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Linking mental health disorders to childlessness: The roles of disorder type and partnership

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Article

Abstract

Objective: Drawing on a life-course perspective that emphasises partnership-related processes, we examine how different mental health disorders relate to childlessness and whether these associations are explained by partnership status and partner's mental health.

Background: Mental health problems are increasing, while childlessness is becoming more common.

Method: We use Finnish total population register data and discrete-time event history models to estimate the annual likelihood of having a first child.

Results: All types of mental health disorders are associated with a lower likelihood of first-time childbearing. In age-controlled models, the annual probability 0.8–1.3 %-points lower for women and 1.0–1.8 %-points for men, with the strongest associations observed for severe mental disorders. Accounting for partner's mental health and partnerships attenuates these associations, particularly among men (for any mental health disorder, 13% for women and 36% for men compared with age-controlled models).

Conclusion: Partnerships and partner's mental health are important in understanding the association between mental health disorders and childlessness across the life course, especially among men.

Key words: mental health, childlessness, partnerships, partner, fertility

1. Introduction

The prevalence of mental health disorders has increased significantly, while fertility rates have concurrently declined, with rising levels of childlessness observed among men and women over recent decades in Western countries (Abbing-Karahagopian et al., 2014; Jalovaara & Miettinen, 2025; Noordam et al., 2015). These parallel developments have drawn growing attention to the relationship between mental health and family formation. A substantial body of research has shown that mental health disorders are associated with both childlessness and having fewer children (e.g., Golovina et al., 2025; Kailaheimo-Lönnqvist et al., 2024; Power et al., 2013). However, the underlying mechanisms driving these relationships remain largely unexamined – why some mental health disorders are more strongly related to childlessness than others?

One potential explanation for the association between mental health disorders and childlessness lies in their connection to partnership dynamics. In contemporary Western societies, entry into parenthood most often occurs within co-residential partnerships (Andersson, 2023), making partnership formation and stability a central context for childbearing. Mental health disorders have been shown to be associated with difficulties in forming and maintaining such partnerships (e.g., Idstad et al., 2015; Metsä-Simola et al., 2018; Mojtabai et al., 2017), suggesting that partnership histories may play an important role in shaping the link between mental health disorders and childlessness. Yet, despite the importamce of partnerships for family formation, research examining how partnership-related processes contribute to the association between mental health and childlessness remains limited.

Only two studies (Golovina et al., 2025; Liu et al., 2024) examined whether ever having a co-residential partner helps to explain the association between mental health conditions and childlessness, while another study focused on depression and incorporated the full partnership history (Kailaheimo-Lönnqvist et al., 2024). These studies consistently show that individuals with mental health disorders are less likely to form co-residential partnerships and that accounting for partnership status partly attenuates the association between mental health disorders and childlessness. However, prior research has typically relied on simplified or static indicators of partnerships, has rarely compared different types of mental health disorders, and has seldom considered partners' mental health.

Drawing on a life-course perspective that emphasises partnership histories and linked lives, we examine how mental health disorders are linked to childlessness. We use longitudinally measured co-residential partnership status and information on partners' mental health to provide a more detailed understanding of partnership-related processes associated with remaining childless. Using Finnish total population register data, which uniquely capture co-residential partnerships nationwide over nearly four decades, allows us to examine these associations over time in a comprehensive population-based setting.

This study makes three contributions to the literature. First, we examine the role of longitudinally measured co-residential partnership history in the association between different mental health disorders and childlessness, acknowledging that partnership status is inherently time-varying. In line with life course theory, which emphasises the timing, sequencing, and duration of life events and transitions (e.g., Elder, 199; Elder et al., 2003), this approach recognises partnerships as dynamic processes rather than static states. Second, we provide new knowledge about the role of partner's mental health for the risk of staying childlessness. Third, we contribute to the limited body of research comparing the strength of the association between childlessness and different types of mental health disorders (e.g., Liu et al., 2024).

2. Background

The rise in mental health problems has been well documented (Abbing-Karahagopian et al., 2014; Noordam et al., 2015). In Finland, the use of antidepressants has doubled over the past 15 years (Suomen lääketilasto 2011; Suomen lääketilasto 2023) and according to the Finnish School Health Survey, one in five girls experiences moderate or severe anxiety. Anxiety among boys is less common but has also increased (Kouluterveyskysely, 2023). During the same period, over the 2010s, fertility levels have declined in many high-income countries, including but not limited to the Nordic countries and the United States (e.g., Hellstrand et al., 2021; Root et al., 2024). The incidence of childlessness has also risen in recent decades. In Finland, for example, the proportion of men who are childless at age 45 increased from 19% in 1987 to 29% in 2020, and the proportion of childless women from 14% to 20% (Jalovaara & Miettinen, 2025).

These parallel developments have generated growing interest in the relationship between mental health and family formation. Previous research shows that mental health disorders are associated with both childlessness and having fewer children (e.g., Golovina et al., 2025; Kailaheimo-Lönnqvist et al., 2024; Power et al., 2013). However, much less is known about the processes linking mental health to family formation outcomes, and about how the strength of these associations differs between different mental health disorders. In particular, limited attention has been paid to the role of partnerships as a key context in which associations between mental health and childlessness may emerge.

To address this gap, we adopt a life-course perspective in which mental health, partnerships, and childbearing are understood as interlinked processes unfolding over time (Elder, 1994; Elder et al., 2003; Bernardi et al., 2019). From this perspective, childlessness is not viewed as the result of a single reproductive decision, but as an outcome that reflects trajectories of health, relationship formation and stability, and socioeconomic circumstances across the life course. Mental health problems often emerge in adolescence or early adulthood, coinciding with the period when partnership formation and entry into parenthood typically occur (Golovina et al., 2025; Liu et al., 2024; Solmi et al., 2022). As a result, mental health may shape family formation indirectly, through its associations with partnership circumstances over the reproductive life course.

Several theoretical perspectives help explain how mental health may be linked to partnership and, through them, to childlessness. Drawing on health selection theories, this study recognises that mental health conditions can shape individuals' life-course outcomes across multiple domains (Case & Paxson, 2010; Goldman, 2001). Applied to intimate relationships, this perspective highlights that partnership formation and continuity take place within a partner market in which health constitutes a valued attribute. Mental health problems may affect individuals' relative position in this market through impairments in social functioning, emotional regulation, behavioural patterns, and economic participation, thereby shaping opportunities to enter, maintain, and progress within intimate partnerships. Partner choice is further structured by assortative mating, whereby individuals tend to form partnerships with others who have similar health characteristics, socioeconomic resources, or life-course profiles (Goldman, 1993; Fu & Goldman, 1996; Tybur & Gangestad, 2011; Peyrot et al., 2016).

The strength and consequences of these processes are likely to vary by different mental health disorders. Conditions that more strongly interfere with social functioning, emotional regulation, or economic participation may pose greater challenges for sustained partnership trajectories, whereas other conditions may have weaker implications. Across the life course, repeated difficulties in partnership formation, quality, or continuity may reduce exposure to partnership contexts in which childbearing most commonly occurs, thereby increasing the likelihood of remaining childless.

These life-course processes highlight the central role of partnerships in understanding transitions to parenthood. In contemporary European societies, the majority of first births occur within co-residential partnerships, making partnership status a key context for childbearing (Andersson, 2023). Individuals who experience extended periods without a partner or unstable partnership circumstances are therefore more likely to remain childless over the life course.

Empirical studies consistently show that mental health problems are associated with lower probabilities of being in a co-residential partnership and with less stable partnership circumstances over time, consistent with health selection processes whereby mental health conditions shape individuals' partnership trajectories (Breslau et al., 2011; Idstad et al., 2015; Metsä-Simola et al., 2018; Mojtabai et al., 2017). However, most previous research on mental health and childlessness has relied on static or simple indicators of partnership, such as ever having had a partner, thereby overlooking the longitudinal nature of partnership status and the cumulative implications of health selection across the life course. From a life-course perspective, partnership status varies over time, and whether individuals are in a co-residential partnership at a given point in the life course is likely to matter for transitions to parenthood. Only one prior study has used detailed longitudinal measures of partnership status when examining mental health and childlessness, showing that accounting for partnership status substantially attenuates the association, particularly among men (Kailaheimo-Lönnqvist et al., 2024).

Building on this work, we focus on co-residential partnership status as a key context for childbearing. We therefore hypothesise:

H1: *Not having a co-residential partner represents an important mechanism through which mental health disorders are associated with childlessness.*

The importance of partnership status for childbearing is likely to differ by gender. Men's transition to parenthood is more strongly conditional on being in a co-residential partnership, whereas women are more likely to enter parenthood outside such unions (Andersson, 2023). If mental health is primarily associated with childbearing through partnership circumstances, its association with childlessness is therefore expected to be stronger among men than among women. This leads to our second hypothesis:

H2: *The association between partnership status and childlessness is stronger for men than for women.*

Family trajectories are embedded in linked lives, meaning that individuals' life-course outcomes are shaped in interaction with those of their partners (Bernardi et al., 2019; Elder et al., 2003). Mental health problems tend to cluster within couples due to assortative mating, shared social environments, and mutual influence over time (Peyrot et al., 2016; Torvik et al., 2023). As a result, some individuals form partnerships in which both partners experience mental health problems, making dyadic patterns in childlessness relevant to examine.

When both partners experience mental health problems, challenges related to these conditions may overlap within the couple, shaping relationship functioning, and perceived readiness for parenthood (Butterworth & Rodgers, 2008; Kailaheimo-Lönnqvist et al., 2024). We hypothesise that:

H3: *Among partnered individuals, childlessness is most likely when both partners have a mental health disorder, compared with couples in which none or only one partner is affected.*

Taken together, the hypothesis outlined above imply that mental health disorders are unlikely to be uniformly associated with childlessness. Rather, the strength of these associations are expected to vary across different types of mental health conditions.

Evidence from Finland and Sweden suggests that severe mental disorders, such as schizophrenia and other psychotic disorders, are more strongly related to childlessness than less severe but more common mood and anxiety disorders (Liu et al., 2024). Other mental health conditions such as substance use disorders are known to have adverse effects on relationship quality and stability (Birkeland et al., 2018), which could be expected to decrease the probability of having a child. However, people with substance use disorders are also more likely to engage in high-risk sexual behaviours (Chen et al., 2018), which could lead to unplanned pregnancies and thus reduce the likelihood of remaining childless. We hypothesise that:

H4: *Severe mental disorders, such as psychotic disorders, are more strongly associated with childlessness than mood and anxiety disorders.*

H5: *Substance use disorders are associated with an increased likelihood of having a child outside the context of a co-residential partnership.*

We test these five hypotheses by using Finnish total population register data with links to individuals' complete co-residential partnership history and partners' characteristics. A strength of these register data is that they include information on cohabiting unions and partners, which are linked with other register data, such as high-quality information on fertility of men. Our study contributes understanding on the relationships between mental health disorders and childlessness in the following ways. First, we incorporate a comprehensive history of co-residential partnerships of individuals when an individual is 18 to 38 years old. Second, we examine the role of current partners' mental health conditions on childlessness. Third, we compare the associations of different mental health disorders with childlessness and thus extending the knowledge beyond depression while accounting for the complete partnership history (e.g., Kailaheimo-Lönnqvist et al., 2024). These are important and unique features of this study given that mental health disorders affect both the formation and stability of partnerships, and as partners' mental health disorders can be expected to have joint effects on a couple's likelihood of having a child (c.f. Kailaheimo-Lönnqvist et al., 2024).

3. Data and methods

3.1 Data

We use Finnish total population register data on cohorts born between 1977 and 1980, following individuals annually from the age of 18 to 39. The childlessness rates differ only slightly between the ages of 40 and 45 (Jalovaara & Miettinen, 2025; Nisén et al., 2014). Thus, our sample captures childlessness and having the first child relatively well; however, we acknowledge that some individuals may have their first child after the

age of 39, and that our results should be interpreted only with caution as indicative of lifetime childlessness. Evidence from Finland shows that childlessness declines only modestly between ages 40 and 45—by about six percentage points for men (35% to 29%) and three percentage points for women (23% to 20%) (Jalovaara & Miettinen, 2025). Thus, measuring childlessness only up to age 39 introduces a small bias, particularly for men, who are more likely than women to become first-time parents at older ages. The sample is restricted to individuals born in Finland, as for these persons we were able to achieve nearly complete linkage of education, healthcare, and sociodemographic data throughout the study period. Our final analytical sample includes 123,182 women and 128,468 men.

The outcome variable is whether an individual has a first child in a given year. Mental health disorders are coded as partly time-varying dummy variables, meaning that when an individual has received a diagnose or has been prescribed medication for a mental health disorder, s/he will be categorized as having mental health disorder from that year onwards. Thus, we allow no recovery in the measurement because when using diagnose data (instead of only medication data), the possible recovery year is not measurable. Individual's mental health disorder is the primary independent variable, and we distinguish between three categories of disorders: common mental disorders, severe mental disorders, and behavioural and addiction-related disorders (Table 1). The categories are not mutually exclusive; thus, an individual can be in multiple categories simultaneously over time.

The category of the *common* mental disorders includes depression and anxiety disorders that do not involve psychosis or major cognitive dysfunction, and that are typically treated in primary care. The category of behavioural and addiction-related disorders (*behav*) includes disorders characterized by problematic behaviour such as alcohol misuse and gambling that may cause significant harm in everyday life. The category of *severe* mental disorders includes conditions with psychotic symptoms (such as schizophrenia, bipolar disorder), higher functional impairment, and complex treatment needs, and they are typically treated in specialized health care. The category of any *mental disorder* is coded as one since the year of first observation of any of these conditions.

Mental disorders are measured using diagnose information (ICD-10 codes) from the special health care registers and medication information (ATC-codes) from the prescription register of Social Insurance Institution of Finland (measured from a first diagnose or medication information from the registers). All psychotropic medication is prescribed by clinical doctors, and all persons residing in Finland are entitled to reimbursement for medication expenses by the Social Insurance Institution of Finland. Therefore, our data includes mental health measured both by diagnose data and medication data and thus increasing the validity of our measure. The partner's disorders are measured in the same way as the index person's disorders.

The fully time-varying control variables include current partnership status, the (cumulative) number of partners, age, highest achieved educational level, and student status. We can define partnerships as co-residential unions, including both marriages and cohabitations. The current partnership status is classified into three categories: 1) having a partner without a mental health disorder, 2) having a partner with a mental health disorder, 3) not having a partner. Number of partners refers to the cumulative number of co-residential partners an individual has ever had by each observation year; it remains constant when a partnership dissolves and increases when a new partnership is formed. Age is treated as a categorical variable with one-year steps ranging from 18 to 39 years. Educational attainment is categorized into three levels: basic, secondary (including vocational and general tracks), and tertiary (which includes those with a bachelor's degree or higher). Education is treated as a time-varying covariate that may reflect both prior socioeconomic selection and processes unfolding after the onset of mental health problems, rather than as a mediator in a strict causal sense. Importantly, our models include all levels of educational attainment allowing educational trajectories to change across adulthood. In addition, student status is included as a separate time-varying covariate to capture ongoing education and to distinguish current enrolment from attained educational level.

Table 1: Categories for mental health disorders and their construction. Each mental health condition is defined both by diagnosis data and medication data.

	ICD-10	Medication	Labelled
Common mental disorders: Neurotic, stress-related, somatoform, depressive and mood disorders	F32-39 (excluding F32.3 & F33.3), F40-F45	N05B, N05C, N06A, N06C	Common
Behavioral and addiction-related disorders: Mental and behavioral disorders due to psychoactive substance use, habit and impulse disorders and paraphilias	F10-F19, F63, F65	N07BB, N07BC	Behav
Severe mental disorders: Schizophrenia, schizotypal, and delusional disorders, manic episodes, bipolar disorders and depression with psychotic symptoms	F20-F29, F30-F31, F32.3, F33.3	N05A	Severe

Note: The diagnostic information (ICD-10 codes) is from the specialised healthcare registers, and medication information (ATC codes) is from the prescription register of the Social Insurance Institution of Finland.

3.2 Methods

We use discrete-time event history models with a logistic link, conducting all analyses separately for women and men. We predict the time-varying binary variable 'birth of a first child' in time t by mental health disorder status in year t-1. We use similar lagging of covariates for all time-varying variables. Our analytical procedure consists of two parts. First, we fit discrete-time event history models to examine the annual likelihood of having a first child (i.e., as opposed to staying childless). These results are presented as predicted probabilities in the figures. Right-censoring occurs upon emigration, death, or at age 39. We conduct the models first for any mental health disorder and then separately for different mental health disorders. There are separate stepwise models where we first control only for age (M1), then for current partnership status and number of partners (M2), and in the last model for education and student status (M3). We use stepwise modelling because it allows us to assess the role of partnerships by quantifying to what extent the predicted probability of a first birth changes when partnerships are accounted for (H1) and whether this change is different for women and men (H2).

Second, to assess the potential impact of the accumulation of mental health disorders within couples, we will include an interaction term between an individual's mental health disorder and current partnership status and further distinguish between partners with and without a mental health disorder (H3). These results are presented as predicted probabilities from fully controlled models. To assess any differences in these associations between different mental health conditions, we similarly present these results from analyses both for any mental health disorder and for different mental health disorders (H4–H5).

4. Results

4.1 Descriptive results

Table 2 shows the prevalence of different mental health disorders (MHD) and childlessness by the age of 39 by sex. The categories are not mutually exclusive. In general, mental health disorders are more common among women than men, with 37% of women and 28% of men having (had) a mental health disorder by age 39. However, severe disorders (8%) are about as common among men and women, whereas men are substantially more often diagnosed with behavioural disorder (6%) than women (3%). Childlessness at the age of 39 is more common among those with any MHD as compared to those without, regardless of gender. Childlessness is most common among those with severe disorders: 38% of women and 56% of men with such a disorder are childless at age 39.

The descriptive statistics of other variables at the age of 39 (i.e., end of the follow-up period) are presented in Table 3 by both sex and mental health disorder (=MHD). Individuals with any mental health disorder are less educated and less likely to have a partner or a child compared to individuals without a mental health disorder. In addition, having a mental health disorder is more strongly associated with the likelihood of being in a partnership in men than in women. As expected, based on assortative mating, individuals with a mental health disorder have more often also a partner with mental health disorder (Table 3; Table A1).

Table 2: The percentages of mental health disorders and childlessness in the sample at the age of 39. Note that the mental health categories are not mutually exclusive.

	Women		Men	
	% with MHD	% childless	% with MHD	% childless
No MHD	62.7	21	72.5	30
Any MHD	37.3	27	27.5	42
Mood & anxiety disorders (Common)	36.3	26	25.7	41
Behavioural and addiction-related disorders (Behav)	2.7	33	6.3	46
Schizophrenia, schizotypal, delusional disorders, bipolar (Severe)	8.6	38	8.1	56

Note: MHD=any mental health disorder.

Table 3: Descriptive statistics by mental health disorder status at the age of 39.

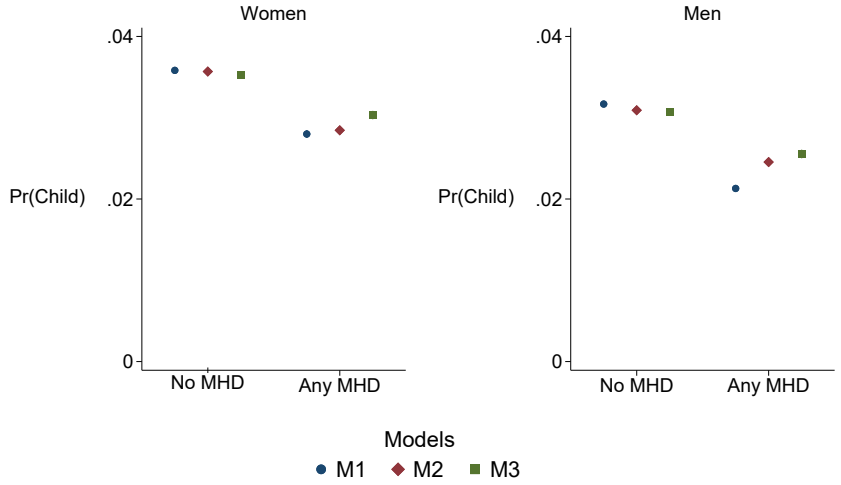
		Women (%)		Men (%)	
		No MHD	Any MHD	No MHD	Any MHD
Highest education					
	Primary	5.1	8.8	9.1	21.1
	Secondary	40.0	45.8	52.2	55.0
	Tertiary	54.9	45.4	38.7	23.9
Student status		2.6	3.6	1.2	1.9
Partnership					
	Partner, no MHD	87.5	82.6	81.2	70.8
	Partner, any MHD	5.0	8.9	7.4	10.8
	No partner	7.5	8.5	11.4	18.4
		Mean (SD)		Mean (SD)	
Number of partners		1.14 (0.99)	1.09 (1.13)	1.05 (0.98)	0.86 (1.11)

Note: MHD=any mental health disorder, Min/Max for number of partners is 0 and 9 in all categories. Age is treated as a categorical variable in the models.

4.2 Mental health disorders and likelihood of having a child

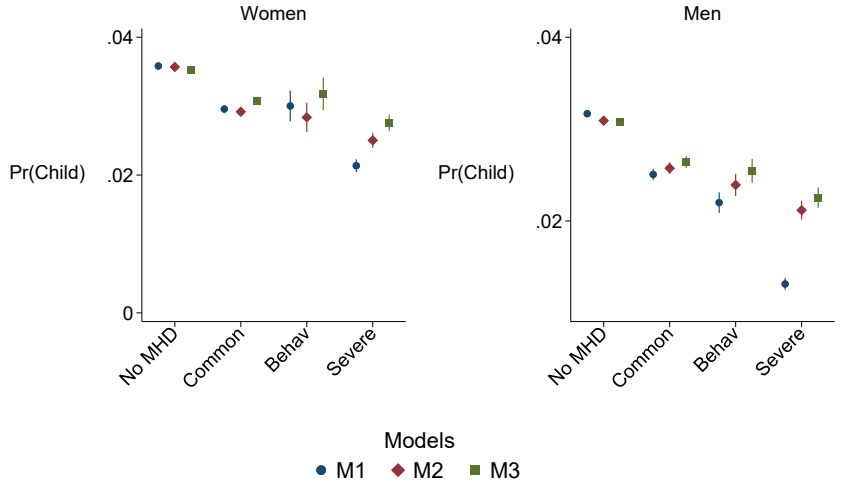
In line with the descriptive results reported above, the results from regression models show that having any mental health disorder is negatively related to the likelihood of having a first child (Figure 1, See also results presented as odds ratios Fig. A1 and relative risk ratios Fig. A2). The decrease in the annual probability of having a child was 0.8 %-points for women and 1.1 %-points for men in age-controlled models (Table A3). Controlling for the current partnership status and number of partners reduced the estimate more for men than women (Figure 1 M1 vs M2 13% for women and 36% for men). In turn, controlling for education reduced the estimate of any mental health disorder more for women (Figure 1 M2 vs M3 38% for women and 14% for men). This suggests that partnerships are more important mediators of the relationship between mental health and the likelihood of having a first child for men, while education may be more important for women.

Figure 1: The association between any mental health disorder and likelihood of having a child. Discrete-time event history model presented as predicted probabilities with 95% CIs.



Note: M1: age; M2: M1 + current partnership status, number of partners; M3: M2 + highest education and student status. MHD= any mental health disorder.

Figure 2: The association between different mental health disorders and likelihood of having a child. Discrete-time event history model presented as predicted probabilities with 95% CIs.



Note: M1: age; M2: M1 + current partnership status, number of partners; M3: M2 + highest education and student status. MHD=any mental health disorder.

Figure 2 (See also results presented as odds ratios and relative risk ratios Fig. A3) shows associations between different mental health disorders and the likelihood of having a child. For both women and men, the strongest associations were for severe disorders. Controlling for partnerships (M2) explained a large share of the negative association between severe mental disorders and likelihood of having a first child (especially for men) and the estimates became rather similar to other mental health disorders. This suggests that partnerships explain differences in the strength of the associations between different mental health disorders and childlessness. In contrast, controlling for the highest education and student status (M3) explained more of the negative association between mental health disorders and likelihood of having a child for women, especially for those diagnosed with severe mental disorders.

To summarize, controlling for partnerships explains more of the negative association for men than for women, thus suggesting that partnerships play a more important role for the association of mental health disorders and childlessness for men. As for any mental health disorder, education seems to be more

decisive for the relationship in women (controlling for education explains 25% of negative association for women and 10% for men compared to age-controlled models), which is plausibly related women's higher average levels of education.

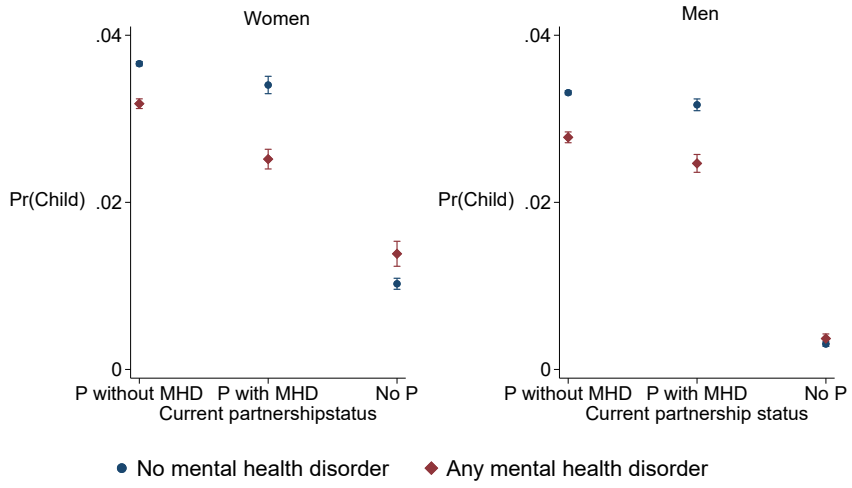
Across all mental health disorders, those with a disorder were less likely to have a child than those without a disorder. Compared to those without any mental health disorder, the annual predicted probability of having a child decreased by 0.8–1.3 %-points

for women in age-controlled models and 1.0–1.8 %-points for men respectively. In fully controlled models these attenuations were 0.5-0.7 %-points for women and 0.5–0.8 %-points for men (Figure 2).

4.3 Accumulation of mental health disorders within couples

In this section we further examined the role of accumulation of mental health disorders within couples. We assess the interaction between (any) own mental health disorder and current partnership status and include a further distinction between partners with and without any mental health disorder (Figure 3, see also results presented as odds ratios and relative risk ratios Fig. A4 and A5). It is notable that the patterns for men and women were largely similar. If a partner had a mental health disorder, the likelihood of having a child was lower than if only the index person had a disorder, especially in women. Among women whose partner had a disorder, also own mental health diagnosis seemed to matter more than was the case for men. These results suggests that accumulation of poor mental health within couples increases the risk of the couple to remain childless. In addition, for women, having a mental health disorder was linked with a slightly higher likelihood of having a child outside the context of co-residential partnerships.

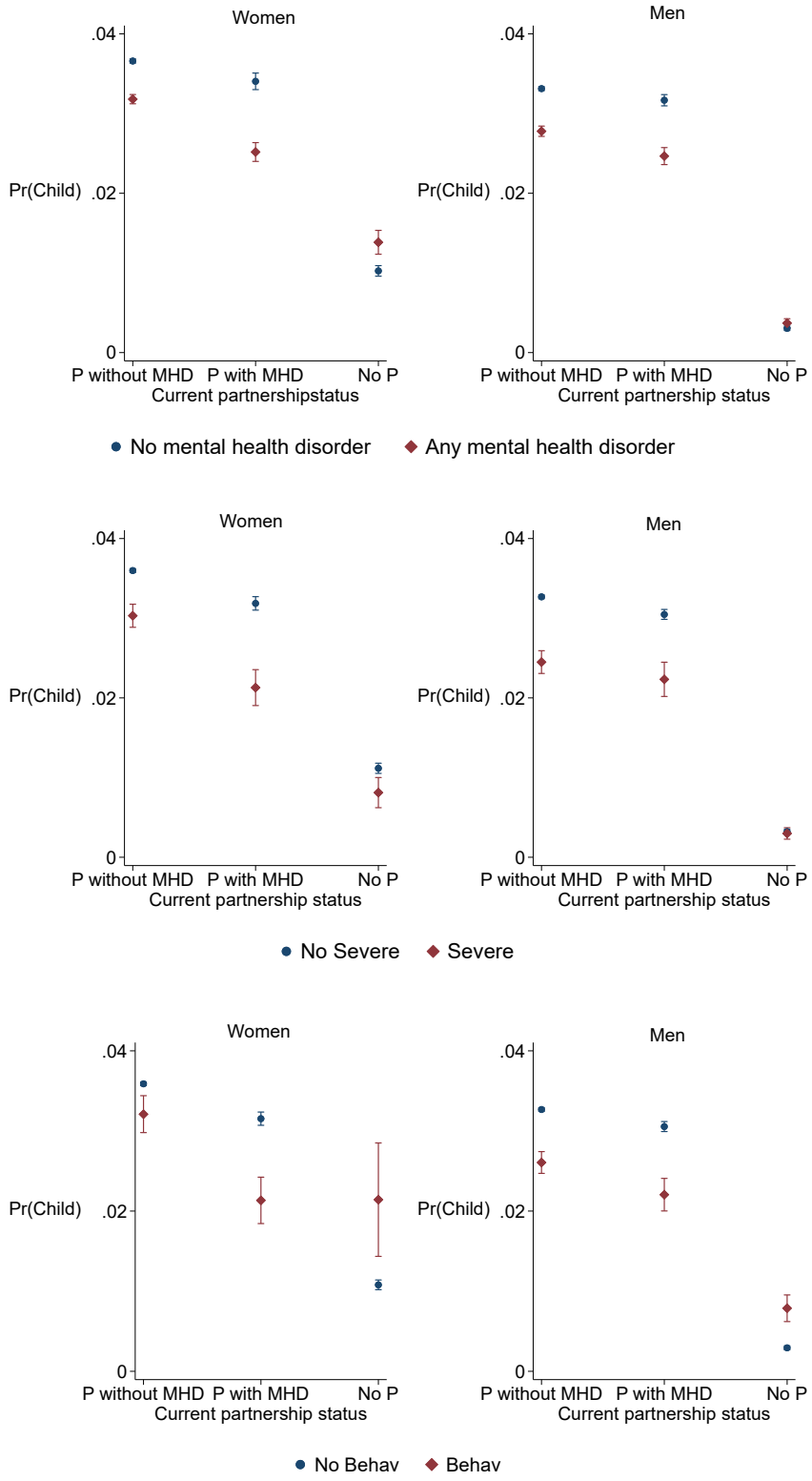
Figure 3: The association between any mental health disorder and likelihood of having a child by current partnership status. Discrete time event history models presented as predicted probabilities with 95% CIs.



Note: model controls for age, highest education, student status and number of partners. P=partner, MHD=any mental health disorder.

Next, the respective interaction analyses were carried out for different mental health disorders separately. All mental health conditions showed that if both partners had a mental health disorder, the likelihood of having a child was lower than if only one of the partners had a disorder, with modest variation between different diagnoses (Figure 4, see also results presented as odds ratios Fig. A6). Interestingly, for non-partnered women both common (Common) and behavioural and addiction-related disorders (Behav) were linked with slightly higher likelihood of having a child compared to non-partnered women without mental health disorder. A similar pattern was visible for men only for behavioural and addiction-related disorders. Thus, some mental health disorders seem to slightly increase the likelihood of having a child outside the context of co-residential partnership.

Figure 4: The association between different mental health disorders and likelihood of having a child by current partnership status. Discrete-time event history models presented as predicted probabilities with 95% CIs.



Note: model controls for age, highest education, student status and number of partners. P=partner, MHD=any mental health disorder.

4.4 Robustness analyses

As robustness analysis we conducted the models otherwise similarly, but we distinguished the partners' different mental health disorders. The results remained similar but the differences by partner's different mental health disorders where small which indicates that the type of the partner's mental health disorder seems to matter only to a limited extend (Descriptive statistics Table A2, Interaction models Figure A7).

4.5 Support for hypotheses

We found support for H1 and H2, according to which partnerships partially mediate the associations between mental health disorders and the likelihood of having a first child, especially for men (Figures 1 and 2). We also found support for H3, according to which childlessness is more prevalent among couples where both partners have a mental health disorder compared to those couples where only one or especially neither of the partners have a mental health disorder (Figures 3 and 4). Furthermore, we find support for H4, which states that severe mental disorders such as schizophrenia are more strongly associated with childlessness than common disorders such as mood and anxiety disorders (Figures 2 and 4). We additionally found that the explanatory power of partnerships status was strongest for severe mental health disorders, which contributes to their stronger associations with childlessness. In fully controlled models, the differences between different mental health disorders were small. Lastly, support was found for H5, which states that substance use disorders are associated with an increased risk of having a child outside the context of co-residential partnerships (Figure 4).

5. Discussion and conclusion

5.1 Discussion

We investigated the association between various mental health disorders and childlessness to better understand how rising levels of mental health problems relate to childlessness. Adopting a life-course perspective as a conceptual framework, we examine how childlessness is associated with health-related and partnership-related factors measured over adult ages. By comparing multiple mental health disorders and incorporating longitudinal measures of co-residential partnership status and partners' mental health, our study extends previous research that has largely relied on static or simplified indicators of family formation.

Our findings show that all examined mental health disorders are associated with an increased likelihood of remaining childless. These patterns are consistent with earlier studies from Finland and other countries (e.g., Golovina et al., 2025; Liu et al., 2024; Power et al., 2013). Our study shows that differences across disorder types are closely related to differences in partnership status observed over adulthood. In age-controlled models, the annual probability of having a child was 0.8–1.3 percentage points lower for women with any mental health disorder compared to those without, and 1.0–1.8 percentage points lower for men. The strongest associations were observed for severe mental health disorders, whereas common mental health disorders showed weaker associations for both women and men.

To illustrate the implications of these annual differences over the life course, we translated the estimated probabilities into predicted risks of remaining childless by age 40. Assuming onset of a mental health disorder at age 25, severe mental health disorders were associated with an increase of 7.9 percentage points in childlessness among women and 11.0 percentage points among men, while common mental health disorders increased childlessness by 5.3 and 6.9 percentage points, respectively. These estimates highlight how persistent differences in annual probabilities can translate into substantial disparities in childlessness over adulthood.

From a life-course perspective, a central contribution of this study is to demonstrate the key role of partnership status in understanding the association between mental health disorders and childlessness. Empirically, accounting for partnership status attenuated the association between mental health disorders and childlessness by 13% among women and by 36% among men compared with age-controlled models. This shows that partnership status constitutes a particularly important pathway linking mental health to

childlessness among men, whose transition to parenthood is more strongly conditional on being in a co-residential partnership (Kailaheimo-Lönnqvist et al., 2024).

Importantly, these life-course processes unfold within partnerships and are therefore embedded in linked lives. Consistent with this perspective, we find that among partnered individuals, the likelihood of having a first child is lowest if both partners have a mental health disorder. Similar results have been reported in a previous study using a comparable design focusing on depression (Kailaheimo-Lönnqvist et al., 2024). Notably, the strength of this association was similar across different mental health disorders, and the pattern observed was additive rather than multiplicative. Given the clustering of poor mental health within couples (Torvik et al., 2023; Peyrot et al., 2016), and the fact that the majority of children are born within co-residential partnerships (96.6% of all children born to Finnish women born in 1969–1976; Andersson, 2023), these findings highlight the importance of accounting for both partners' mental health when studying family outcomes.

Differences between mental health disorders were also substantially reduced once partnership status was taken into account, particularly among men. This suggests that the stronger associations observed for severe mental health disorders are largely explained by differences in partnership status. From a health selection perspective, severe disorders may constrain partnership formation and stability through impaired functioning, economic disadvantage, or social stigma, thereby reducing the likelihood of being in a partnership context in which childbearing typically occurs. Previous research from Finland shows that almost half of Finns, especially men, who remain childless have not lived in a cohabiting union, while a large share have union histories characterized by instability (e.g. several brief cohabitation spells) (Jalovaara & Fasang, 2017).

Extending these life-course interpretations, our results suggest heterogeneity in pathways to parenthood across different types of mental health disorders. Behavioural and addiction-related disorders were associated with a somewhat higher likelihood of childbearing outside the context of a co-residential partnership for both women and men, and common mental health disorders showed a similar among women. However, these associations were modest, and the underlying mechanisms cannot be directly identified with our data. One possible explanation, consistent with earlier research, is that some mental health disorders are associated with risky sexual behaviours and reduced contraceptive consistency, which may increase the likelihood of unplanned or early pregnancies (Østergaard et al., 2017; Skogslund et al., 2019). Such processes may, in turn, contribute to non-partnered births, as mental health problems have been linked with a higher incidence of unplanned pregnancies (Wellings et al., 2013).

Taken together, our findings suggest that while some mental health disorders may increase the likelihood of childbearing outside co-residential partnerships at certain stages of the life course, mental health disorders overall are associated with a lower likelihood of childbearing within partnerships across the reproductive life course, thereby increasing the risk of remaining childless.

Methodological considerations and future research

Future research should examine the role of different mental health disorders in relation to the timing and the eventual likelihood of a first birth and number of children. This could provide a more comprehensive understanding of the relationship between mental health and fertility. Additionally, identifying protective and compensatory factors in the relationship between mental health disorders and fertility outcomes should be examined. Our study is limited in that it could not distinguish between the timing and likelihood of a first birth, and thus more research is needed here. Moreover, lack of a partnership (e.g., Braithwaite & Holt-Lunstad, 2017) or challenges related to having children (Baldur-Felskov et al., 2013; Klemetti et al., 2010) may also influence mental health. We minimised the effects of such reverse causality in our analyses by lagging the mental health information by one year.

A key strength of our study lies in its use of Finnish total population registers, which enable analyses with minimal selection bias, loss to follow-up, or reporting bias. Finnish register data are uniquely comprehensive, covering co-residential partnerships nationwide over nearly 40 years. Even most other Nordic countries do not offer such extensive coverage. Moreover, we combine diagnostic information from specialized health care with medication data, allowing us to more effectively capture individuals with mental health disorders compared to previous studies using only diagnostic data from specialized health care (Golovina et al., 2025; Liu et al., 2024). Thus, in our study, we have information about mental health disorders also from the primary health care, occupational health and private sector though medication records.

Nonetheless, certain limitations should be acknowledged, such as the lack of information on the quality of partnerships and dating behaviour. For instance, we do not have information on the ways in which mental health disorders prevent men in particular from forming stable partnerships – this is important as we showed that partnerships play a strong role in men's childlessness. Such information would help to explain why mental health disorders are associated with a lower likelihood of having a partner and becoming a parent.

A further limitation concerns the measurement of mental health disorders. Our indicators are based on specialised healthcare diagnoses and psychotropic medication purchases, but diagnosis data do not contain information on recovery, remission, or changes in symptom severity. We observe when an individual receives treatment, but not whether or when the disorder later resolves. Medication data would, in principle, allow more precise time-varying modelling, yet relying solely on medication may poorly cover many disorders (e.g., behavioural disorders such as addictions). Previous Finnish study (Kailaheimo-Lönnqvist et al., 2024) on depression, show that such static exposure definitions tend to attenuate associations between mental health and childlessness as compared to time-varying definitions, meaning that our current estimates likely represent conservative estimates of the true underlying associations.

Our register-based study also lacks information on fertility intentions. Some studies suggest that mental health disorders may affect individuals' desire to have children (e.g., Carlsson & Kim, 2024), and this is one potential mechanism underlying the association that we find. However, as we show, partnerships are an important mechanism, especially in the case of more severe disorders and among men. These two mechanisms are also not entirely unrelated, as partnership status has been found to have a positive influence on individuals' desires for having children (Sturm et al., 2023). Unfortunately, we cannot differentiate between voluntary and involuntary childlessness in this study. In the Finnish Family Barometer (2023), about 17% percent of participants answered that their ideal number of children was zero in 2022 and 15% correspondingly in 2015 (Sorsa et al., 2023). Future studies should investigate the relationship between mental health and voluntary childlessness.

Finally, the broader societal context of Finland should be considered when interpreting these results. Finland represents a universalistic Nordic welfare state, in which access to health care, including mental health services, is comparatively universal and less strongly stratified by income than in many other countries. However, equal access to services does not imply equal exposure to mental health problems. Mental health disorders remain socially patterned in Finland and are more prevalent among individuals from socioeconomically disadvantaged backgrounds and those with less favourable family circumstances (Evensen et al., 2020). Moreover, despite the principle of universalism, increases in user fees and other barriers may disproportionately affect access to mental health services among less advantaged groups (Wahlbeck et al., 2008).

In welfare regimes with weaker social protection and more unequal access to health care, mental health problems may therefore pose an even greater obstacle to entry into parenthood due to higher financial risks and more limited access to treatment and support. By contrast, the relatively universal provision of mental health services in Finland may attenuate the observed associations between mental health problems and family formation. Overall, the associations identified in this study are therefore likely conservative in the Finnish context, and comparative research across different welfare regimes is needed to better assess how variation in social inequality and institutional contexts shapes the relationship between mental health and family formation.

5.2 Conclusion

All mental health disorders are associated with an increased risk of childlessness, and this association is stronger for severe disorders. However, taking current partnership status into account largely explains the differences in the strength of the association between different mental health disorders. This indicates that for some mental health disorders the reduced risk of having a child is strongly mediated by partnerships. Lastly, when both partners in a couple have a mental health disorder, the likelihood of childlessness is higher than in couples where neither or only one of the partners has a disorder.

Our research offers valuable insights on the relationship between mental health and childlessness. Additionally, it aims to provide guidance for decision-makers and stakeholders in supporting individuals and couples in achieving their desired number of children. We encourage these actors to recognise mental health problems in individuals and couples of childbearing ages as a potential barrier to parenthood.

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Statistics Finland's Board of Statistical Ethics (K/23/07.03.00/2024, U0256_C_22) and Findata permission (THL/6303/14.06.00/2023) have approved the use of the register data underlying this study.

Data availability statement

Finnish register data is available for approved users from Statistics Finland, subject to fees.

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Information in German

Deutscher Titel

Zusammenhang zwischen psychischen Störungen und Kinderlosigkeit: Die Rolle der Art der Störung und der Partnerschaft

Zusammenfassung

Fragestellung: Die Studie untersucht, wie verschiedene psychische Erkrankungen mit Kinderlosigkeit zusammenhängen.

Hintergrund: Psychische Probleme nehmen zu, während Kinderlosigkeit immer häufiger vorkommt. Ausgehend von einer Lebensverlaufsperspektive, die partnerschaftsbezogene Prozesse in den Vordergrund stellt, untersuchen wir, inwiefern verschiedene psychische Störungen mit Kinderlosigkeit zusammenhängen und ob sich diese Zusammenhänge durch den Partnerschaftsstatus sowie die psychische Gesundheit des Partners erklären lassen.

Methode: Wir verwenden finnische Registerdaten und diskrete Ereigniszeitmodelle, um die jährliche Wahrscheinlichkeit der Geburt eines ersten Kindes zu analysieren.

Ergebnisse: Alle Arten psychischer Störungen sind mit einer geringeren Wahrscheinlichkeit verbunden, erstmals ein Kind zu bekommen. In alterskontrollierten Modellen ist die jährliche Wahrscheinlichkeit für Frauen um 0,8–1,3 Prozentpunkte und für Männer um 1,0–1,8 Prozentpunkte niedriger, wobei die stärksten Zusammenhänge bei schweren psychischen Störungen zu beobachten sind. Die Berücksichtigung von Partnerschaften und der psychischen Gesundheit des Partners schwächt diese Zusammenhänge ab, insbesondere bei Männern (für jegliche psychische Störung: 13 % bei Frauen und 36 % bei Männern im Vergleich zu alterskontrollierten Modellen).

Schlussfolgerung: Partnerschaften und die psychische Gesundheit des Partners bzw. der Partnerin sind wichtig, um den Zusammenhang zwischen psychischen Störungen und Kinderlosigkeit im Lebensverlauf zu verstehen, insbesondere bei Männern.

Schlagwörter: psychische Gesundheit, Kinderlosigkeit, Partnerschaften, Partner, Fertilität

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