme of research on perinatal mental health and employment, and a way for HR professionals to begin to think about the issue. Both the research community and HR practitioners begin from a base of extremely scarce knowledge—the author is aware of no existing research that addresses this topic. Bioecological systems theory explicitly considers the complex inter-relationships between the body, environment, agency and time, and enables exploration of PMI and employment pathways.

Pocock et al. (2012, p. 406) acknowledge that such systems models 'do not tell us what to expect when we begin analysing a system, or how change in one domain will necessarily affect another', instead pointing to 'domains that matter, interactions and factors that are likely to be significant, and the need to locate analysis in a larger macro social and political context'. This paper has indicated the domains that matter to exploring PMI and employment. Empirical research is now essential to draw out the interplay of factors, at different points in time, and in different places. Engaged activist scholarship (Rouse & Woolnough, 2018) is also encouraged, to campaign for change at different levels of the system.

At the level of the workplace, governance regimes, cultural schemas and relationships are presented as key. HR professionals are encouraged to audit and improve the PMI 'rhythm intelligence' (Rouse et al., 2021) of their workplace and key actors. They can work on plugging exosystem support gaps in their policies and procedures, and attempt to influence cultural norms and management accountability. They can also influence the nature of

relationships—both within the work micro-setting (via learning and development interventions) and between the micro-settings of work, health care and home (the meso-system). Evaluation of the impact of any action is vital, to support an ongoing business case for investment.

As a final comment, it is important to note that the framework presented in this paper focusses on the birthing parent. The framework could be usefully adapted to consider the non-birthing partner, or mental illness associated with adoption. It is estimated that one in ten fathers experience PMI (Royal College of General Practitioners, n.d.), a conservative estimate as men are less likely to be screened and diagnosed. Adoptive parents can be similarly affected (Foli et al., 2016). These issues are less widely acknowledged, and there might be greater levels of stigma attached. An individual's experience at work when their partner experiences PMI also warrants consideration, especially if ways of parenting are affected (Beestin et al., 2014). By including partners (where available and supportive) in conversations about reasonable adjustments for PMI, more than one set of employee and workplace could benefit.

ACKNOWLEDGEMENTS

I would like to thank the Associate Editor Maike Andresen and the three anonymous reviewers at *Human Resource Management Journal* for the crucial guidance on the development of the paper, and the encouragement throughout the process.

DATA AVAILABILITY STATEMENT

Data sharing not applicable as no new data generated, or the article describes entirely theoretical research.

ORCID

Krystal Wilkinson https://orcid.org/0000-0003-0391-0870

ENDNOTES

[1] Protected characteristics are 'aspects of a person's identity that make them who they are'. There are nine protected characteristics identified in the Equality Act 2010.

[2] Where someone meets the definition of a disabled person in the Equality Act 2010, employers are required to make reasonable adjustments to any elements of the job which place a disabled person at a substantial disadvantage compared to non-disabled people.

[3] Keeping in Touch days are up to ten days that an individual can work during their maternity/adoption leave without bringing the leave or pay to an end. They are designed so individuals can maintain connections with work and attend training/development activities.

REFERENCES

Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender and Society*, *4*(2), 139–158.

Alaimo, S., & Hekman, S. (2008). *Material feminisms. Bloomington*. Indiana University Press.

Alvesson, M., & Karreman, D. (2000). Varieties of discourse: On the study of organizations through discourse analysis. *Human Relations*, *53*(9), 1125–1149.

American Pregnancy Association. (2019). *After a miscarriage: Surviving emotionally*. https://americanpregnancy.org/pregnancy-loss/miscarriage-surviving-emotionally/

Atkinson, C., Beck, V., Brewis, J., Davies, A., & Duberley, J. (2021). Menopause and the workplace: New directions in HRM research and HR practice. *Human Resource Management Journal*, *31*(1), 49–64.

Baska, M. (2019). *Government must act on maternity discrimination or risk more redundancies, say MPs*. People Management.

Beestin, L., Hugh-Jones, S., & Gough, B. (2014). The impact of maternal postnatal depression on men and their ways of fathering: An interpretative phenomenological analysis. *Psychology and Health*, *29*(6), 717–735.

Bone, K. (2015). The bioecological model: Applications in holistic workplace well-being management. *International Journal of Workplace Health Management*, *8*(4), 256–271.

Bradley, H. (2012). *Gender*. Polity Press.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.
Bronfenbrenner, U. (1999). Environments in developmental perspective: Theoretical and operational models. In S. Friedman & T. Wachs (Eds.), *Measuring environment across the life span: Emerging methods and concepts* (pp. 3–28). American Psychological Association Press.
Bronfenbrenner, U. (2000). Ecological systems theory. In A. Kazdin (Ed.), *Encyclopedia of psychology* (Vol. 3, pp. 129–133). Oxford University Press.
Brouwers, E. P. M., Joosen, M. C. W., Van Zelst, C., & Van Weeghel, J. (2020). To disclose or not to disclose: A multi-stakeholder focus group study on mental health issues in the work environment. *Journal of Occupational Rehabilitation*, *30*(1), 84–92.
Campbell, D. (2019, September 5). *New mothers' mental health problems going undetected, says charity*. The Guardian.
Choudhry, F. R., Mani, V., Ming, L. C. & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta-synthesis. *Neuropsychiatric Disease and Treatment*, *12*, 2807–2818.
CIPD. (2016). *Pregnancy and maternity discrimination*. https://www.cipd.co.uk/news-views/policy-engagement/consultations/maternity-discrimination
Corrigan, P., Larson, J., & Kuwabara, S. (2007). Mental illness stigma and the fundamental components of supported employment. *Rehabilitation Psychology*, *52*(4), 451–457.
Danziger, J. (2012). Childbirth myths around the world. *Midwives*, *15*(4), 42.
Dex, S., & Scheibl, F. (2001). Flexible and family-friendly working arrangements in UK-based SMEs: Business cases. *British Journal of Industrial Relations*, *39*(3), 411–431.
Dolman, C., Jones, I., & Howard, L. (2013). A systematic review and meta-synthesis of the experience of motherhood in women with severe mental illness. *Archives of Women's Mental Health*, *16*(3), 173–196.
Doughty, S., & Moore, J. (2021). Understanding inclusive organizations through ecological systems theory. *International Journal of Research in Business Studies and Management*, *8*(1), 7–14.
Elraz, H. (2018). Identity, mental health and work: How employees with mental health conditions recount stigma and the pejorative discourse of mental illness. *Human Relations*, *71*(5), 722–741.
Farren, J., Jalmbrant, M., Falconieri, N., Mitchell-Jones, N., Bobdiwala, S., Al-Memar, M., Tapp, S., Van Calster, B., Wynants, L., Timmerman, D., & Bourne, T. (2020). Posttraumatic stress, anxiety and depression following miscarriage and ectopic pregnancy: A multicenter, prospective, cohort study. *American Journal of Obstetrics and Gynecology*, *222*(4), 367.e1–367.e22.
Foli, K. J., South, S. C., Lim, E., & Jarnecke, A. M. (2016). Post-adoption depression: Parental classes of depressive symptoms across time. *Journal of Affective Disorders*, *200*, 293–302.
Follmer, K., & Jones, K. (2018). Mental illness in the workplace: An interdisciplinary review and organizational research agenda. *Journal of Management*, *44*(1), 325–351.
Fotaki, M., Dawn Metcalfe, B., & Harding, N. (2014). Writing materiality into management and organization studies through and with Luce Irigaray. *Human Relations*, *67*(10), 1–25.
Gatrell, C. (2011a). Managing the maternal body: A comprehensive review and transdisciplinary analysis. *International Journal of Management Reviews*, *13*(1), 97–112.
Gatrell, C. (2011b). Policy and the pregnant body at work: Strategies of secrecy, silence and supra-performance. *Gender, Work and Organization*, *18*(2), 158–181.
Gatrell, C. (2011c). 'I'm a bad mum': Pregnant presenteeism and poor health at work. *Social Science and Medicine*, *72*(4), 478–485.
Gatrell, C. (2013). Maternal body work: How women managers and professionals negotiate pregnancy and new motherhood at work. *Human Relations*, *66*(5), 621–644.
Gaudet, C., Séjourné, N., Camborieux, L., Rogers, R., & Chabrol, H. (2010). Pregnancy after perinatal loss: Association of grief, anxiety and attachment. *Journal of Reproductive and Infant Psychology*, *28*(3), 240–251.
Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster.
Greil, A. L., Slauson-Blevins, K., & McQuillan, J. (2010). The experience of infertility: A review of recent literature. *Sociology of Health & Illness*, *32*(1), 140–162.
Grosz, E. (2004). *The nick of time: Politics, evolution, and the untimely*. Allen and Unwin.
Hamann, J., Mendel, R., Reichhart, T., Rummel-Kluge, C., & Kissling, W. (2016). A "mental-health-at-the workplace" educational workshop reduces managers' stigma toward depression. *The Journal of Nervous and Mental Disease*, *204*(1), 61–63.
Haynes, K. (2008). Transforming identities: Accounting professionals and the transition to motherhood. *Critical Perspectives on Accounting*, *19*(5), 620–642.
Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., & Scott, R. (1984). *Social stigma: The psychology of marked relationships*. Freeman.
Kachi, Y., Fujiwara, T., Eguchi, H., Inoue, A., Baba, S., Ohta, H., & Tsutsumi, A. (2021). Association between maternity harassment and depression during pregnancy amid the COVID-19 state of emergency. *Journal of Occupational Health*, *63*(1), 12196.

Karl, M., Schaber, R., Kress, V., Kopp, M., Martini, J., Weidner, K., & Garthus-Niegel, S. (2020). Precarious working conditions and psychosocial work stress act as a risk factor for symptoms of postpartum depression during maternity leave: Results from a longitudinal cohort study. *BMC Public Health*, *20*(1), 1–11.

Katila, S. (2019). The mothers in me. *Management Learning*, *50*(1), 129–140.

Kelly, M., & Coughlan, B. (2019). A theory of youth mental health recovery from a parental perspective. *Child and Adolescent Mental Health*, *24*(2), 161–169.

King, E., & Botsford, W. (2009). Managing pregnancy disclosures: Understanding and overcoming the challenges of expectant motherhood at work. *Human Resource Management Review*, *19*(4), 314–323.

Kossek, E. E., Pichler, S., Bodner, T., & Hammer, L. B. (2011). Workplace social support and work–family conflict: A meta-analysis clarifying the influence of general and work–family-specific supervisor and organizational support. *Personnel Psychology*, *64*(2), 289–313.

Ladegaard, Y., Skakon, J., Elrond, A. F., & Netterstrøm, B. (2019). How do line managers experience and handle the return to work of employees on sick leave due to work-related stress? A one-year follow up study. *Disability and Rehabilitation*, *41*(1), 44–52.

Lamont, S., Brunero, S., Perry, L., Duffield, C., Sibbritt, D., Gallagher, R., & Nicholls, R. (2017). 'Mental health day' sickness absence amongst nurses and midwives: Workplace, workforce, psychosocial and health characteristics. *Journal of Advanced Nursing*, *73*(5), 1172–1181.

Law, R., Dollard, M., Tuckey, M., & Dormann, C. (2011). Psychosocial safety climate as a lead indicator of workplace bullying and harassment, job resources, psychological health and employee engagement. *Accident Analysis & Prevention*, *43*(5), 1782–1793.

Law, S., Ormel, I., Babinski, S., Plett, D., Dionne, E., Schwartz, H., & Rozmovits, L. (2021). Dread and solace: Talking about perinatal mental health. *International Journal of Mental Health Nursing*, *30*(S1), 1376–1385.

Lefebvre, H. (2004). *Rhythmanalysis: Space, time, and everyday life*. Continuum.

Martin, A., & Fisher, C. (2014). Understanding and improving managers' responses to employee depression. *Industrial and Organizational Psychology*, *7*(2), 270–274.

Martin, A., Woods, M., & Dawkins, S. (2015). Managing employees with mental health issues: Identification of conceptual and procedural knowledge for development within management education curricula. *The Academy of Management Learning and Education*, *14*(1), 50–68.

Martin, A., Woods, M., & Dawkins, S. (2018). How managers experience situations involving employee mental ill-health. *International Journal of Workplace Health Management*, *11*(6), 442–463.

Martin, M., Marchand, A., Boyer, R., & Martin, N. (2009). Predictors of the development of posttraumatic stress disorder among police officers. *Journal of Trauma & Dissociation*, *10*(4), 451–468.

Mellor, N., & Webster, J. (2013). Enablers and challenges in implementing a comprehensive workplace health and well-being approach. *International Journal of Workplace Health Management*, *6*(2).

NHS. *Perinatal mental health*. https://www.england.nhs.uk/mental-health/perinatal/

NHS. (2017). *Postnatal depression*. https://www.nhs.uk/conditions/post-natal-depression/

NHS. 2021). *Overview: Antidepressants*. https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/antidepressants/overview/

NICE. (2014). *Antenatal and postnatal mental health: Clinical management and service guidance* (updated ed.). NICE Clinical Guidelines, No. 192.

Ogbonna, E. (2019). The uneasy alliance of organisational culture and equal opportunities for ethnic minority groups: A British example. *Human Resource Management Journal*, *29*(3), 309–327.

O'Hara, M., & Wisner, K. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice & Research. Clinical Obstetrics & Gynaecology*, *28*(1), 3–12.

Pocock, B., Williams, P., & Skinner, N. (2012). Conceptualizing work, family and community: A socio-ecological systems model, taking account of power, time, space and life stage. *British Journal of Industrial Relations*, *50*(3), 391–411.

Ragins, B. R. (2008). Disclosure disconnects: Antecedents and consequences of disclosing invisible stigmas across life domains. *Academy of Management Review*, *33*(1), 194–215.

Rouse, J., Atkinson, J., & Rowe, A. (2021). Peering inside mutual adjustment: Rhythmanalysis of return to work from maternity leave. *International Small Business Journal*, *39*(8), 0266242620984739.

Rouse, J., & Sappleton, N. (2009). Managing maternity fairly and productively: Support for small employers. *International Small Business Journal*, *27*(2), 215–225.

Rouse, J., & Woolnough, H. (2018). Engaged or activist scholarship? Feminist reflections on philosophy, accountability and transformational potential. *International Small Business Journal*, *36*(4), 429–448.

Royal College of General Practitioners. (n.d.). *Perinatal Mental Health Toolkit*. https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx

Royal College of Psychiatrists. (2018). *Postnatal depression*. https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-natal-depression

Shann, C., Martin, A., & Chester, A. (2014). Improving workplace mental health: A training needs analysis to inform *beyondblue*'s online resource for leaders. *Asia Pacific Journal of Human Resources*, *52*(3), 298–315.

Shaw, R., Bernard, R., DeBlois, T., Ikuta, L., Ginzburg, K., & Koopman, C. (2009). The relationship between acute stress disorder and posttraumatic stress disorder in the neonatal intensive care unit. *Psychosomatics*, *50*(2), 131–137.

Stevenson, D., & Farmer, P. (2017). *Thriving at work: The Stevenson/Farmer review of mental health and employers*. https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Stokols, D. (2000). Social ecology and behavioral medicine: Implications for training, practice, and policy. *Behavioral Medicine*, *26*(3), 129–138.

Stumbitz, B., Lewis, S., & Rouse, J. (2018). Maternity management in SMEs: A transdisciplinary review and research agenda. *International Journal of Management Reviews*, *20*(2), 500–522.

Toyoki, S., Spicer, A., & Elliott, R. (2006). Beyond old horizons: Theorising the rhythms of social reproduction. *TAMARA: Journal of Postmodern Critical Organization Science*, *5*(2), 96–115.

van Amsterdam, N. (2014). Othering the 'leaky body'. An autoethnographic story about expressing breast milk in the workplace. *Culture and Organization*, *21*(3), 269–287.

Verhaak, C., Smeenk, J., Evers, A., Kremer, J., Kraaimaat, F., & Braat, D. (2007). Women's emotional adjustment to IVF: A systematic review of 25 years of research. *Human Reproduction Update*, *13*(1), 27–36.

Vliegen, N., Casalin, S., & Luyten, P. (2014). The course of postpartum depression: A review of longitudinal studies. *Harvard Review of Psychiatry*, *22*(1), 1–22.

Voydanoff, P. (2008). A conceptual model of the work-family interface. In *Handbook of work-family integration* (pp. 37–55). Academic Press.

Warin, M. (2015). Material feminism, obesity science and the limits of discursive critique. *Body & Society*, *21*(4), 48–76.

WHO. Sustainable development goals. World health organisation. https://www.who.int/topics/sustainable-development-goals/targets/

Zhao, H., Wayne, S., Glibkowski, B., & Bravo, J. (2007). The impact of psychological contract breach on work-related outcomes: A meta-analysis. *Personnel Psychology*, *60*(3), 647–680.

How to cite this article: Wilkinson, K. (2022). Maternal (perinatal) mental health and employment: An agenda for research and practice. *Human Resource Management Journal*, 1–16. https://doi.org/10.1111/1748-8583.12434