

When Partnerships End: Mental Health Consequences of Union Dissolution by Own and Partner's Migration Background in the Netherlands

Background

Major life course transitions can be disruptive, generating stress and significantly altering subsequent health trajectories (Pearlin 2010; Pearlin et al. 1981). Divorce is one of the most profoundly stressful life events (Bloom, Asher, and White 1978), with severe consequences for morbidity, life satisfaction, health behaviour, and well-being, as well as mortality (Lorenz et al. 2006; Luhmann et al. 2012; Sbarra and Coan 2017; Tilstra and Kapelle 2025). Although some individuals recover quickly from disruptive life course events, vulnerability to adverse health outcomes resulting from separation varies by individual-level characteristics, such as gender or education. While men experience transient declines in well-being and satisfaction, women face medium- and long-term risks of increased depression, mental health declines, financial strain, and mortality (Holden and Smock 1991; Leopold 2018; Shor et al. 2012).

Despite extensive research on the consequences of divorce and separation, less is known about how these processes unfold across different migration backgrounds, including the social inequalities therein. Migrants often face vulnerabilities, such as language barriers, weaker social networks, limited access to pensions and healthcare, and legal or institutional constraints (Viruell-Fuentes, Miranda, and Abdulrahim 2012). These challenges can further intensify during disruptive life course transitions (Spallek, Zeeb, and Razum 2011), such as divorce, which amplifies stress, economic strain, and social isolation. Female migrants, in particular, may be more exposed to these risks due to lower levels of social integration and financial independence. Two recent studies that analyse divorce yield mixed results: Loi et al. (2024) find that migrants are at a higher risk of experiencing negative health effects in both the short and long term in Germany. On the other hand, Van den Broek & Kravdal (2025) show that trajectories in mental health care use are similar between native-borns and migrants in Denmark.

Social structures and roles influence exposure to stress and the availability and mobilisation of coping resources (Pearlin 2010; Pearlin et al. 1981). In line with this, a growing body of literature documents that union type — whether both partners are native-born, both are migrants, or one of each — influences individuals' experiences and well-being. For migrants, native-born partners can provide social integration, support, and access to resources, as well as knowledge of the healthcare system, thereby improving migrants' mental health and life satisfaction (e.g., Eibich and Liu 2021; Milewski and Gawron 2019). Furthermore, access to social and financial resources is an important protective mechanism that mitigates the relationship between partnership dissolution to adverse health outcomes (Sbarra and Coan 2017).

Migrants make up a growing number of the population in Europe, and gaining insights into health inequality patterns of migrants and natives, particularly on migrants' mental health care needs, is crucial to effectively aligning policies and health care and upholding human rights. In this paper, we investigate migration background differences in how the union dissolution process may impact mental health. We focus on the Netherlands, a high-income country with a considerable migrant population¹, and define union dissolution as either the end of marriage or the end of cohabitation,

¹ As of 1st January 2024, 16.2% of the population were born abroad (CBS 2024).

recognising cohabitation as an established form of partnership in Western Europe (Kiernan 2002). With novel evidence from register-based mental health data, we address three specific research questions:

- 1) How do short- and medium-term health outcomes change over the union dissolution process, depending on the migration background?
- 2) How does this vary by union type (intra- and inter-migrant couples)?
- 3) What socio-demographic differences exist?

In doing so, we provide critical extensions to the literature on migration, health, and the life course. First, we build on well-established literature that integrates the stress process framework and life course perspectives by providing novel evidence from register-based mental health data in the Netherlands. Second, we combine this approach with a migration perspective and extend the migrant health literature by examining whether prior exposure to migration-related stress shapes vulnerability to later-life disruptions. Lastly, it contributes new evidence by analysing health trajectories across different union types.

Data & Methods

To answer our research questions, we utilise rich administrative data from the Netherlands (Centraal Bureau voor de Statistiek [CBS]), which includes information on health, demographics, partnerships, and socio-economic status (SES). The data contain information on all families in the Netherlands (approximately 17 million individuals) and provide rich insights into mental health. We include both marriages and cohabiting partnerships, focusing on union dissolution as the focal event, rather than divorce, to capture the full dissolution process and to avoid missing anticipatory effects preceding formal separation.

These register-based data have several major advantages over survey-based datasets. First, they enable us to utilise non-self-reported indicators of health, thereby reducing misreporting and social desirability biases. Second, extensive temporal data allows us to more accurately document the time periods before, during, and after separation. Third, with full-population data on migrants in the Netherlands, we are able to investigate subpopulations within migrants (including differences by gender, migrant generation, or origin regions).

We use two mental health outcomes: declared healthcare costs and reimbursed medications. Both datasets stem from health insurance reimbursement records, which capture all medically covered treatments and prescriptions in the Netherlands. They are available annually for healthcare costs from 2009 onwards and monthly for medication use from 2006 onwards. These administrative sources record all prescriptions and reimbursements at the individual level, allowing us to identify whether and when a person received mental health treatment or medication. Although the data do not measure underlying need, they provide an objective record of healthcare consumption that avoids self-reporting bias and enables comparisons across migrant and native populations.

To investigate the partnership dissolution process, we use fixed-effects linear probability models. Fixed-effect models enable the analysis of within-individual changes in health, adjusting for various time-varying variables. We include individuals who have been together or married for at least three years. We centre on the time of first separation, measured at the time when the household dissolves ($t=0$), and include observations five years after dissolution. Thus, we are able to capture anticipatory, immediate, and post-dissolution effects. We distinguish between four groups: native-born individuals in a relationship with a native-born individual (NN), native-born individuals in a relationship with a

migrant (NM), migrants in a relationship with a native-born individual (MN), and migrants in a relationship with a migrant (MM). All analyses are stratified by sex. Migrants are defined as individuals born in a country other than their country of residence, and second-generation migrants are excluded.

Expected findings

We expect partnership dissolution to be relatively more prevalent among migrant populations, particularly among mixed (migrant-native) couples, consistent with previous evidence showing higher instability in exogamous unions (Smith, Maas, and Van Tubergen 2012). We expect anticipatory increases in mental health care use and medication uptake across all groups, peaking around separation and gradually declining thereafter. These patterns align with the stress process framework, which views union dissolution as a significant stressor that triggers temporary declines in well-being. Effects are likely stronger among women, consistent with evidence of greater post-dissolution vulnerability and slower recovery in women's mental health.

We expect stronger negative effects of separation on health because migrants face additional stressors and thus experience dissolution more negatively. This should be particularly pronounced for migrant women, who might face a "double jeopardy". Financial barriers to healthcare are minimal in the Netherlands. Nonetheless, we are measuring healthcare usage, and language and cultural barriers may still play a significant role. Especially the stigma around mental health among migrant men could mask their underlying health care needs.

Regarding the role of migrants' partners' background, we formulate competing hypotheses. If the partner is native-born, this could be a source of support, for instance, in access to networks and information on the healthcare system. This should then result in lower baseline mental health needs (and thus, uptake). In this case, anticipatory effects and long-term negative effects on mental health should be stronger due to (anticipated) loss of support. Conversely, cultural differences in the partnership might be a source of conflict, which could result in higher baseline mental health uptake and lower immediate negative consequences of the dissolution. However, the dissolution might still have long-lasting negative effects.

If the migrants' partner is a migrant, separation might be culturally more sanctified. In this case, separation is a strong sign of problems in the partnership, which could result in higher anticipatory mental health needs, but quicker recoveries. On the other hand, these couples might have less access to resources, resulting in higher baseline mental health care usage.

We do not formulate specific hypotheses regarding how the migration background of native-born partners influences the mental health consequences of union dissolution for native-born individuals.

In the Netherlands, access to healthcare is universal so we would expect smaller differences in healthcare usage by SES. However, higher SES might indicate a greater ability to navigate the healthcare system, recognise symptoms, and have the flexibility and confidence to seek care, thus moderating differences in mental health care uptake by migration background.

Future steps

The analyses for this study will commence in January 2026. Multiple authors have experience with the Dutch registry data, including projects on mental health, migration background, and union type. Thus, we are confident that results will be ready for presentation at the European Population Conference in June 2026.

Literature

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