

## **Do Mental Health Declines Contribute to Falling Fertility Motivations? A Cohort Analysis from Australia**

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### **ABSTRACT**

Both average mental health and fertility rates sharply declined across various societies in the 21<sup>st</sup> century, especially among younger people. However, it remains unclear whether these two population level trends are interconnected, and whether declines in mental well-being are contributing to falling fertility motivations and ultimately fertility rates. Recent research indicates this may be the case, as people with poor mental health have lower fertility expectations and fewer births. We extend this research by investigating if mental health is associated with the intention to remain childfree, whether it predicts the gap between desiring and expecting to have a(nother) child, and whether these relationships have changed among young people aged 18-23 born in the 1980s, 1990s, and 2000s in Australia. We use data from the HILDA panel, generalized linear models with within- and between estimators, and decomposition analyses to address these questions. Indeed, we find that higher levels of mental distress predict childfree intentions, and that this association got stronger among the younger birth cohorts. Although the *within-person* association (how changes in an individual's mental health relate to changes in their own childfree intentions over time) did not differ across birth cohorts, the *between-person* association (whether people with poorer mental health than others are also more inclined toward childfree intentions than others) grew stronger from the 1980s to the 1990s birth cohort. Most of this increase was due to strengthening in the association between poor mental health and childfree intentions, not because the proportion of people with poor mental health increased. Poor mental health also predicted a larger gap between desiring and expecting to have a(nother) child, although the strength of this association did not vary by birth cohort. In sum, mental health not only emerges as a significant predictor of fertility motivations, but it has also gained in importance in predicting childfree intentions among the most recent Australian birth cohorts.

### **Acknowledgements**

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## Introduction and Background

Over the past two decades, two population-level trends have unfolded simultaneously: First, total fertility rates have declined more steeply than in prior decades across many high-income countries (HFD, 2025), and were accompanied, at least in some contexts, by falling fertility motivations, e.g. in Finland, Norway, USA (Dommermuth et al., 2025; Golovina (née Savelieva) et al., 2023; Hartnett & Gemmill, 2020). Second, mental health appears to have deteriorated, particularly among young people. In Australia, recent research documents marked cohort differences in reported mental health, with worse mental health outcomes being reported by more recent generations, especially at younger ages (Botha et al., 2023). Yet, whether and how these two trends may be interconnected and potentially cause or reinforce each other remains understudied.

Many aspects that may be underlying falling fertility are currently being discussed and investigated, for instance economic challenges and uncertainty (Vignoli et al. 2020), increase in precarious work arrangements & automatization (Matysiak et al., 2023) gender in/equality & shifting gender norms (Erfani & Pilon, 2025), housing problems (van Wijk & Feijten, 2025), climate change & environmental concerns (Peters et al., 2025), environmental & health related factors such as rising infecundity, plastic and toxins (Tricotteaux-Zarqaoui et al., 2024), partnering changes (Tan et al. 2025, Reimondos et al. 2025) or “shifting priorities” around for instance leisure or parenting (Kearney & Levine, 2026).

However, psychological factors, though likely important, have received little attention in the context of investigating fertility motivations and behaviours in general (McAllister et al., 2016) and in the context of the current fertility declines in particular. Emerging evidence, however, points to a meaningful link between mental health and fertility: people with severe mental illness have been documented to have fewer children in the UK, Scotland, and Finland (Golovina et al., 2023; Hope et al., 2020; MacBeth et al., 2023). A recent study from Australia further shows that people with poor mental health expect to have fewer children (Lazzari & Beaujouan, 2025).

Despite these first studies into the mental health & fertility link, many pressing research questions remains to date unanswered: Does poor mental health predict childfree desires among young people? Does it predict the gap between desiring children and expecting to have them? Are there cohort differences in these relationships? And has rising poor mental health contributed to observed declines in fertility intentions and eventually birth rates?

The current preliminary version of this study addresses the first three questions. To address them, we use data from the HILDA and multilevel logit panel regression models with within- and between-variance estimators (Mundlak estimator) to examine the link between mental health and childfree intentions or mental health and the desire-expectation gap across birth cohorts among young childless Australians. The next version of our study will also turn to the broader question of whether rising rates of poor mental health help explain the observed decline in the intention to ever have children by applying decomposition analyses.

## Data, Measures and Methods

### *Data*

Data were drawn from the Household, Income and Labour Dynamics in Australia (HILDA) longitudinal survey (2000–2023). Analyses were restricted to respondents born in the 1980s, 1990s, or 2000s (Gen Z), observed between ages 18 and 23 — the common age window available across all three birth cohorts ( $N = 11,043$ ).

### *Measures*

We created two dependent variables. First, *childfree* intending status was defined as being currently childless and intending zero future children. Second, each HILDA respondent provides a rating from 1 to 10 on their desire to have more children (*iclike*) as well as their expectation they will have more children (*icexpect*). The measure for the *gap* between childbearing desires and expectation was created by subtracting the latter from the former. Please note that the second analysis on the desire-expectation gap is estimated on a larger sample that includes larger age ranges and parents. We will streamline the sample in the next version of this study.

The key predictor, *mental health* was assessed using the MHI-5 (range 0–100) and decomposed into between-person (Level 2, person-mean) and within-person (Level 1, deviation from mean) components.

*Demographic characteristics* were determined for each person in each cohort (males and females aged between 18 and 23, born in the 1980s, 1990s, 2000s). As the survey is longitudinal, most respondents were observed more than once and so we took the last observation except for age where we calculated the average age per person. Note that education represents the highest level of education achieved where the minimum is highschool (Year 12), and so “none” indicates the person has not finished high school (Year 12).

### *Analytic Strategy*

Cohort and sex differences in MHI-5 scores were estimated using a linear mixed model (LMM). Cohort differences in the proportion of childfree individuals were estimated using a generalised linear mixed model (GLMM; binomial family, logit link, random intercept for person) with fixed effects for age and birth cohort, fitted separately by sex. In order to test whether the effect of mental health on childfree intentions varied by cohort, we modelled the probability of wishing to remain childfree ( $\pi$ ) in a multilevel logistic regression. The total variation in mental health was partitioned into between- and within-person components, which were included as Level 2 and Level 1 predictors respectively (i.e., a *Mundlak*-hybrid model, Mundlak, 1978). The result of interest was the interaction between cohort and each mental health component: a significant cohort interaction with the between-person component would indicate that cohorts differ in how a person’s average mental health relates to their fertility intentions, while a significant interaction with the within-person component would indicate that cohorts differ in how fluctuations in an individual’s own mental health relate to shifts in those intentions. Random intercepts for individuals were included to account for the non-independence of repeated observations across waves. The associations between mental health and the probability of intending to remain childfree ( $\pi$ ) or the desire-

expectation gap were tested using a generalised additive model (GAM; binomial family) including both mental health components, cohort, a cohort  $\times$  between-person mental health interaction, and smooth age effects by sex and cohort. We further employed decomposition analyses to decompose the between person variance in the association between mental health and childfree intentions into the composition component (differences in MH levels between cohorts) and the coefficient component (difference in the association between MH and children intention), comparing the 1980s to the 1990s and the 1980s to the 2000s cohort. Please note that the analyses are based on bivariate logistic regressions that do not control for any covariates currently.

## Results

### *Sample Description*

The sample comprised 1,851 (2000s), 5,071 (1990s), and 4,121 (1980s) respondents, with approximately equal sex distributions (~50% female) across cohorts. Table 1 depicts descriptive statistics for each of the three birth decade cohorts. Cohorts differed in expected ways with age and time: the GenZ cohort (2000s) was less likely to be observed at older ages (see Appendix for common age range results); the prevalence of couples increased with cohort from 20% in Gen Z (2000s) to 34% in 1980s; likewise, parenthood increased from 4.8% to 13% and education levels also increased with cohort, consistent with more frequent observations at older ages.

Table 1. Sample characteristics by birth cohort

| <b>Characteristic</b>                                                 | <b>2000s</b><br>N = 1,851 | <b>1990s</b><br>N = 5,071 | <b>1980s</b><br>N = 4,121 | <b>p-value<sup>1</sup></b> |
|-----------------------------------------------------------------------|---------------------------|---------------------------|---------------------------|----------------------------|
| Female, % (n/N)                                                       | 50% (925/1,851)           | 51% (2,572/5,071)         | 50% (2,062/4,121)         | 0.76                       |
| Age, Median (IQR)                                                     | 19.00 (18.50 – 20.00)     | 20.50 (20.20 – 21.00)     | 20.50 (20.50 – 22.00)     | <0.001                     |
| Born, Median (IQR)                                                    | 2,002 (2,001 – 2,004)     | 1,994 (1,992 – 1,997)     | 1,985 (1,982 – 1,988)     | <0.001                     |
| Coupled, % (n/N)                                                      | 20% (377/1,851)           | 34% (1,713/5,071)         | 34% (1,391/4,121)         | <0.001                     |
| Parent, % (n/N)                                                       | 4.8% (89/1,851)           | 11% (558/5,071)           | 13% (529/4,121)           | <0.001                     |
| Education, % (n/N)                                                    |                           |                           |                           | <0.001                     |
| Degree                                                                | 7.0% (129/1,851)          | 16% (823/5,071)           | 16% (647/4,121)           |                            |
| Highschool                                                            | 60% (1,117/1,851)         | 56% (2,856/5,071)         | 52% (2,163/4,121)         |                            |
| None                                                                  | 33% (605/1,851)           | 27% (1,392/5,071)         | 32% (1,311/4,121)         |                            |
| <sup>1</sup> Pearson's Chi-squared test; Kruskal-Wallis rank sum test |                           |                           |                           |                            |

### Birth Cohort Trends in Mental Health

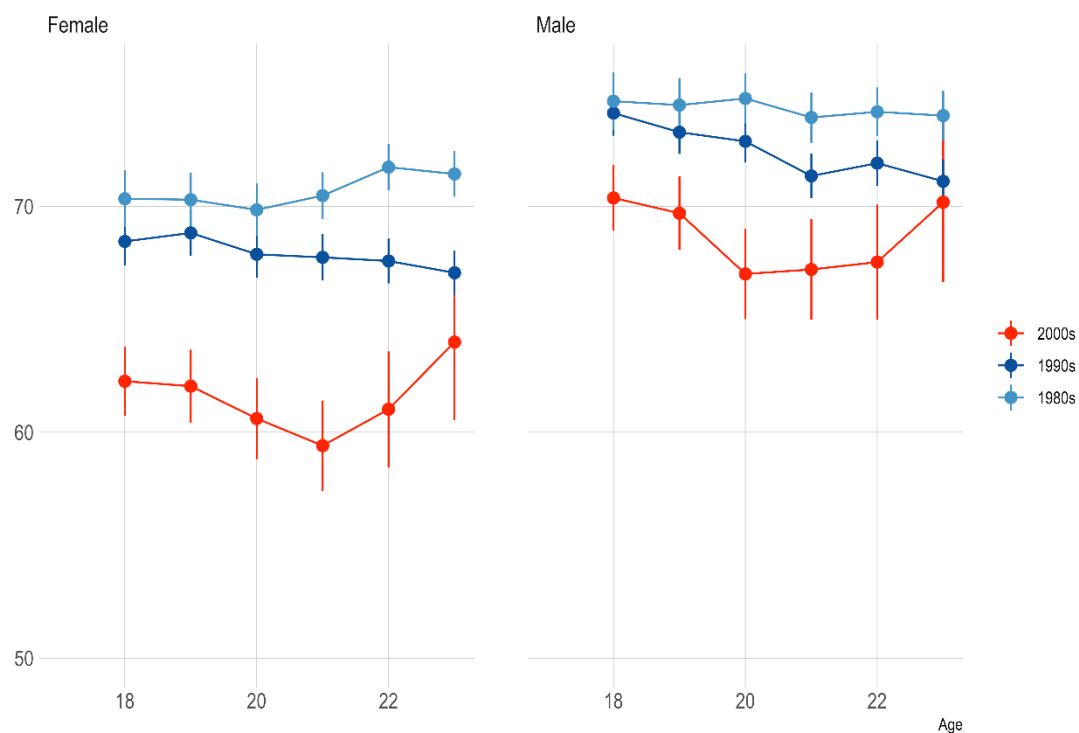
Figure 1 shows average mental health by birth cohort and age, for women and men separately. The most recent cohort (2000s) had significantly lower mental health on average than each earlier cohort ( $p < .001$ ). Females had significantly lower mental health than males ( $p < .001$ ). The sex difference in mental health was significantly larger in the 2000s relative to earlier cohorts (largest  $p = .004$ ).

The LMM confirms these results (Table 2). It revealed that the 2000s cohort had significantly lower mean MHI-5 scores (intercept = 61.44) than both the 1990s ( $\beta = 6.09, p < .001$ ) and 1980s cohorts ( $\beta = 8.95, p < .001$ ). Females had significantly lower mental health than males overall ( $\beta = 7.30, p < .001$ ), and this sex gap was significantly narrower in the 1990s ( $\beta = -2.58, p = .004$ ) and 1980s ( $\beta = -3.77, p < .001$ ) cohorts relative to the 2000s, indicating the sex difference in mental health was largest in Gen Z.

Figure 1: Mental health by age, birth cohort, and gender

#### Mental health is lower among recent generations

Mean MHI-5 score (0 - 100)



**Table 2: LMM summary: Mental health cohort differences**

| effect | term       | estimate | std.error | statistic | df        | p.value |
|--------|------------|----------|-----------|-----------|-----------|---------|
| fixed  | 2000s      | 61.441   | 0.545     | 112.707   | 9,678.478 | 0.000   |
|        | 1990s      | 6.087    | 0.630     | 9.656     | 9,337.324 | 0.000   |
|        | 1980s      | 8.950    | 0.654     | 13.677    | 9,478.309 | 0.000   |
|        | Male       | 7.300    | 0.784     | 9.310     | 9,706.644 | 0.000   |
|        | 1990s:Male | -2.580   | 0.908     | -2.843    | 9,371.717 | 0.004   |
|        | 1980s:Male | -3.771   | 0.941     | -4.007    | 9,541.696 | 0.000   |

### *Birth Cohort Differences in Childbearing Intentions*

Birth cohort differences in childbearing intentions were also present. Figure 2 indicates that the proportion of women wishing to remain childfree was highest in Gen Z; the GLMM, shown in Table 3, confirmed that the log-odds of intending to remain childfree were significantly lower in the 1990s (log-odds =  $-0.375$ ,  $p = .012$ ) and 1980s (log-odds =  $-0.898$ ,  $p < .001$ ) cohorts relative to the 2000s, after adjusting for age. No significant cohort differences were found in men (lowest  $p = .116$ ), and no cohort  $\times$  age interaction was detected in women ( $p = .437$ ).

Figure 2: The proportion of *childfree intending* people by sex and birth cohort.

### **More Gen Z women wish to remain childfree than Millennial women**

Proportion of females and males aged 18-23 who are childless and wish to remain childfree (by birth cohort)

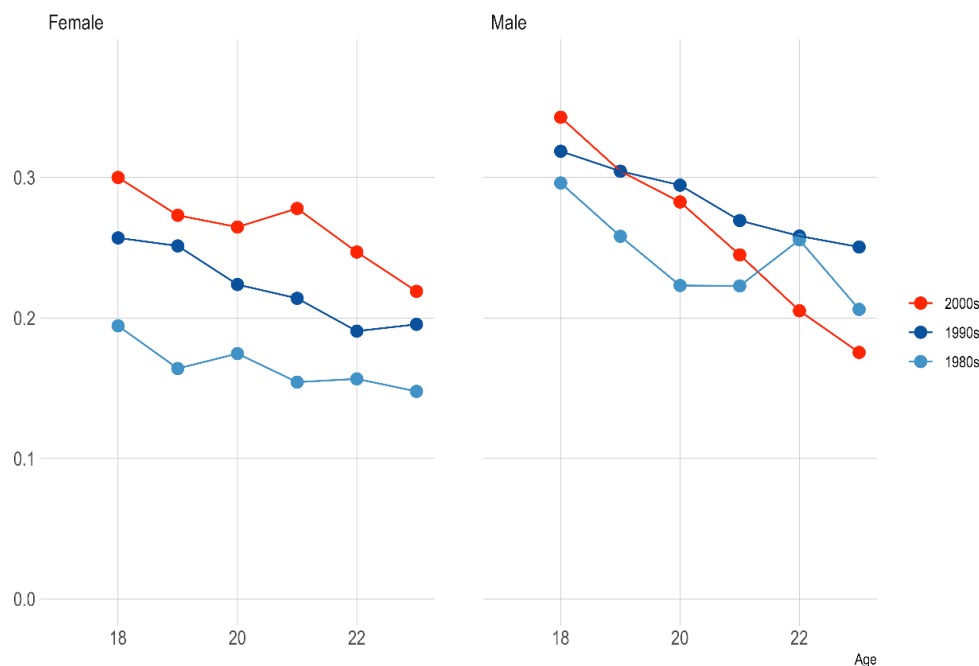


Table 3 confirms that the proportion of young women who wish to remain childfree was higher among Gen Z (2000s birth cohort) relative to Millennials (1990s, 1980s). A generalized linear multilevel model (i.e., a binomial **GLMM** with a logit link function and random intercept for individuals to account for repeated measures) estimating the fixed effect of age and cohort on *childfree* women confirmed the proportion was significantly less among 1990s women (log odds -0.375,  $p = .012$ ) and 1980s women (log odds -0.898,  $p < .001$ ).

**Table 3: GLMM summary: Female childfree intending trends**

| effect | term        | estimate | std.error | statistic | p.value |
|--------|-------------|----------|-----------|-----------|---------|
| fixed  | (Intercept) | 0.049    | 0.340     | 0.145     | 0.885   |
|        | age         | -0.115   | 0.016     | -7.152    | 0.000   |
|        | 1990s       | -0.375   | 0.150     | -2.502    | 0.012   |
|        | 1980s       | -0.898   | 0.157     | -5.724    | 0.000   |

A separate model of men found no significant differences between cohorts wishing to remain childfree (lowest  $p = .116$ ), and further sensitivity tests of the women confirmed no significant cohort-specific trends (interaction between age and cohort  $p = .4369$ ).

#### *Intending to remain childfree and mental health*

We modelled the probability of wishing to remain childfree ( $\pi$ ) in a logistic regression model to test whether the effect of mental health on  $\pi$  varied by cohort. The total variation in mental health was partitioned into between- and within-person components, which were included as Level 2 and Level 1 predictors respectively. The model also included smooth effects of age to control for the non-linear effects of age on  $\pi$ .

**Table 4: ANOVA table: Probability childfree**

| Terms              | df | Chi.sq | p-value |
|--------------------|----|--------|---------|
| Cohort             | 2  | 30.47  | <.001   |
| Between-MH         | 1  | 118.10 | <.001   |
| Within-MH          | 1  | 17.50  | .00003  |
| Cohort:Between-MH2 | 2  | 6.01   | .04942  |
| Cohort:Within-MH   | 2  | 1.36   | .50674  |

The Type III analysis of deviance for the full model indicated a significant main effect of cohort ( $\chi^2(2) = 30.47$ ,  $p < .001$ ), a strong effect of between-person mental health ( $\chi^2(1) = 118.10$ ,  $p < .001$ ), and a smaller but significant effect of within-person mental health ( $\chi^2(1) = 17.50$ ,  $p < .001$ ) on the probability of wishing to remain childfree ( $\pi$ ). Both

mental health components were associated with lower odds of intending to remain childfree, consistent with better mental health – whether measured as a person’s average level or as a temporary improvement relative to their own average – being associated with stronger fertility intentions.

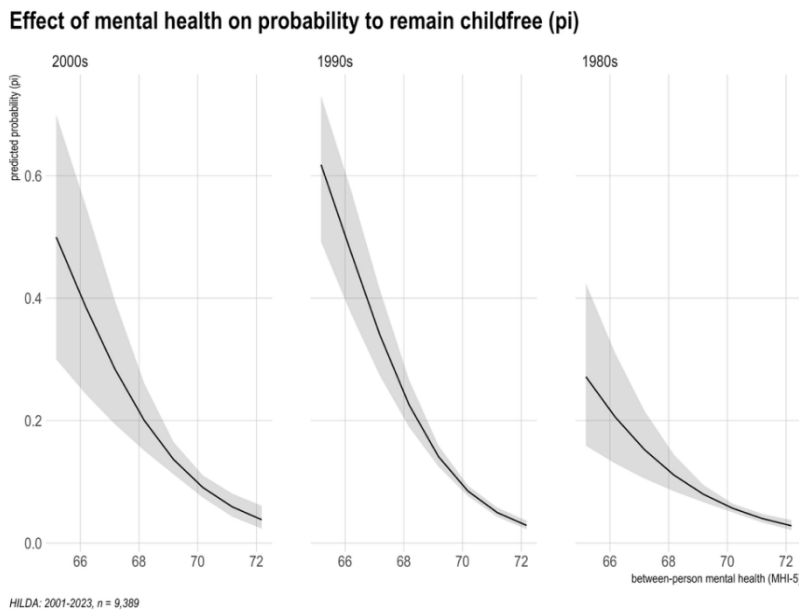
The interaction between cohort and the between-person mental health component was significant in both the planned Wald test and a follow-up likelihood ratio test (Wald  $\chi^2(2) = 6.01$ ,  $p = .049$ ; likelihood ratio test,  $\chi^2(2) = 6.03$ ,  $p = .049$ ), indicating that the strength of the between-person association varied across cohorts. Note that AIC favoured the model including the interaction, while BIC favoured the simpler model excluding it, reflecting the borderline nature of the interaction.

In contrast, the interaction between cohort and the within-person mental health component was not significant (Wald  $\chi^2(2) = 1.36$ ,  $p = .507$ ; likelihood ratio test,  $\chi^2(2) = 1.36$ ,  $p = .507$ ), with AIC and BIC in agreement in favouring the simpler model. This indicates no evidence that the association between within-person fluctuations in mental health and fertility intentions differed across cohorts.

Pairwise comparisons of cohort-specific slopes showed that the between-person interaction was driven specifically by a stronger association in the 1990s cohort (slope =  $-0.57$ ) compared to the 1980s cohort (slope =  $-0.37$ ; difference =  $-0.21$ ,  $SE = 0.08$ , Tukey-adjusted  $p = .039$ ). The 2000s cohort (slope =  $-0.46$ ) did not differ significantly from either the 1990s ( $p = .56$ ) or 1980s ( $p = .68$ ) cohorts, and its estimate carried a wider confidence interval, likely reflecting fewer repeated observations available for this younger cohort within the study’s observation window. Taken together, these results suggest that cohort differences in the relationship between mental health and fertility intentions operate primarily at the between-person level – reflecting who tends to want to remain childfree – rather than at the within-person level, which showed a consistent association across all three cohorts.

A plot of the marginal effect of between-person mental health shows the 2000s and 1990s cohorts had a steeper slope for the effect of mental health on  $\pi$  than the 1980s cohort, indicating the probability of wishing to remain childfree ( $\pi$ ) was higher when mental health was poor (low) in more recent cohorts.

Figure 3



As a preliminary, post hoc follow-up to the Mundlak-hybrid analysis, we conducted a nonlinear counterfactual decomposition of the observed gap in childfree probability between the 1990s and 1980s and the 2000s and 1980s cohorts, in order to establish whether this gap primarily reflected the two cohorts having different *levels* of mental health (a compositional explanation) or a different *association* between mental health and childfree probability (a coefficients explanation). Results are shown in table 5. Separate logistic models predicting childfree probability from mental health were fitted for each cohort on complete cases (respondents with missing mental health scores excluded), and the total gap in mean predicted probability between cohorts was decomposed by constructing counterfactual predicted probabilities under each cohort's covariate distribution combined with the other cohort's fitted coefficients. To address the sensitivity of this decomposition to the choice of reference group, both directions (1980s coefficients applied to the 1990s distribution, and vice versa) were computed and averaged.

This decomposition indicated that the majority of the gap between cohorts (84.4%) was attributable to the differing *association* between mental health and childfree probability across cohorts, rather than to the cohorts differing in their average mental health levels (15.6% of the gap). This split was similar across both reference-group specifications (88.9%/11.1% and 79.9%/20.1% before averaging, suggesting the result is not an artifact of the reference group chosen). Together, this indicates that the cohort difference identified in the primary analysis is unlikely to simply reflect a compositional difference in mental health between cohorts, and is more consistent with mental health translating into fertility intentions differently across cohorts. This result should nonetheless be treated as preliminary and exploratory: it was conducted post hoc following identification of a marginally significant cohort interaction in the primary model, is based on a bivariate specification (mental health only, with no adjustment for other potential compositional differences between cohorts such

as socioeconomic status, education, or relationship history), and does not yet include bootstrapped confidence intervals around the composition/coefficients split. Future work should extend this decomposition to include additional covariates and establish confidence intervals via cluster bootstrap to formally quantify the precision of this split.

*Table 5*  
*Bootstrapped Decomposition of the Cohort Gap in Childfree Probability*

| Component                                       | % of Gap | 95% CI       |
|-------------------------------------------------|----------|--------------|
| <i>1990s vs. 1980s cohorts</i>                  |          |              |
| Composition (different MH levels)               | 15.9     | [9.9, 24.2]  |
| Coefficients (different MH–outcome association) | 84.1     | [75.8, 90.1] |
| <i>2000s vs. 1980s cohorts</i>                  |          |              |
| Composition (different MH levels)               | 27.7     | [17.8, 42.2] |
| Coefficients (different MH–outcome association) | 72.3     | [57.8, 82.2] |

*Note.* MH = mental health. Percentages reflect the average of two reference-group decompositions (younger-cohort and 1980s coefficients) of the gap in predicted probability of remaining childfree between each cohort pair and the 1980s reference cohort, bootstrapped over 1,000 resamples clustered by respondent (xwaveid). CI = confidence interval. The 2000s vs. 1980s pairwise comparison did not reach significance in the primary hybrid model (Tukey-adjusted  $p = .68$ ); this decomposition should therefore be interpreted with particular caution as descriptive/exploratory only.

#### *Gap between desires and expectations*

Below in Figure 4 we show the average individual difference between desire and expectation ( $\delta = \text{iclike} - \text{icexpct}$ ) for childless singles and couples (non-parents), as well as single and coupled parents (with at least one child).

The difference between an individual's desire for more children and expectation of more children ( $\delta$ ) is higher for childless singles than couples, and higher for non-parents than parents. This makes sense as single people are likely to desire children but cannot expect to have children while they remain single (so must have a large difference score). Conversely couples can expect to have children and so the difference between their desire and expectation must be less (and so have a smaller difference score).

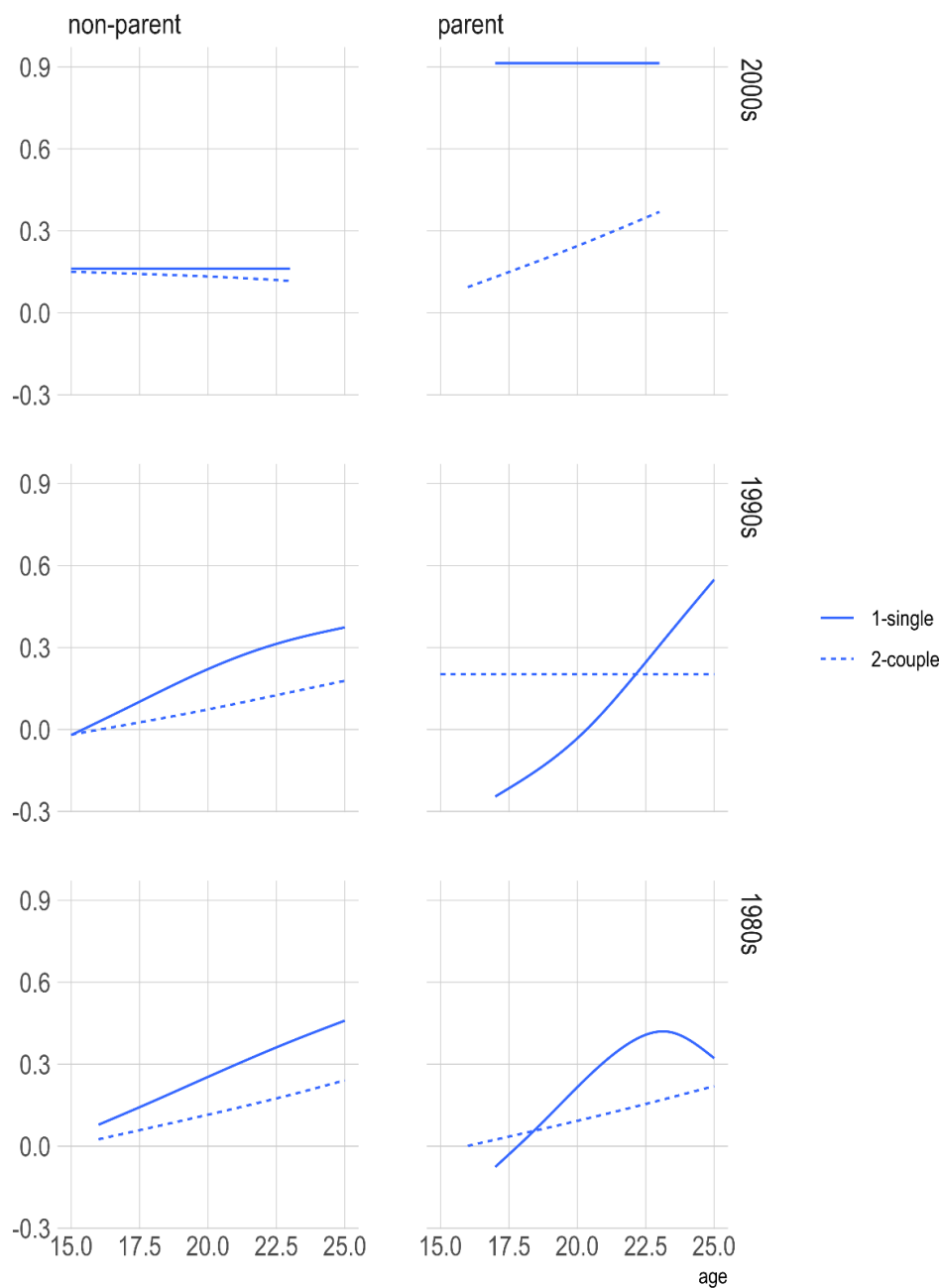
Next, we modelled whether the difference between a person's desire for more children and expectation of more children ( $\delta = \text{iclike} - \text{icexpct}$ ) was explained by variation in mental health. The total variation in mental health was partitioned into between- and within-person components, which were included as Level 2 and Level 1 predictors in a multilevel model of  $\delta$  for each cohort separately. As  $\delta$  varied non-linearly over age, each model also included smooth effects of age as a penalized cubic spline.

The Level 2 between-person variation in mental health explained more difference  $\delta$  than the Level 1 within-person variation in each model except for the 1980s cohort, where both slopes were significant ( $ps < .001$ ). The slope between mental health and  $\delta$  was negative for each cohort except 2000s, and steepest for the 1970s cohort. The direction of the slope in each case

indicates that poor mental health was associated with larger differences between the desire and expectation of more children ( $\delta$ ). Conversely good mental health was associated with smaller difference (Figure 5).

Figure 4

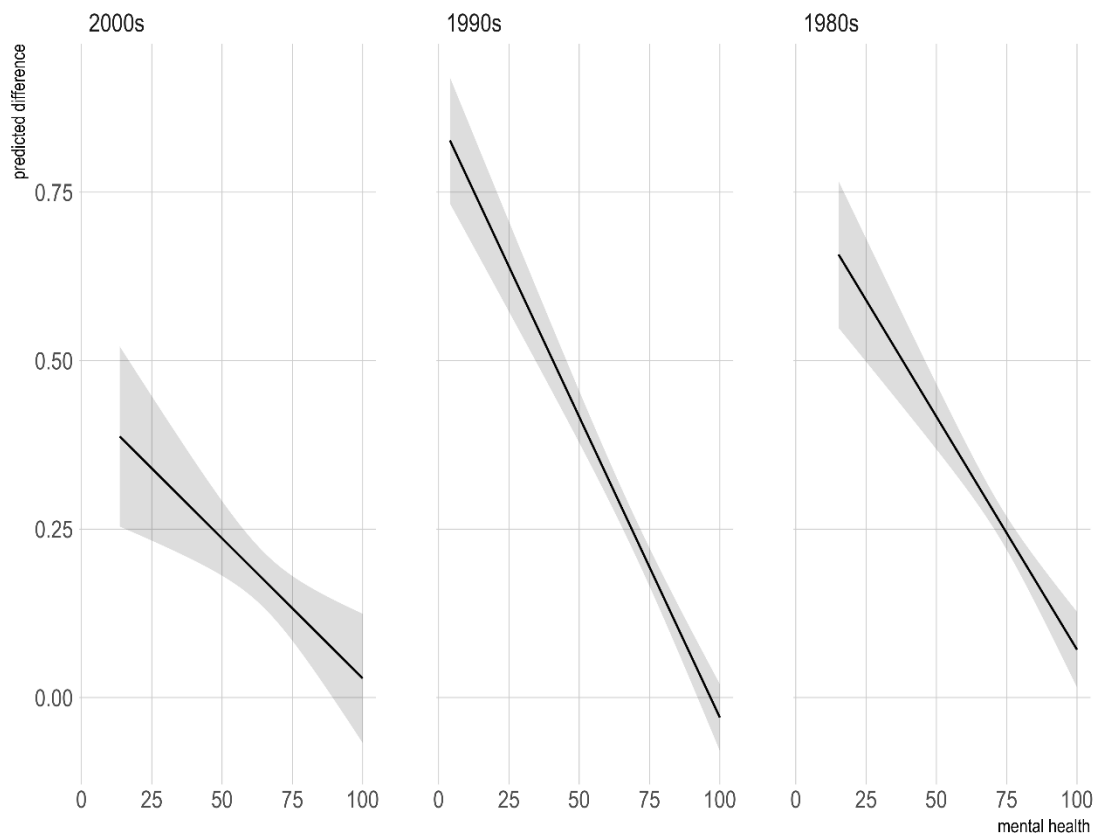
### Difference between desire and expectation of more children by



HILDA: 2001-2023,  $n = 11,183$

Figure 5

### Effect of mental health on difference (desire - expectation)



HILDA: 2001-2023, N = 25,698

## Discussion and Conclusions

Our study set out to study the association between young people's mental health and their fertility motivations. We were interested to understand if poorer mental health may predict lower intentions to ever become a parent among those that are still childless, and if poorer mental health may be linked to a larger gap between the desire and expectation to have a(nother) child among young people without and with children. Further, we investigated if these association differ between young people born in the 1980s, 1990s, and 2000s, to get a sense of whether a potential impact of poor mental health may have become stronger among the more recent birth cohorts.

Indeed, we make several interesting findings.

First, and as documented elsewhere, we show that average mental health has declined with each subsequent birth cohort among young Australians aged 18-23 (Botha et al., 2023). It is also lower among young women compared to young men. We also find that the proportion of young people with intention to ever become a parent has declined among subsequent birth cohorts.

Second, our key finding was that these two trends are associated. Lower mental health predicted lower intentions to ever become a parent, both within persons over their life course time (within effect) as well as between persons (between effect).

Third, while there were no cohort differences in the within-person association between mental health and fertility intentions, we found a significant strengthening of the between person component from the 1980s to the 1990s cohort. The interaction effect was not significant between the 1980s and 2000s cohort, which may be due to smaller sample size of the 2000 cohort.

Fourth, a preliminary and exploratory decomposition analyses indicated that most (84 percent) of the significant 1980s to 1990s difference in the between person association between mental health and childfree intention was due to an increase in the effect strength of the association between mental health and childfree intention, while only 16 percent were due to compositional changes in levels of mental health between the two cohorts. Hence, even though subsequent cohorts of young people show more depressive symptoms, this pure level increase in poor mental health is not the main driver of the strengthening association between poor mental health and childfree intentions from the 1980s to the 1990s cohort. Rather, how strongly poor mental health is associated with childfree intentions has risen.

Fifth, mental health also predicted the gap between desiring and expecting to have a(nother) child, yet, there were no apparent cohort differences in this association.

While we find a significant positive relationship between (good) mental health and (higher) intentions to become a parent, the mechanisms underlying this link, and changes in the strength of the link over birth cohorts, remain unclear. Several pathways may be at play: Poor mental health may lead to difficulty forming or maintaining partnerships; feeling too unwell to raise children; having concerns about the impact of pregnancy on one's own health; fear of passing illness to offspring may underlie the association; or the reluctance of a partner to have a child with a mentally unwell person could contribute. Alternatively, mental health and childbearing motivations may be driven by common underlying factors such as adverse childhood experiences or poor general health. Of course, various of these, or additional, mechanisms may be at play simultaneously. More research is needed to examine these underlying pathways.

Also, future research should aim to understand what drives the strengthening relationship between poor mental health and childfree intentions between the 1980s and 1990s birth cohorts our findings document. Our preliminary decomposition analyses indicate that this may not be primarily due to level increases in poor mental health. Rather, the strengthening association between having poor mental health and childfree intentions deserves more attention. The strengthening may be due to various factors such as weakening pronatalist norms that encouraged childbearing irrespective of personal circumstances in the older cohort, rising cultural expectations around intensive and psychologically demanding parenting, and a growing emphasis on psychological readiness as a precondition for parenthood. A more direct pathway may also be at work: if people with poor mental health are less likely to find and retain partners in younger cohorts than in the past, reduced partnering could itself mediate the strengthening link between poor mental health and childfree ideation. Finally, growing uncertainty about the future, for instance around factors such as climate change and economic precarity, may weigh especially heavily on individuals

with poor mental health, making them more likely than their healthier peers to opt out of parenthood altogether in the younger cohort.

## References

- Botha, F., Morris, R. W., Butterworth, P., & Glozier, N. (2023). Generational differences in mental health trends in the twenty-first century. *Proceedings of the National Academy of Sciences*, 120(49), e2303781120. <https://doi.org/10.1073/pnas.2303781120>
- Dommermuth, L., Lyngstad, T. H., & Wiik, K. A. (2025). Fertility Intentions Across Five Decades in Norway. *Comparative Population Studies*, 50. <https://doi.org/10.12765/CPoS-2025-09>
- Erfani, A., & Pilon, L. (2025). Gender Equality in the Division of Housework and Fertility Intentions in Canada: The Moderating Effect of Employment and Education. *Journal of Family Issues*, 46(5), 784–804. <https://doi.org/10.1177/0192513X241299419>
- Golovina, K., Elovainio, M., & Hakulinen, C. (2023). Association between depression and the likelihood of having children: A nationwide register study in Finland. *American Journal of Obstetrics and Gynecology*, 228(2), 211.e1-211.e11. <https://doi.org/10.1016/j.ajog.2022.10.016>
- Golovina (née Savelieva), K., Nitsche, N., Berg, V. E., Miettinen, A., Rotkirch, A., & Jokela, M. (2023). Birth cohort changes in fertility ideals: Evidence from repeated cross-sectional surveys in Finland. *European Sociological Review*, 1–16. <https://doi.org/10.1093/esr/jcad048>
- Hartnett, C. S., & Gemmill, A. (2020). Recent Trends in U.S. Childbearing Intentions. *Demography*, 57(6), 2035–2045. <https://doi.org/10.1007/s13524-020-00929-w>
- HFD. (2025). *Human Fertility Database* [Data set]. <https://www.humanfertility.org/>
- Hope, H., Parisi, R., Ashcroft, D. M., Williams, R., Coton, S., Kosidou, K., Pierce, M., & Abel, K. M. (2020). Fertility trends of women with serious mental illness in the United Kingdom 1992–2017: A primary care cohort study using the clinical practice research datalink. *Journal of Affective Disorders*, 269, 141–147. <https://doi.org/10.1016/j.jad.2020.03.037>
- Kearney, M. S., & Levine, P. B. (2026). *NBER WORKING PAPER SERIES. Working Paper 33989*.
- Lazzari, E., & Beaujouan, É. (2025). Self-assessed Physical and Mental Health and Fertility Expectations of Men and Women Across the Life Course. *Demography*, 62(2), 543–569. <https://doi.org/10.1215/00703370-11873109>
- MacBeth, A., McSkimming, P., Bhattacharya, S., Park, J., Gumley, A., St Clair, D., & Barry, S. J. E. (2023). General and age-specific fertility rates in non-affective psychosis: Population-based analysis of Scottish women. *Social Psychiatry and Psychiatric Epidemiology*, 58(1), 105–112. <https://doi.org/10.1007/s00127-022-02313-y>
- Matysiak, A., Bellani, D., & Bogusz, H. (2023). Industrial Robots and Regional Fertility in European Countries. *European Journal of Population*, 39(1), 11. <https://doi.org/10.1007/s10680-023-09657-4>
- McAllister, L. S., Pepper, G. V., Virgo, S., & Coall, D. A. (2016). The evolved psychological mechanisms of fertility motivation: Hunting for causation in a sea of correlation. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 371(1692), 20150151. <https://doi.org/10.1098/rstb.2015.0151>
- Peters, S., Striessnig, E., Trimarchi, A., Testa, M. R., & Nitsche, N. (2025). Too worried about the environment to have children? Or more worried about the environment after having children? *Population and Environment*, 47(3), 31. <https://doi.org/10.1007/s11111-025-00501-x>
- Tricotteaux-Zarqaoui, S., Lahimer, M., Abou Diwan, M., Corona, A., Candela, P., Cabry, R., Bach, V., Khorsi-Cauet, H., & Benkhalifa, M. (2024). Endocrine disruptor chemicals exposure and female fertility declining: From pathophysiology to epigenetic risks. *Frontiers in Public Health*, 12, 1466967. <https://doi.org/10.3389/fpubh.2024.1466967>
- van Wijk, D., & Feijten, P. (2025). Rising House Prices, Falling Fertility? How Rising House Prices Widen Fertility Differences between Tenure Groups. *European Journal of Population = Revue Européenne De Demographie*, 41(1), 33. <https://doi.org/10.1007/s10680-025-09754-6>