JRIP Editorial

Authors:

Zoë Darwin, School of Human and Health Sciences, University of Huddersfield, HD1 3DH, UK.

Gracia Fellmeth, National Perinatal Epidemiology Unit, Nuffield Department of Women's and Reproductive Health, University of Oxford, OX2 6GG, UK.

Paul Galdas, Department of Health Sciences, University of York, YO10 5DD, UK.

Amy Jenkin, Sheffield Perinatal Mental Health Service, Sheffield Health Partnership University NHS Foundation Trust, S5 7AT, UK.

Vaheshta Sethna, Institute of Psychiatry, Psychology & Neuroscience, King's College London, SE5 8AF, UK.

Title:

Relative Protection? What Becomes Illuminated When Paternal Perinatal Suicide Is Seen

Fathers contribute across societies and cultural contexts yet remain peripheral within perinatal research, policy, and practice. Concerns about fathers being unseen are commonly understood either in terms of hidden risks to mothers and infants or hidden support they may offer - their perceived *protective value for their relatives* – reflecting masculinity norms that position men through their roles. Both perspectives matter, alongside a third: invisibility leaves fathers overlooked, obscuring their wellbeing and support needs, with serious consequences.

Against this backdrop, new evidence raises critical questions: what becomes visible when paternal suicide is counted, what patterns of risk and protection emerge, and what does this mean for research, policy, and practice?

Men’s parental status is rarely captured in mortality datasets, leaving paternal deaths invisible in perinatal statistics, limiting understanding and timely response. A landmark Welsh population study provides the first national estimate of paternal suicide during the 1,001 days from conception to age two, using 22 years of suicide and birth records

(Marchant et al., 2025). The study identified 107 paternal deaths compared with 16 maternal deaths, revealing a gender gap far greater than that observed across the life course. Under-reporting is likely to be greater for fathers, particularly for non-resident fathers and those not named on birth certificates, whose parental status is less discernible within data. Clear disparities emerged: paternal suicide was more common among those in the most deprived areas and among first-time fathers. Data gaps prevented estimation of ethnicity-related disparities.

Crucially, suicide rates among fathers during the 1,001 days were lower than those observed in age-matched men, mirroring Scandinavian registry findings that parenthood can confer a degree of protection (Sörberg Wallin et al., 2022). Thus, paternal *suicide* is *high relative to mothers* in this transition period but *low relative to other men* of comparable age. In the same period, paternal *depression* is *high relative to other men* of comparable age. This seemingly contradictory pattern – elevated depression alongside conditional protection against suicide – suggests we must ask not only why and when fathers die, but also what buffers many from escalation despite distress, and how such mechanisms vary across health systems and cultural contexts. Understanding what drives this buffering offers important opportunities for broader public health suicide-prevention efforts and underscores the value of strengths-based research into the relational, social, cultural, and structural factors that support fathers' safety, resilience, and wellbeing.

In parallel, we should attend to the broader ways men may experience or express psychological suffering. Distress may manifest in forms more commonly described in the men's mental health literature – notably, increased substance use, withdrawal or avoidance, relational conflict or controlling behaviours, aggression, or changes in sexual behaviour - as well as under-acknowledged forms, including disruptions in sleep, work functioning, or physical tension and pain (Darwin et al., 2017). Many of these presentations may go unseen when using common measures of psychological distress, including when cultural norms influence how distress is expressed.

Evidence from South America suggests that, for some men, suicide risk may be heightened during affective episodes with mixed features, including mania (Quevedo et al., 2011), meaning that depression-only screening risks missing clinically important additional presentations. Suicidal and self-harm ideation are not rare among fathers (Fogarty et al., 2024). While not indicating imminent risk, these figures underscore the need to develop and evaluate acceptable and effective approaches for identifying suicidality in perinatal men – echoing recent calls in women's

perinatal care (Dudeney et al., 2021). Currently, health and social care rarely involve *any form* of paternal mental health assessment, illustrating a structural pattern through which fathers' experiences and needs are unrecognised and unmet.

Critically, men's suicidality is shaped by structural and sociocultural conditions, including economic pressures, mental health stigma, and norms about help-seeking. Suicide disproportionately affects low-and-middle-income countries, where patterns of risk differ: poverty, financial insecurity, conflict, and access to lethal means are strongly associated with suicide, while depression appears less strongly linked than in high-income countries. Yet, many studies – including those focused on maternal health – omit asking suicidality questions because of perceived risk-management concerns, restricting insight into how it manifests across contexts. There are significant methodological challenges in maternal suicide death surveillance including under-reporting, misclassification, and lack of surveillance beyond the early postpartum period in many settings (Fuhr et al., 2014). A global systematic review to estimate suicide's relative contribution to maternal mortality (Simmons et al., 2024) will offer further learning for paternal suicide surveillance.

Some national policies have begun to address gaps in paternal perinatal mental health provision – for example, routine mental health assessment of fathers and LGBTQ+ non-birthing parents in Australia; a dedicated postnatal visit for non-birthing parents in Sweden; and commitments to offer brief partner assessment within specialist perinatal mental health services in England. However, implementation remains inconsistent, and evidence on effective approaches across diverse cultural, socioeconomic, and healthcare settings is limited. These gaps are compounded by many fathers and non-birthing parents remaining marginalised or absent in perinatal research, policy, and practice, including non-resident fathers, fathers not named on birth certificates, adoptive fathers, trans men who are birthing parents, LGBTQ+ non-birthing parents, and parents bereaved through pregnancy or baby loss – all of whom face distinctive barriers to recognition and access.

Addressing paternal suicide – and paternal mental health more broadly – requires systemic change. This need not detract from maternal or newborn wellbeing; indeed, supporting fathers may enhance both. Nor does it override the requirement that partner involvement in maternity care must always be based on explicit consent from birthing parents (usually women). Instead, it involves recognising that perinatal mental health is shaped by interconnected relational, socioeconomic, and cultural systems. Policy and practice responses will necessarily differ across global

settings and cultural contexts, and they require inclusive strategies to address the needs of diverse and multicultural populations, including marginalised groups who may face additional barriers.

Ultimately, progress requires a conceptual shift: family-centred approaches must move beyond rhetoric to ensure each person is recognised as both an individual and a member of a relational system, embedded in wider structural contexts. As researchers, we are well placed to help drive this change.

References

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., & Gilbody, S. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: A qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth, 17*, 45. https://doi.org/10.1186/s12884-017-1229-4

Dudeney, E., Meades, R., Ayers, S., & McCabe, R. (2025). Questionnaire items to identify suicidality in perinatal women: A Delphi study. *Archives of Suicide Research, 30*(1), 163-185. https://doi.org/10.1080/13811118.2025.2509645

Fogarty, A. L., McMahon, G., Findley, H., Hosking, C., Schulz, M., Seymour, M., Leach, L. S., Borschmann, R., Garfield, C. F., & Giallo, R. (2024). Prevalence of suicidal and self-harm ideation in fathers during the perinatal and early parenting period: A systematic review and meta-analysis. Australian & New Zealand Journal of Psychiatry, 58(12), 1020–1033. https://doi.org/10.1177/00048674241267896

Fuhr, D. C., Calvert, C., Ronsmans, C., Chandra, P. S., Sikander, S., De Silva, M. J., & Patel, V. (2014). Contribution of suicide and injuries to pregnancy related mortality in low income and middle income countries: A systematic review and meta analysis. *The Lancet Psychiatry, 1*(3), 213–225. https://doi.org/10.1016/S2215-0366(14)70282-2

Marchant, A., Delpozobanos, M., Meligy, N., Dienes, K., Ellis-Davies, K., & John, A. (2025). *Paternal suicide in the 1001 critical days from pregnancy.* National Centre for Suicide Prevention and Self Harm Research. https://www.1001criticaldays.com/article/paternal-suicide-in-the-1001-critical-days

Simmons, E., Gong, J., Daskalopoulou, Z., Quigley, M. A., Alderdice, F., Harrison, S., & Fellmeth, G. (2024). Global contribution of suicide to

maternal mortality: A systematic review protocol. *BMJ Open, 14*(9), e087669. https://doi.org/10.1136/bmjopen-2024-087669

Sörberg Wallin, A., Sjöqvist, H., Dehara, M., Wells, M. B., Dykxhoorn, J., Kosidou, K., & Dalman, C. (2022). Parenthood and lower risk of suicide in women and men: The total Swedish population followed across adulthood. *Social Psychiatry and Psychiatric Epidemiology, 57*, 2241–2250. https://doi.org/10.1007/s00127-022-02321-y

Quevedo, L., da Silva, R. A., Coelho, F., Tavares Pinheiro, K. A., Horta, B. L., Kapczinski, F., & Pinheiro, R. T. (2011). Risk of suicide and mixed episode in men in the postpartum period. *Journal of Affective Disorders, 132*(1–2), 243–246. https://doi.org/10.1016/j.jad.2011.01.004