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Regular Article

Parental mental health and the economic preferences of the next generation☆,☆☆

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ABSTRACT

This paper provides the first evidence that children's economic preferences vary systematically with parental mental health. Using experimentally elicited measures of economic preferences from more than 4500 children in Bangladesh, we document that children of parents with indications of mental illness are less prosocial but more patient than their peers with mentally healthy parents. Attitudes towards risk remain unchanged. We discuss potential pathways through which parental mental health may influence the formation of children's preferences, documenting that children of parents with indication of mental illness assume greater responsibilities within the family, experience less parental involvement, and are exposed to a more adverse home environment.

1. Introduction

Approximately one in four people worldwide experience a mental illness during their lifetime (WHO, 2001). Notably, around 68 percent of women and 57 percent of men with mental health disorders are parents (Ayano et al., 2022). In recent years, a growing literature has examined the individual and societal costs of mental health disorders, documenting how severely mental illness affects individual decision making, behavior, and life outcomes (e.g., De Quidt and Haushofer, 2019; Baranov et al., 2020; Jolivet and Postel-Vinay, 2024; Biasi et al., Forthcoming; Bhat et al., 2022) as well as the economy as a whole (e.g., Arias et al., 2022; Abramson et al., 2024).

Despite these advances, there is still much to be learned about the intergenerational implications of mental health. In particular, it is an open question whether and how parental mental illness influences children's economic preferences.

Economic preferences — time, risk, and social preferences — shape everyday decisions and are closely linked to important life outcomes. Time preferences predict health behaviors, education and labor market outcomes, savings, and criminal behavior. In childhood and adolescence, especially impatience is related to poorer educational outcomes, an increased likelihood of receiving disciplinary referrals at school, smoking and drinking alcohol, a higher body mass index, and a lower propensity to save (Castillo et al., 2011; Sutter et al., 2013; Castillo et al., 2019, 2024). More impatient adults have lower educational attainment, occupational success, income and wealth (Ventura, 2003; Eckel et al., 2005; DellaVigna and Paserman, 2005; Golsteyn et al., 2014; Cadena and Keys, 2015; Sunde et al., 2022), worse health outcomes (Fuchs, 1982; Kirby et al., 1999; Bickel et al., 1999; Kirby and Petry, 2004; Chabris et al., 2008; Golsteyn et al., 2014; Cadena and Keys, 2015), and are more likely to be involved in crime (Åkerlund

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et al., 2016). Risk preferences are associated with health and labor market outcomes, investment and migration decisions for adults (Barsky et al., 1997; Hong et al., 2004; Bonin et al., 2007; Anderson and Mellor, 2008; Kimball et al., 2008; Jaeger et al., 2010; Dohmen et al., 2011; Dohmen and Falk, 2011; von Gaudecker et al., 2011; Becker et al., 2012; Dawson and Henley, 2015; Hsieh et al., 2017). More risk-taking children and adolescents are more likely to be overweight (Sutter et al., 2013), display poorer behavior at school, and are less likely to complete high school (Castillo et al., 2011). Finally, social preferences mainly predict cooperative behaviors towards others. For adults, social preferences predict cooperative behavior at work, donation decisions, repayment of loans, or management of common pool resources (Karlan, 2005; Dohmen et al., 2009; Rustagi et al., 2010; Carpenter and Seki, 2011; Becker et al., 2012; Burks et al., 2016; Deming, 2017). Children with more pronounced social preferences demonstrate greater prosocial behavior in daily life and exhibit fewer behavioral and emotional problems (Breitkopf et al., 2024). Importantly, measures of economic preferences in childhood or adolescence also predict adult outcomes (Borghans et al., 2008; Golsteyn et al., 2014).

Economic preferences emerge in childhood and undergo significant development before stabilizing in adulthood (Schildberg-Hörisch, 2018; Heckman, 2007). On average, children become more patient, less risk-seeking, and more prosocial as they grow (Sutter et al., 2019).[1] As such, childhood and adolescence represent a critical window for preference development, underlining that parental mental health can potentially have lasting and important effects on the economic choices and life outcomes of the next generation.

According to the seminal model of skill formation by Cunha and Heckman (2007), both parental investments and the intergenerational transmission of preferences shape the development of children's economic preferences. Evidence on whether adults' economic preferences vary with own mental illness is limited and inconsistent, yielding largely null results, see Bhat et al. (2022) and Cobb-Clark et al. (2022). However, parental mental illness is likely to affect several dimensions of parental investments in children's skills. For example, parental mental illness may hamper positive parenting styles and high-quality interactions between parents and children or lower monetary investments due to reduced household income or a changing composition of expenses. Baranov et al. (2020) show that a cognitive behavioral therapy intervention in Pakistan with perinatally depressed women not only reduced their depression, but also induced higher monetary and time investments in children and improved parenting style, with larger and more significant effects for mothers than fathers. Falk et al. (2021) demonstrate that 7–9-year old children who experience a more positive parenting style and more high quality interactions with their parents are more patient and prosocial but less risk-taking. Jointly, this evidence suggests that parental mental illness compromises parental investments, which is likely to affect children's skill development, resulting in less prosocial, less patient and perhaps more risk-seeking behavior.

Still, the role of parental mental illness for preference formation is theoretically ambiguous, calling for empirical evidence. On top of possibly suffering from lower parental investments, having a mentally ill parent can lead children to assume new roles and responsibilities within the family. These children often take over a greater share of family duties, may engage in caregiving activities for their siblings or parents (Gladstone et al., 2011), or start working to contribute to family income. By adopting these adult-like responsibilities, they may develop new competencies and mature more rapidly (Aldridge and Becker, 2003), making them behave in a more prosocial and patient manner than their peers with mentally healthy parents.

[1] The decrease in risk-taking mainly occurs before adolescence, while risk preferences seem to exhibit less of an age trend during adolescence (Sutter et al., 2019).

This paper advances our understanding of the consequences of mental health by documenting that children's economic preferences vary systematically with parental mental health. Establishing such a link poses a challenge, as it requires detailed data on parental mental health and measures of offspring preferences that remain unaffected by parental circumstances. We use data on more than 3300 households in rural Bangladesh. Three waves of panel data include comprehensive measures of children's preferences and parental mental health, as well as detailed information about the household environment, parental characteristics, and child outcomes. Children and adolescents in our sample were between the ages of 6 and 16 during the first wave of data collection and subsequently grew older as they participated in the follow-up waves, resulting in an age range of 6 to 19 years across all waves. Importantly, we use incentivized experiments to measure the core dimensions of children's economic preferences—time, risk, and social preferences. Our preference measures thus rely on children's revealed behavior instead of parental assessments, ruling out any possible influence of parental mental health on the assessment of children's preferences. The experiments were carried out in one-on-one settings within the families' homes, and interviewers ensured that household members could not influence each other's decisions. To assess parental mental health, both mothers and fathers answered the well-established 12-item General Health Questionnaire (GHQ-12) by Goldberg (1978).

Our results provide novel evidence on a strong link between parental mental health and children's economic preferences. Children of parents with indications of mental illness are significantly less prosocial but more patient. By contrast, risk taking is not related to parental mental health. The gaps in children's preferences by parental mental health are robust to multiple hypothesis testing and sizable. For example, the patience and prosociality gaps by parental mental health exceed the gap by socio-economic status in those preference dimensions in our sample. Moreover, we observe broadly consistent patterns for maternal and paternal mental health.

We further examine heterogeneity by child age and gender, as well as family socio-economic status. Our results are robust across age subgroups. They do vary meaningfully by child gender, however. Maternal indications of mental illness are associated with a much stronger decrease in prosociality and increase in patience for daughters than sons. For paternal indications of mental illness, a contrasting pattern emerges for patience: sons exhibit a much stronger increase than daughters. These asymmetries likely reflect gendered patterns of parent–child interaction in rural South Asia, where mothers serve as primary caregivers and interact more intensively with daughters (Yeung et al., 2018). Daughters in these contexts typically assume greater domestic responsibilities than sons (Punch, 2001)—a burden that likely intensifies when mothers experience mental health difficulties. We find no comparable heterogeneity by family SES.

Although these results are correlational, we leverage unique features of the data to address possible interpretational concerns. First, parental mental health may respond to child preferences, creating the possibility of reverse causality. To mitigate this concern, we control for lagged values of children's economic preferences. Second, parental mental health may vary with the family's economic circumstances. To isolate the distinct relationship between parental mental health and children's preferences, we control for a comprehensive measure of socio-economic status that is based on families' assets throughout the analysis as well as for lagged family income and household-level shocks in robustness checks. Third, we include lagged parental economic preferences as control variables to address the intergenerational transmission of economic preferences (e.g., Chowdhury et al., 2022; Dohmen et al., 2012). Finally, to acknowledge the possibility that parents with a greater predisposition to mental health problems may have children with systematically different characteristics, we estimate an alternative specification using a child fixed effects model. This approach analyzes how changes in parental mental health influence changes in child preferences, effectively controlling for time-invariant

confounders. Reassuringly, the results from this approach closely align with our main findings.

After presenting the first evidence on the relation between parental mental health and children's economic preferences, we continue by exploring potential underlying pathways, focusing on the role of children's responsibilities and parental investments. Our analysis suggests that probable parental mental health issues leave a mark on both dimensions. Children of mothers with indication of mental illness experience reduced parental investments (lower parental involvement and a deteriorated atmosphere at home), while simultaneously taking on more responsibilities, including income-generating activities. These additional responsibilities often come at the expense of their human capital investments, as evidenced by increased school dropout rates. Similarly, paternal indications of mental illness increase children's likelihood of taking on additional responsibilities, such as working outside the home or helping on the family farm. However, the relationship between paternal mental health and paternal investments in children is notably weaker and statistically insignificant. These patterns suggest two distinct channels through which parental mental health issues may shape children's preferences: diminished parental investments — in particular, fewer positive, high-quality interactions within the household — appear to reduce children's prosocial behavior, a mechanism documented in previous research (Falk et al., 2021; Eisenberg et al., 2013) and particularly pronounced for maternal mental health issues given their stronger role for investments. Meanwhile, children's forced adaptation to adult-like roles and responsibilities at an early age may foster patience as these tasks demand a level of maturity and discipline that is typically only expected of adults. Subgroup analyses support this interpretation. Increased responsibilities concentrate among currently enrolled children, indicating active adaptation to family circumstances rather than pre-existing differences. Younger children primarily assume work on the family farm while remaining in school; older children show elevated dropout rates and increased paid work. Higher levels of paid work are more common in smaller families, consistent with fewer siblings necessitating a larger compensatory burden per child. Firstborn children show particularly pronounced increases in farm work, suggesting they bear disproportionate responsibility for substituting parental labor.

We go beyond previous work in several respects. Recent research on mental health in families has highlighted that early-life economic circumstances can causally shape mental health in adulthood, partly through altered parental behaviors (Persson and Rossin-Slater, 2018; Adhvaryu et al., 2019), and has documented an intergenerational transmission of mental health, with reported parent–child correlations ranging from 0.1 to 0.2 (Bütikofer et al., 2024; Johnston et al., 2013; Akbulut-Yuksel and Kugler, 2016). Building on this literature, we examine the link between parental mental health and child outcomes beyond mental health. We present novel evidence that parental mental health predicts children's economic preferences that, in turn, leave a lasting imprint on children's life trajectories. Moreover, we expand the evidence on the role of mental health across generations by studying the setting of a less developed country, Bangladesh, whereas most prior work refers to developed countries (see, e.g., Bütikofer et al., 2024).

At the same time, we add parental mental health as a new critical determinant to the literature on the formation of children's economic preferences or skills more broadly (Cunha et al., 2010; Cunha and Heckman, 2008). Among existing research, our paper is most closely related to Falk et al. (2021), who document that family socio-economic status significantly predicts disparities in economic preferences among seven to nine year old children in Germany.

By studying children from the age of 6 until adulthood, we also contribute evidence to the "missing middle" in child development, a critical period for which there is relatively little research (Almond et al., 2018). Most prior work, primarily from psychology, examines children's socio-emotional and cognitive development in response to parental mental health, focusing on early childhood. In particular, the rise in maternal depression associated with pregnancy and childbirth (Ahammer et al., 2023) has made pre- and postnatal depression a predominant area of study (e.g., Baranov et al., 2020). As Currie and Zwiers (2023) point out, these studies often argue that postnatal depression disrupts maternal-infant bonding and thus leads to adverse effects on very early child development (Slomian et al., 2019; Netsi et al., 2018; Honda et al., 2023). Sevim et al. (2024) find that a psychosocial intervention targeting perinatally depressed mothers improved maternal mental health and led to modest but transient gains in children's socio-emotional skills during the first year of life, with positive effects at 6 and 12 months but no significant impact at 36 months. We extend this literature by examining how parental mental health shapes children during middle childhood and adolescence, when they become increasingly aware of their environment and parental conditions. In this developmental stage, children arguably play a more active role in adapting to and compensating for the consequences of parental mental health within the family.

The next section describes the data, Section 3 outlines the empirical strategy, Section 4 presents the empirical results, and Section 5 concludes.

2. Data

This section introduces the data. We start by describing the recruitment and interview process for families as well as how parents' mental health is measured. We then explain the incentivized experiments designed to elicit children's preferences. Finally, we introduce the further measures that assess parents' economic preferences, parenting style and parental involvement, atmosphere at home, socio-economic status, income, and recent household-level shocks.

2.1. Sampling and data collection

In this study, we use data from incentivized experiments and surveys involving more than 4500 children aged 6 to 19 years and their parents, spanning over 3300 households in Bangladesh (see Breitkopf et al., 2024). Data were collected in four districts (Netrokona, Sunamganj, Chandpur, and Gopalganj) representing four of the country's eight administrative divisions. Within the four districts, eleven subdistricts were initially selected based on the presence of local non-governmental organizations (NGOs) willing to collaborate by implementing delayed payments to participants. From these subdistricts, 150 villages were randomly selected. Within these villages, most children in our sample were randomly drawn from local elementary school class lists.

In total, four waves of panel data, each consisting of several separate parts, were collected by trained interviewers of a specialized survey firm (ECONS Evaluation & Consulting Services Limited) in the families' homes. First, economic preferences (time, risk, and social preferences), personality traits, and cognitive skills were elicited via paper-and-pencil interviewing for the sampled children, up to one sibling, and both parents (if available). Children and parents were interviewed individually and separately to ensure independent responses. During these sessions, mothers also answered a paper-and-pencil questionnaire about their children, assessing, among other things, their children's strengths and difficulties as well as their own parenting style and involvement with their children. Second, household surveys using computer-assisted personal interviews collected information on socio-demographics, income, expenditures, employment, land ownership, credits and savings, assets, and household exposure to shocks. Household surveys were answered by either the household head or his/her spouse (whoever was the most knowledgeable person for the respective part). Moreover, both spouses completed the 12-item General Health Questionnaire (GHQ-12) to assess their mental health.

This paper uses three out of the four waves of panel data: wave 1 was collected in March to May 2018 for both parts, wave 2 in 2019/2020 (household survey in March to May 2019, experiments in

January to February 2020) and wave 4 in 2022 (household survey in May to August, experiments in May to October). Due to the outbreak of the Covid-19 pandemic after only a small share of household survey interviews had been conducted, wave 3 does not encompass data on parental mental health and cannot be used in this study.[2] We used exactly the same tools across all waves to elicit the GHQ-12, children's economic preferences (experiments), parents' economic preferences (survey items), parenting style, and shocks that we describe in detail below.

Appendix Table A.1 presents the number of observations by age and survey wave. Appendix Table A.2 provides summary statistics for the sample.

2.2. Parental mental health

To assess parental mental health, parents answered the 12-item General Health Questionnaire (GHQ-12). Originally developed as a screening tool for psychiatric disorders (Goldberg, 1978), the GHQ is now widely used to provide an indication of individuals' mental health, also by economists (e.g., Haushofer et al., 2020; Dustmann and Fasani, 2016; Metcalfe et al., 2011; Clark, 2003). Moreover, it has been validated in numerous low- and middle-income countries, including Bangladesh (Goldberg et al., 1997; Ovi et al., 2024). The GHQ is effective in indicating both temporary conditions, such as depression and anxiety, as well as more permanent disorders such as schizophrenia (Goldberg and Williams, 1988). However, the GHQ-12 is a screening tool that does not provide a verified diagnosis. A higher score indicates probable mental health problems and the need for further evaluation.

The GHQ-12 consists of 12 items to be answered on a 4-point Likert scale (see Appendix Table A.3). The items can be combined into a single index by applying a cutoff to the response to each individual item before adding them (see, e.g., Metcalfe et al., 2011; Clark, 2003). Specifically, a score of one is assigned for any item where the respondent selects one of the two top response options, indicating a potential mental health symptom. This binary scoring method (0–0–1–1) results in an index ranging from 0 (no indication of mental illness) to 12 (likely severe mental illness). Fig. A.1 illustrates the resulting distributions, which are very similar for mothers and fathers. In our main specification, we follow Clark (2003), Ovi et al. (2024) and define an individual as experiencing probable mental health problems if they exhibit more than two symptoms (i.e., have a score of 3 or higher on the 12-point scale). This threshold has been validated as highly predictive of mental illness in South Asian countries (Minhas, 1996).[3]

[2] During the school year 2019, a social and emotional learning program was implemented as a randomized, school-based intervention, that we do not analyze here. The paper at hand only analyzes data from the control group children who live in villages in which no child was exposed to the school-based intervention. Additionally, 11.7 percent of the observations in our sample come from households that have been randomly sampled from the 150 selected villages in the course of an earlier study between 2014 and 2016, providing a randomized information campaign on arsenic water contamination. In Appendix A.3, we describe the study in more detail and show that our results are robust to controlling for participation in its treatments—as one would expect.

[3] An alternative approach aggregates responses on the original 0–3 scale, resulting in a variable that ranges from 0 to 36 (Likert scoring method), and then applies a single cutoff. Although Piccinelli et al. (1993) indicate that both scoring methods are equally effective in identifying probable mental health issues, there is less guidance regarding the appropriate cutoff in our context. In a robustness check, we generate an alternative mental health index by classifying parents as probably having mental health issues if their GHQ score is 16 or higher on the 36-point scale. This cut-off is informed by statistics on diagnosed mental illness in Bangladesh (WHO, 2020) and corresponds closely to that in Haushofer et al. (2020).

2.3. Experiments: Children's time, risk, and social preferences

To assess the three core dimensions of children's economic preferences, all children took part in incentivized experiments. The use of experiments enables us to measure preferences through actual, revealed behavior, enhancing the reliability and comparability of our preference measures between participants. By focusing on children's own behavior, we also mitigate any potential influence of parental mental health on the measurement of children's preferences.[4]

To elicit preferences, we rely on well-established measurement tools, previously used in developing countries to assess time and risk preferences. Detailed experimental protocols can be found in Appendix B. These measures were carefully pre-tested and adapted for children. Standardized control questions verified children's understanding of the instructions. Interviewers intermittently asked children to repeat their explanations for each game. Each time, the interviewer recorded whether the child understood the game after the first, second, or third explanation, or if the child still did not understand it after three explanations. Appendix Tables A.5, A.6, and A.7 document that comprehension rates are very high. For the 2019/20 and 2022 waves — from which we draw our outcome measures —, we exclude children who still failed the comprehension checks after three repeated explanations of the interviewer, ensuring that our estimates reflect valid behavioral responses.

Appendix Table A.8 provides summary statistics of the preference measures by wave and age group. Figs. A.2 and A.3 display the distributions of preferences by survey wave and age group, respectively, confirming meaningful variation across the full sample.

The sequence of experiments was randomized by rolling a die. Children could earn either money or stars, which were later converted into money using age-specific exchange rates. We chose stars as our experimental currency in the social and time preference games to keep the experimental instructions simple and constant across age groups while still being able to make the monetary incentives age-appropriate. Based on an initial survey on children's weekly pocket money, we used a conversion rate of stars into money where one star equaled approximately half of the average weekly pocket money of children of a given age (see Appendix Table B.9). Children were explicitly informed of their applicable exchange rate. Each child received one star as a participation fee. All experiments were conducted one-on-one in the participants' homes, ensuring that household members could not influence each other's decisions.

Social preferences. Children's social preferences were assessed through dictator games, following the experimental protocol of Fehr et al. (2008), later extended by Bauer et al. (2014). The children made four allocation choices (see Table 1), dividing stars between themselves and another child of the same gender and similar age, who was unknown and unrelated. In each choice, one option was an equal split, the allocation $(1, 1)$, i.e., one star for each child, while the alternative allocation favored one child. For analysis, we aggregate a child's decisions in all four games into a single measure: the share of overall stars allocated to the other child, calculated as

$$\frac{\text{stars given to the other child}}{\text{total stars given and kept}}.$$

This share ranges from 0.29 to 0.58, with higher values indicating more pronounced social preferences. The mean is 0.48, with a standard deviation of 0.07.

Time preferences. Children's time preferences were measured using a simple choice-list approach, similar to the method employed by Bauer et al. (2012) with adults in rural India. Each child made six choices

[4] For instance, studies often assess young children's socio-emotional skills using questionnaires completed by their mothers (e.g., Cunha and Heckman, 2008). This approach introduces a bias if maternal mental health not only influences children's preferences, but also mothers' perceptions of them.

Table 1
Social preferences experiment for children.

	Choice 1	Choice 2
Costly prosocial game	1 star for me 1 star for the other child (1,1)	2 stars for me 0 stars for the other child (2,0)
Costless prosocial game	1 star for me 1 star for the other child (1,1)	1 star for me 0 stars for the other child (1,0)
Costless envy game	1 star for me 1 star for the other child (1,1)	1 star for me 2 stars for the other child (1,2)
Costly envy game	1 star for me 1 star for the other child (1,1)	2 stars for me 3 stars for the other child (2,3)

Notes. Own representation.

Table 2
Time preferences experiment for children.

	Option 1	Option 2
Choice Set 1	2 stars tomorrow 2 stars tomorrow	3 stars in 3 weeks 4 stars in 3 weeks
Choice Set 2	2 stars tomorrow 2 stars tomorrow	3 stars in 3 months 4 stars in 3 months
Choice Set 3	2 stars in 1 month 2 stars in 1 month	3 stars in 4 months 4 stars in 4 months

Notes. Own representation.

Table 3
Risk preferences experiment for children (example for ages 10 to 11).

	Low amount (50% chance)	High amount (50% chance)	
Gamble 1	25	25	*risk-averse*
Gamble 2	22	48	
Gamble 3	20	60	
Gamble 4	15	75	
Gamble 5	5	95	*risk-neutral*
Gamble 6	0	100	*risk-seeking*

Notes. Own representation.

that reflect a trade-off between a smaller, earlier reward and a larger, later reward (see Table 2). The six choices were organized into three choice sets, each containing two choices with identical time delays. The early payment was scheduled for the next day (choice sets 1 and 2) or one month later (choice set 3), while the later payment occurred after three weeks (choice set 1), three months (choice set 2), or four months (choice set 3), respectively. The order of the choice sets was randomized. We define the following experimental measure of patience: the total number of patient choices (option 2) across the six decisions. Consequently, this measure ranges from zero to six. Both mean and standard deviation are 1.98.

Risk preferences. Children's risk preferences were elicited using a setup based on Binswanger (1980), which has been widely applied in less developed countries (see, e.g., Bauer et al., 2012, in India). Each child chose one of six gambles, each offering high or low payoffs with equal probability (Table 3). Choices of higher gamble numbers imply greater risk-taking: from gamble one to five, both expected value and variance increase in each successive gamble, whereas in gamble six only the variance increases relative to gamble five. 48.8 percent of the children exhibit risk-averse preferences, 30.2 percent are risk-neutral, and 21.0 percent demonstrate risk-seeking behavior. In our analysis, we treat this variable as discrete, with higher values indicating a greater propensity for risk-taking behavior. The variable takes values ranging from one to six. The mean is 4.29, with a standard deviation of 1.36.

For our analyses, we standardize all preference measures to have a mean of zero and a standard deviation of one across all available observations.

2.4. Further measures

Socio-economic status. We use detailed information on household assets to construct a comprehensive measure of families' socio-economic status (SES). The use of assets is common in developing countries where earned income plays a less significant role (see, e.g., Muralidharan et al., 2019). Specifically, we utilize data on household assets from the 2019/20 wave, which has the largest number of observations and ensures a stable measure across waves. We limit our measure to those household assets that are owned by at least 200 households in the sample, see Appendix Table A.16. We apply a principal component analysis (PCA) to the respective 23 items and use the first resulting factor as the SES index. Appendix Table A.17 shows the respective factor loadings. Reassuringly, families of high socio-economic status, as measured by our SES index, differ from low socio-economic households also with regard to more traditional facets of socio-economic status such as income and education that are commonly used in developed countries. For instance, the correlation of our SES index with family income is 0.244. It is 0.299 for father's education level and 0.268 for mother's education level.

Shocks at the household level and family income. While the comprehensive SES index is well-suited for capturing families' general economic situation, it does not account for temporary economic hardship. To address this, households were asked to report in each wave whether they had experienced any shocks, such as a loss of crops or robbery, and to provide information on all sources of monthly income. We aggregate the various sources of income into total family income and divide it by the number of household members to obtain a measure of monthly per capita income. The mean in our sample is 3372 Taka, approximately 27 US Dollars at the end of 2024. To capture recent family shock experiences, the household head was asked in the 2018 wave whether the family had experienced any shocks in the previous five years. In subsequent waves, they were asked whether any shocks had occurred in the past two years, corresponding to the period since the prior data collections in the 2019/20 and 2022 waves.[5] We use this information to construct a binary variable that takes the value of one in each wave if a household reported experiencing a shock in that period, and zero otherwise. This additional data enables us to capture temporary episodes of economic distress at a more granular level.

[5] Note that newly interviewed households in the 2019/20 wave were asked whether they had experienced shocks in the previous five years, just as all households in the 2018 wave.

Parents' economic preferences. Parents' economic preferences were assessed through a series of experimentally validated survey questions (Falk et al., 2023, 2018). To measure risk preferences, parents were asked: "Please tell me, in general, how willing you are to take risks", where 1 indicates "completely unwilling to take risks" and 7 indicates "very willing to take risks", for time preferences: "How willing are you to give up something beneficial for you today in order to benefit more from it in the future?", and for social preferences: "How willing are you to give to good causes without expecting anything in return?". For the latter two, a score of 1 means "completely unwilling to do so" and a score of 7 means "very willing to do so".

Mothers' parenting style. Mothers' parenting style was assessed using responses to a survey module adapted from Thönnissen et al. (2023). In each wave, mothers rated items such as "I use words and gestures to show my child that I love her/him" and "I talk to my child about things s/he has done, seen, or experienced outside the home" on a five-point scale from "never" to "very frequently". We construct a measure of positive parenting using the items related to emotional warmth and monitoring of the child's activities (see Appendix Table A.9). To do so, we apply principal component analysis to these items and use the first resulting factor as our measure of positive parenting (characterized by high emotional warmth and monitoring). Appendix Table A.10 presents the respective factor loadings.

Parental involvement. To measure mothers' and fathers' involvement with their children, each parent individually completed a survey module in the 2022 wave. They rated their frequency of engagement in activities such as discussing important challenges in their children's lives or helping with homework, using a five-point scale from "never" to "very frequently". Appendix Tables A.11 and A.12 provide further details on the items and responses. To create an index of mothers' and fathers' involvement, we applied principal component analysis to these items, using the first factor as our measure of parental involvement. Appendix Tables A.13 and A.14 present the respective factor loadings that underline that our measures reflect high quality time that mothers and fathers spend with their children.

Atmosphere at home. In 2022, mothers and fathers responded individually to an 11-item survey module assessing the atmosphere at home, asking them to rate statements such as "In our family, we regularly help one another" or "We shout and yell at each other" (reversed item) on a seven-point scale ranging from "never" to "very often". Appendix Table A.15 provides further details on the complete list of items and the distribution of responses. We construct a summary index of home atmosphere following Anderson (2008), aggregating the items into a weighted sum where the weights are given by the inverse of the covariance matrix. This weighting scheme assigns lower weight to items that are highly correlated with others, reducing redundancy and maximizing the independent information captured by the index. Importantly, we pool responses from both mothers and fathers into a single index by averaging their assessments for each item before constructing the Anderson index, which helps mitigate depressive reporting bias that may affect individual parent-reported measures of home atmosphere (Richters, 1992). When only one parent's assessment is available, the index is based on that parent's responses alone. The inverse-covariance weighting is computed using all non-missing items for each household.

3. Estimation

To study the relation between parental mental health and children's economic preferences, we estimate the following regression equation:

$$Y_{i,t} = \beta_0 + \beta_1 parental\_mental\_health_{i,t} + \beta_2 Y_{i,t-1} + P_{i,t-1}\lambda + \delta SES_i + X_{i,t}\gamma + \kappa_j + \mu_t + u_{i,t}, \quad (1)$$

where $Y_{i,t}$ denotes experimentally elicited economic preferences (social, time, or risk) of child i at time t. The main explanatory variable, $parental\_mental\_health_{i,t}$, captures either maternal or paternal indications of mental illness. We control for the child's lagged preference dimension $Y_{i,t-1}$, parents' lagged social, time, and risk preferences $P_{i,t-1}$, the family's socio-economic status SES_i, demographic controls ($X_{i,t}$ for child age and gender), and district fixed effects κ_j. To maximize the sample size, we conduct our analysis on all available waves, always controlling for survey year fixed effects μ_t. We cluster standard errors at the household level.

The coefficient of interest is β_1, which reflects the relation between either maternal or paternal mental health and children's economic preferences. While we do not claim to capture a causal parameter with this specification, we believe that our approach mitigates some of the most urgent concerns regarding its interpretation. First, parental mental health may respond to children's preferences, potentially introducing reverse causality. To address this concern, we control for the child's lagged preference dimension. Second, parental mental health may be correlated with economic conditions. To ensure that we are capturing the distinct effect of parental mental health, we control for a comprehensive measure of SES. In a robustness check, we also account for additional economic variables, such as lagged income and household-level shocks, and document that the results remain unchanged. Third, we account for the intergenerational transmission of economic preferences by including lagged parental preferences as control variables. In a final step, we address the concern that parents with a greater predisposition to mental illness may have systematically different children, introducing a time-invariant omitted variable bias. We do so by estimating a child fixed effects model as an alternative specification. This approach examines how changes in parental mental health impact changes in children's preferences, thereby removing potentially confounding time-invariant factors.

4. Results

This section documents inequalities in the economic preferences of children who grow up in families with mentally healthy parents versus parents with indication of mental illness. Our aim is to first uncover the importance of parental mental health for the formation of children's economic preferences before discussing possible mechanisms such as differences in parental involvement, parenting style, the atmosphere at home, as well as the likelihood that children leave school earlier or work outside the home.

4.1. Gaps in child preferences by parental mental health

Panel A of Table 4 displays our main findings on the link between parental mental health and children's economic preferences. They are illustrated in Fig. 1. The circles represent the coefficient β_1 of indications of maternal mental illness that results from estimating Eq. (1), the triangles the corresponding coefficients for indications of paternal mental illness. The figure shows that children's prosociality and patience, but not their risk attitudes vary systematically with parental mental health and do so in a very similar way for mothers' and fathers' mental health.[6] In particular, children of parents with indications of mental illness are less prosocial but more patient than their peers

[6] The null result for risk preferences is not due to a lack of variation in children's risk preferences, see Appendix Fig. A.3. Similar to our finding of unchanged risk attitudes in children, Cobb-Clark et al. (2022) report no significant association between depression and risk attitudes in German adults measured through a series of incentivized lottery decisions. However, they do document lower levels of self-rated, general risk-taking. Furthermore, Bhat et al. (2022) find no significant effects of psychotherapy that effectively reduced depression on adults' risk attitudes (both incentivized and self-assessed) in India, but report significant positive effects on self-assessed, but not on incentivized measures of patience and altruism.

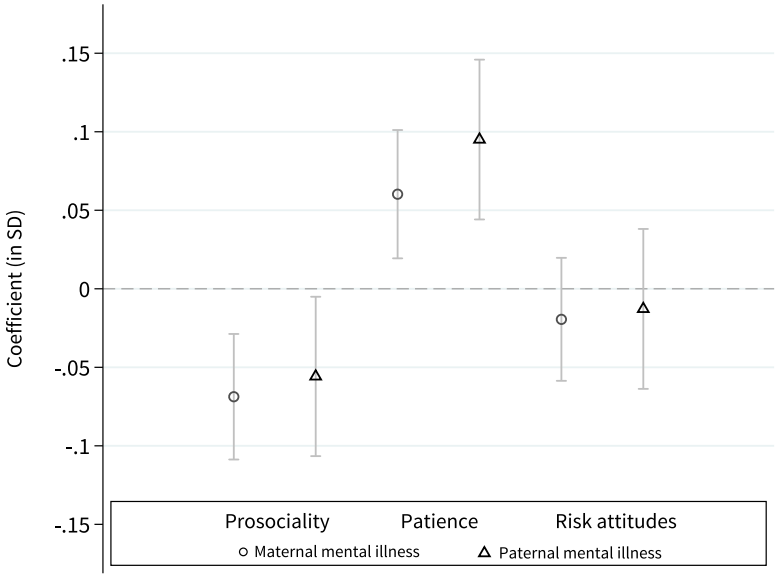


Fig. 1. Parental mental health and children's economic preferences.
Notes. This figure illustrates the gaps in children's economic preferences by parental mental health. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. The circles and triangles plot the coefficients of maternal and paternal mental health from six separate regressions (see Panel A of Table 4), in which we regress children's social, time, and risk preferences on maternal or paternal mental health, respectively, controlling for the lagged parental preferences, the child's lagged outcome variable, an SES index, district fixed effects and individual-level controls (age fixed effects and gender), with standard errors clustered at the household level. Child outcomes are from the 2019/20 and 2022 waves. Error bars show 90 percent confidence intervals.

with mentally healthy parents.[7] Children of mothers with indication of mental illness have a 6.9 percent of a standard deviation lower level of prosociality, while the corresponding estimate is 5.6 percent of a standard deviation for fathers. The increase in patience is 6.0 percent of a standard deviation for mothers and 9.5 percent for fathers with indications of mental illness. These gaps in child preferences by parental mental health are sizable. For example, in our sample, both the patience and prosociality gap by parental mental health exceed the SES gaps in the same preference dimensions (see Table A.19). Moreover, the size of the patience gap by parental mental health is roughly comparable to the gender gap in patience that amounts to 7.0 percent of a standard deviation (see Table A.19).

Robustness. The results for prosociality and patience are robust to multiple hypothesis testing, with the exception of paternal mental illness and prosociality (see Table A.20).

Panel B of Table 4 includes lagged family income and an indicator for recent household-level shocks, such as a loss of crops or robbery, as additional control variables. The results remain unchanged when including these more fine-grained measures of temporary family economic conditions, suggesting that economic conditions only play a minimal role in explaining the link between parental mental health and child preferences.

Appendix Table A.22 further shows that the findings are robust to excluding lagged child preferences as control variables. This addresses concerns about potential endogeneity if unobserved shocks jointly determine parental mental health and child preferences in the prior period, rendering lagged preferences correlated with the error term.

In Panel C of Table 4, we leverage the panel structure of our data by estimating a child fixed effects model. This approach estimates the impact of changes in indications of parental mental health on changes in children's preferences, removing any time-invariant factors. For example, one concern could be that parents with a genetically higher predisposition to mental illness may have genetically different children which may be reflected in their preferences. Reassuringly, the results remain similar when accounting for such potential time-invariant confounders.

Furthermore, the results do not differ systematically by age subgroup (Table A.23), alleviating concerns that they might be driven by older children who may have better comprehension of the experimental tasks. Fig. A.3 further documents meaningful variation in our preference measures across the full age distribution.

Finally, Appendix Table A.21 assesses the robustness of our estimates to various ways of constructing the measure of mental health. Panel A repeats our main specification. Panel B applies a stricter threshold to classify individuals as probably mentally ill. In Panel C, we use the mental health measure as a continuous variable, ranging from 0 (no indication of mental illness) to 12 (severe mental illness). Panel D adopts the Likert GHQ scoring method, resulting in a scale from 0–36 before applying a threshold of 16 or higher to obtain a measure of probable mental illness. Overall, the estimates of the link between parental mental health and children's economic preferences remain similar across the different specifications for all three outcome variables. Only the results on paternal probable mental illness and children's prosociality turn out to be less robust in the alternative specifications.

Heterogeneity. Tables 5 and A.24 explore whether the relationship between parental mental health and children's preferences differs by child gender or family socio-economic status. These dimensions may influence children's exposure to indications of parental mental illness and

[7] Zooming into different facets of possible mental illness, the results in Appendix Table A.18 indicate that parental anxiety and depression as well as social dysfunction are the main drivers of the gaps in child preferences, while loss of confidence consistently shows no significant relationship.

Table 4
Parental mental health and children's economic preferences.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Panel A: Main results						
	−0.069***	−0.056*	0.060**	0.095***	−0.019	−0.013
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Wald test (*p*-value)	[0.713]		[0.327]		[0.850]	
Observations	6984	4324	6984	4324	6984	4324
Panel B: Adding lagged family income and shocks as control variables						
	−0.065***	−0.051*	0.064**	0.100***	−0.020	−0.012
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Wald test (*p*-value)	[0.695]		[0.311]		[0.825]	
Observations	6982	4322	6982	4322	6982	4322
Panel C: Estimating a child fixed-effects model						
	−0.063**	−0.079*	0.053*	0.085**	0.007	−0.006
	(0.026)	(0.040)	(0.028)	(0.042)	(0.028)	(0.040)
Wald test (*p*-value)	[0.737]		[0.517]		[0.786]	
Observations	10,065	4877	10,065	4877	10,065	4877

Notes. Each entry represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, lagged parental economic preferences and the child's lagged outcome variable in Panel A. Regressions are based on outcomes from the 2019/20 and 2022 waves. Panel B adds controls for household-level shocks and lagged family income. Panel C presents estimates from a child fixed-effects regression model with additional controls for age and survey year fixed effects. Estimates are based on the 2018, 2019/20, and 2022 waves. Individuals with observations in only one wave are excluded from this specification, as they do not contribute to the coefficient estimates and would only deflate the standard errors. Wald tests report p-values for the null hypothesis of equality between maternal and paternal coefficients. Standard errors clustered at the household level in parentheses. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table 5
Parental mental health and children's economic preferences: Heterogeneity by child gender.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Interaction with child gender						
Mental illness	−0.028	−0.031	0.027	0.152***	−0.009	0.016
	(0.036)	(0.045)	(0.034)	(0.044)	(0.034)	(0.043)
Mental illness × Female	−0.076	−0.048	0.063	−0.110*	−0.020	−0.055
	(0.049)	(0.061)	(0.046)	(0.059)	(0.047)	(0.060)
Main effect + interaction	−0.104***	−0.079*	0.090***	0.043	−0.029	−0.039
	(0.033)	(0.042)	(0.033)	(0.042)	(0.033)	(0.043)
Observations	6984	4324	6984	4324	6984	4324

Notes. This table examines heterogeneity in the relationship between indications of parental mental illness and children's economic preferences by child gender. Each column represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. The coefficient on mental illness refers to boys, the interaction term reflects the differential effect for girls, and the sum of both captures the total effect for girls. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, parental lagged preferences, and the child's lagged outcome value. Regressions are based on child outcomes from the 2019/20 and 2022 waves, and standard errors are clustered at the household level. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

their access to resources that could mitigate or amplify the preference gaps we have documented.

The results in Table 5 suggest that indications of maternal mental illness are associated with a larger imprint on daughters' than sons' preferences. Although the interaction terms themselves are not statistically significant, the total coefficients for daughters of mothers with indications of mental illness are substantial and precisely estimated: girls exhibit a 10.4 percent of a standard deviation decrease in prosociality ($p < 0.01$) and a 9.0 percent of a standard deviation increase in patience ($p < 0.01$), while the corresponding coefficients for boys are smaller and statistically insignificant. For indications of paternal mental illness, a different pattern emerges for patience: fathers' mental health difficulties predict significantly greater patience among sons (15.2 percent of a standard deviation, $p < 0.01$), but the significant negative interaction term ($p < 0.10$) indicates that this relationship is substantially attenuated for daughters.

These asymmetries likely reflect gendered patterns of parent–child interaction in rural South Asia, where mothers serve as primary caregivers and interact more intensively with daughters than sons (Yeung et al., 2018). Several mechanisms may account for the mother–daughter pattern. In rural Bangladesh, as in many developing country contexts, daughters assume substantially greater domestic responsibilities than sons (Punch, 2001). When mothers experience mental health difficulties, these gendered expectations may intensify, requiring

daughters to compensate by taking over caregiving and household tasks. Such responsibilities demand discipline and delayed gratification — potentially fostering patience — while reducing opportunities for positive mother–daughter interactions that support prosocial development (Falk et al., 2021). The pattern is also consistent with same-gender socialization: research documents that maternal attitudes and behaviors shape daughters' outcomes more strongly than sons' (Perales et al., 2021).

We find no comparably strong heterogeneity by family SES (Table A.24).

4.2. How do parental investments and children's responsibilities differ by parental mental health?

The results above provide evidence that parental mental health has predictive power for the development of a child's prosociality and patience. While the pathways through which parental mental health can affect the formation of preferences are numerous and complex,[8] our rich data allow us to shed some light on two important, possible pathways: differences in parental investments and the responsibilities that children take on.

Table 6 examines these pathways in greater detail. Its upper half explores the relationship between parental mental health issues and parental investments, documenting that children of mothers with indication of mental illness are on average exposed to lower parental investments. The results reveal that maternal indications of mental illness predict a significant decline in maternal involvement (by 10.0 percent of a standard deviation) and a pronounced deterioration of the atmosphere at home (by 27.1 percent of a standard deviation), consistent with evidence that maternal depression increases conflicts in families (Burke, 2003).[9] Falk et al. (2021) show that fewer high-quality interactions of mothers and children reduce children's prosociality, establishing a possible pathway underlying our main results. Similarly, Eisenberg et al. (2013) document how emotional neglect and heightened family conflict can foster detachment and mistrust, ultimately diminishing cooperative and altruistic behaviors. Interestingly, maternal positive parenting appears unaffected, suggesting that, while maternal involvement declines in case of probable mental illness, mothers' broader parenting styles remain unchanged. In contrast to maternal indications of mental illness, paternal involvement and the general atmosphere at home do not vary significantly by paternal indications of mental illness. The stronger link between maternal mental health and lower investments in children may partially explain the more robust relationship between indications of mental illness and child prosociality for mothers than fathers.

The bottom part of Table 6 highlights that children in households with indications of parental mental illness take on increased responsibilities. Children of mothers with indications of maternal mental illness are 2.2 percentage points more likely to work for money, a 17 percent increase from the sample mean of 13.3 percent. The probability of children helping on the family farm is 3.3 percentage points higher in case of maternal mental health indications. Similar patterns emerge for indications of paternal mental illness. These additional responsibilities require children to manage adult-like tasks at an early age, which may induce them to mature faster, possibly fostering patience by forcing discipline and delayed gratification on them.[10] However, these additional responsibilities come at the expense of educational opportunities, as children in such households are substantially more likely to drop out of school. In particular, indications of maternal mental illness are associated with an increase in the likelihood of being out of school by more than 20 percent, a 2.0 percentage point increase from the sample average of 9.8 percent.[11]

In sum, our results suggest that children of parents with indications of mental illness are often forced into adult-like roles, inducing them to mature faster, which may foster their patience. The lower investments they are exposed to seem to decrease children's prosociality, likely through a lack of high-quality interactions and increased conflict at home (Falk et al., 2021; Eisenberg et al., 2013).

Subgroup analyses may help to distinguish between these two possible mechanisms, although they are likely at play concurrently. The parental investment mechanism operates relatively uniformly across child age (Table A.25), consistent with reduced parental investments being a direct consequence of mental illness.[12] By contrast, the accelerated maturity mechanism reveals an interesting age pattern: younger children (≤13 years) primarily assume responsibilities on the family farm while remaining in school, whereas older children show elevated dropout rates and increased paid work but no further increase in farm responsibilities (Table A.25). This pattern suggests that children initially take on adult-like responsibilities alongside their education before competing demands eventually force some out of school.

Several additional findings support this interpretation. Responsibility patterns concentrate among currently enrolled children (Table A.26): those already out of school show no significant relationship between parental mental illness and work responsibilities, indicating active adaptation to family circumstances rather than pre-existing differences. The stronger relationships with paid work in smaller families (Table A.27) align with the logic that fewer siblings induce a larger compensatory burden per child. Finally, birth order patterns reveal that firstborns show particularly pronounced increases in farm work when parents experience indications of mental health difficulties (Table A.28), consistent with oldest children bearing disproportionate responsibility for substituting parental labor (Webbink et al., 2013).

5. Conclusion

We present novel and comprehensive evidence that parental mental health predicts disparities in children's economic preferences. Children

[8] For example, parental mental illness is likely to impose substantial stress on children and perhaps induces scarcity. Haushofer and Salicath (2023) provide a comprehensive literature review of the impact of stress and scarcity on time, risk, and social preferences, concluding that the evidence is largely weak and inconsistent. Therefore, we do not further explore the possible role of stress and scarcity for our results.

[9] Parent-reported measures of parental involvement, parenting style, and home atmosphere may be subject to depressive reporting bias (Richters, 1992). We mitigate this concern for home atmosphere by averaging both parents' assessments. The outcomes in the lower panel — child labor and school enrollment — are less susceptible to such bias given their more objective nature.

[10] In our context, this pathway seems to dominate the one documented in Falk et al. (2021), who find that fewer high-quality interactions of mothers and children reduce children's patience.

[11] Child fixed effects models that remove time-invariant factors such as stable household characteristics yield similar patterns (Table A.29). The relationships between maternal mental illness and children's responsibilities persist as does the null result for positive parenting—reinforcing that mothers' broader parenting styles remain stable even as other dimensions of the home environment deteriorate.

[12] Note that the parental investment measures are observed at the household level such that variation comes from between rather than within families, warranting some caution in interpretation. By contrast, the responsibility measures are child-specific and not subject to this limitation.

Table 6
Parental mental health, parental investments and children's responsibilities.

Outcome variable:	Parental involvement		Positive parenting	Atmosphere at home	
Mental illness:	Maternal	Paternal	Maternal	Maternal	Paternal
	−0.100**	−0.056	−0.012	−0.271***	−0.012
	(0.048)	(0.048)	(0.025)	(0.041)	(0.045)
Wald test (p-value)	[0.517]			[0.000]	
Observations	2472	2484	10,290	3615	3003
Outcome variable:	Child working for money		Child helps on family farm	No longer in school	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
	0.022***	0.020**	0.033***	0.040***	0.020***	0.010
	(0.007)	(0.010)	(0.010)	(0.011)	(0.007)	(0.009)
Wald test (p-value)	[0.876]		[0.635]		[0.287]	
Observations	7626	5328	7122	5023	7519	5252

Notes. Each entry represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. Controls include fixed effects for age, district, and survey year, as well as variables for SES and gender. Some outcome variables were not collected in all waves, leading to varying sample sizes. Specifically, the regressions draw on data from waves 2018, 2019/20, and 2022 for maternal positive parenting, from waves 2019/20 and 2022 for working for money, child helping on the family farm, and no longer in school, and from wave 2022 for paternal involvement, maternal involvement, and atmosphere at home. Details on the construction of the indices for paternal and maternal involvement, positive parenting, and atmosphere at home are provided in Section 2.4. In the sample, 13.3 percent of children report working for money, while 66.4 percent help on the family farm, and 9.8 percent are no longer in school. Standard errors clustered at the household level in parentheses. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

of parents with indications of poor mental health are less prosocial and more patient, while their propensity to take risks remains unaffected. The gaps in prosociality and patience by parental mental health are sizable, robust across various specifications and remain largely significant after accounting for multiple hypothesis testing. Our analysis of potential pathways underlying the relationship between parental mental health and children's preferences points at lower parental investments and changes in family environment as well as children's roles within it as possible mechanisms. Maternal indications of mental illness are associated with reduced high-quality interactions of mothers and children and a deteriorated atmosphere at home. Moreover, children in these households take on more responsibilities, including income-generating activities, often at the expense of their education. In households with paternal as opposed to maternal indications of mental illness, the increase in children's responsibilities is similar, but the decrease in paternal investments is weaker and not significant. These findings suggest two primary channels for the observed link between parental mental health issues and children's preferences: the decline in prosociality may be related to diminished positive interactions within the household, a mechanism previously shown to reduce children's prosocial behavior (Falk et al., 2021; Eisenberg et al., 2013). Notably, the stronger relationship between maternal rather than paternal likely mental illness and parental investments aligns with the stronger link between maternal likely mental illness and lower prosociality of children. Meanwhile, increased patience may reflect children's imposed adaptation to adult-like roles and responsibilities at an early age, which may induce them to mature faster.

Differences in children's preferences are important, as they predict functioning in childhood as well as adult outcomes. On average, less prosocial children exhibit more emotional and behavioral problems (Breitkopf et al., 2024). Prosociality in adults is positively associated with individual life satisfaction, the success of groups, and cooperative behavior in various domains of life (Rustagi et al., 2010; Carpenter and Seki, 2011; Becker et al., 2012; Burks et al., 2016; Aknin et al., 2013). In that sense, our results suggest that children of parents with indication of mental illness are likely to be harmed in their long-term life trajectories. Moreover, our results reveal that, in the context of a vulnerable population in a less developed country, parental mental health issues increase the likelihood that children leave school early and start working to increase family income. While higher patience generally favors higher levels of education (Shoda et al., 1990; Cadena and Keys, 2015) and life-time earnings (Heckman et al., 2006; Golsteyn et al., 2014), our results suggest that patience developed as a coping mechanism for adversity may not yield the same benefits.

Our findings also have implications for economic modeling, as economic preferences are fundamental to the structure of individual utility functions. In particular, our results suggest that the characteristics of utility functions are endogenously shaped by parental mental health. Recent work has begun to incorporate how mental health influences individuals' own economic decision-making (Bhat et al., 2022; De Quidt and Haushofer, 2019; Cobb-Clark et al., 2022). Our results highlight the value of additionally accounting for parental mental health in models of children's skill formation and decision-making.

Finally, our results allow us to derive implications for policies that address mental illness. The documented, strong intergenerational link suggests that traditional cost–benefit analyses of mental health interventions for parents, which typically focus on direct benefits to treated individuals, may substantially underestimate social returns by failing to account for their impact on child development. Furthermore, our results underscore the benefits of family-centered policy approaches that combine mental health interventions with parenting support and child development initiatives. These could be particularly valuable for daughters of mothers with mental health issues, who appear to bear a disproportionate burden in case of maternal mental illness.

CRediT authorship contribution statement

Alexander Bertermann: Writing – original draft, Visualization, Methodology, Investigation, Formal analysis, Conceptualization. **Hannah Schildberg-Hörisch:** Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

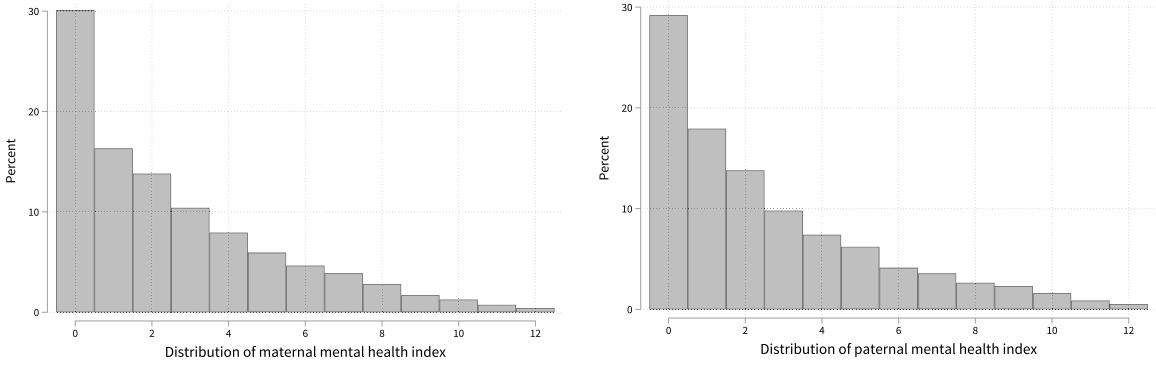
Appendix A. Supplementary material

A.1. Supplementary data descriptions and summary statistics

Table A.1
Numbers of observations by age and survey wave.

Age of child	Wave			Total
	2018	2019/20	2022	
6	200	0	0	200
7	310	221	0	531
8	359	423	3	785
9	504	438	13	955
10	582	501	214	1297
11	520	548	374	1442
12	436	668	395	1499
13	403	556	457	1416
14	281	489	483	1253
15	162	418	582	1162
16	23	323	485	831
17	0	0	376	376
18	0	0	310	310
19	0	0	208	208
Total	**3780**	**4585**	**3920**	**12,285**

Notes. This table shows the frequency distributions categorized by age and survey wave.



(a) Mother (b) Father

Fig. A.1. Histogram of the mental health index. *Notes.* This figure shows the distribution of the mental health index for mothers and fathers.

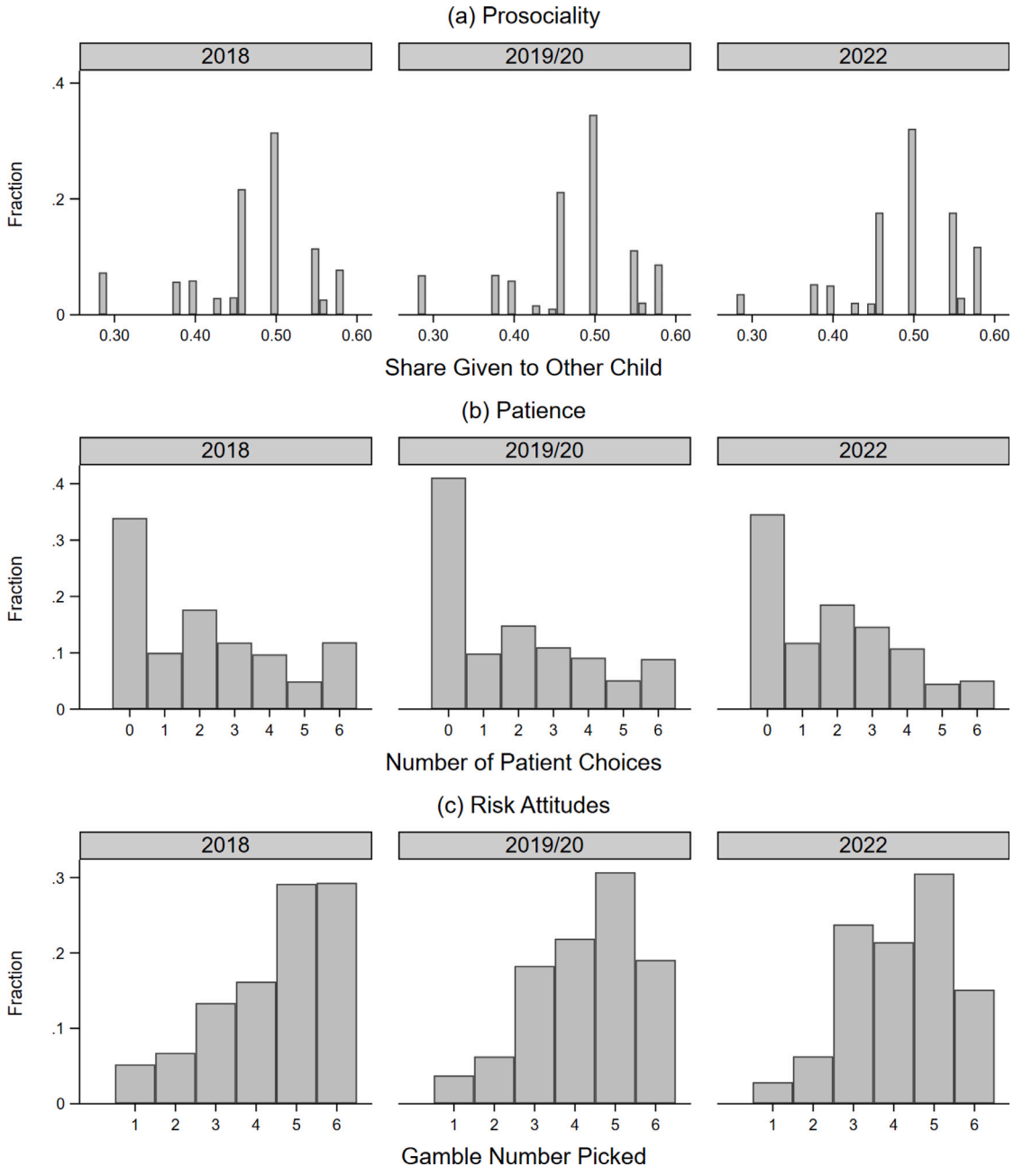


Fig. A.2. Distribution of economic preferences by wave.
Notes. Each panel displays the distribution of economic preferences across survey waves (2018, 2019/20, 2022).

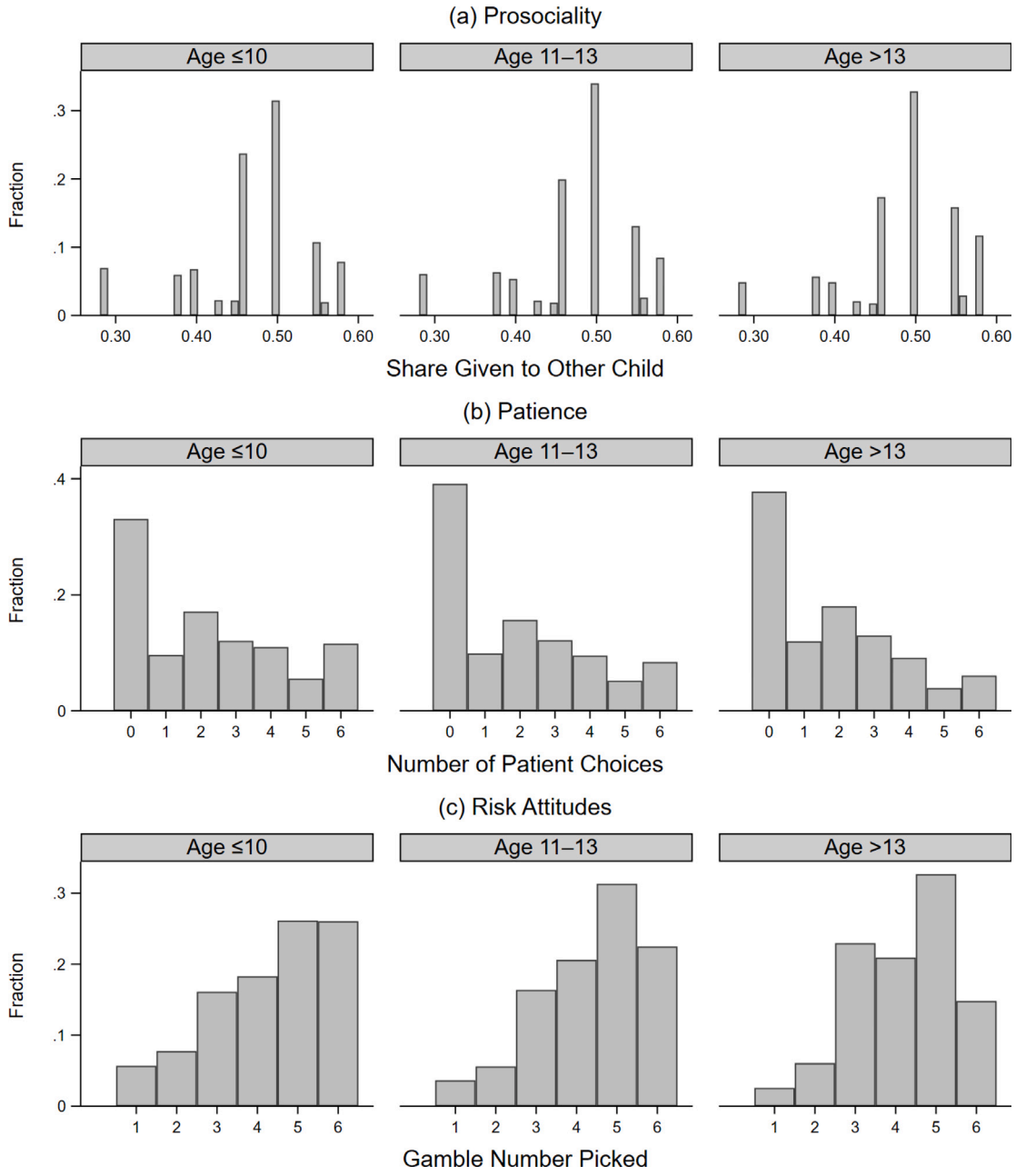


Fig. A.3. Distribution of economic preferences by age group.
Notes. Each panel displays the distribution of economic preferences by age group. Age groups are defined as: ≤10 years, 11–13 years, and >13 years.

Table A.2
Summary statistics.

	Obs.	Mean	Std. dev.	Min.	Max.
Demographic and household characteristics					
Age (in years)	12,265	12.166	2.979	6	19
Gender (female=1)	12,265	0.524	0.499	0	1
Number of siblings	12,263	2.551	1.415	0	12
Firstborn child	12,263	0.332	0.471	0	1
Muslim (yes=1, no=0)	12,265	0.802	0.398	0	1
Mother works as a housewife (yes=1)	12,026	0.874	0.331	0	1
Socio-economic status index	12,265	0.007	0.998	−2.227	6.815
Household-level shock (yes=1, no=0)	12,265	0.676	0.468	0	1
Monthly income per capita (in Taka)	8361	3374	9520	−13,000	752,000
Father's literacy (yes=1, no=0)	7915	0.577	0.494	0	1
Mother's literacy (yes=1, no=0)	8270	0.679	0.467	0	1
Economic preferences					
Children					
Prosociality	12,265	0	1	−2.629	1.450
Patience	12,265	0	1	−0.996	2.038
Risk attitudes	12,265	0	1	−2.419	1.256
Mother					
Prosociality	11,930	0	1	−2.688	1.047
Patience	11,930	0	1	−1.893	1.007
Risk attitudes	11,930	0	1	−2.467	1.144
Father					
Prosociality	9317	0	1	−2.709	0.955
Patience	9317	0	1	−1.890	0.975
Risk attitudes	9317	0	1	−2.617	1.054
Parental mental health measures					
Maternal mental illness (more than 2 symptoms)	10,522	0.398	0.489	0	1
Paternal mental illness (more than 2 symptoms)	6523	0.391	0.488	0	1
Maternal mental illness (more than 4 symptoms)	10,522	0.214	0.410	0	1
Paternal mental illness (more than 4 symptoms)	6523	0.219	0.413	0	1
Continuous maternal mental illness (range: 0–12)	10,522	2.553	2.721	0	12
Continuous paternal mental illness (range: 0–12)	6523	2.592	2.801	0	12
Maternal GHQ submeasure: Anxiety and depression	10,522	1.248	1.290	0	4
Paternal GHQ submeasure: Anxiety and depression	6523	1.258	1.289	0	4
Maternal GHQ submeasure: Social dysfunction	10,522	1.176	1.520	0	6
Paternal GHQ submeasure: Social dysfunction	6523	1.177	1.550	0	6
Maternal GHQ submeasure: Confidence loss	10,522	0.130	0.403	0	2
Paternal GHQ submeasure: Confidence loss	6523	0.157	0.446	0	2
Maternal mental illness (threshold 16 or more out of 36)	10,526	0.160	0.367	0	1
Paternal mental illness (threshold 16 or more out of 36)	6551	0.164	0.370	0	1
Parental investments and children's responsibilities					
Mother's positive parenting	11,877	0	1	−3.763	2.775
Paternal involvement	3185	0	1	−4.032	2.830
Maternal involvement	2613	0	1	−2.982	2.832
Atmosphere at home index (mother's assessment)	3615	0	1	−4.399	2.190
Atmosphere at home index (father's assessment)	3003	0	1	−4.163	1.826
Helping on the family farm (yes=1, no=0)	7694	0.644	0.479	0	1
Working for money (yes=1, no=0)	8253	0.133	0.340	0	1
No longer in school (yes=1, no=0)	8134	0.098	0.298	0	1

Notes. The table presents summary statistics for the sample, consisting of children with complete data on economic preferences and baseline controls (SES, age, gender, and district). Monthly income per capita may be negative in cases where agricultural business expenses, such as labor or feed costs, exceed income. Economic preferences and parental indices are standardized to a mean of zero and a standard deviation of one across the sample.

Table A.3
12-item version of the General Health Questionnaire (GHQ-12).

Have you recently...	(1) Been able to concentrate on whatever you are doing?
	(2) Lost much sleep over worry?
	(3) Felt that you were playing a useful part in things?
	(4) Felt capable of making decisions about things?
	(5) Felt constantly under strain?
	(6) Felt that you could not overcome your difficulties?
	(7) Been able to enjoy your normal day-to-day activities?
	(8) Been able to face up to your problems?
	(9) Been feeling unhappy and depressed?
	(10) Been losing self-confidence in yourself?
	(11) Been thinking of yourself as a worthless person?
	(12) Been feeling reasonably happy, all things considered?
Answer:	Less than usual/No more than usual/Rather more than usual/Much more than usual

Notes. This table shows the GHQ-12 questionnaire.

Table A.4
Decomposition of the GHQ-12 into three distinct facets.

Facet	Have you recently...
Anxiety and depression	(2) Lost much sleep over worry? (5) Felt constantly under strain? (6) Felt that you could not overcome your difficulties? (9) Been feeling unhappy and depressed?
Loss of confidence	(10) Been losing self-confidence in yourself? (11) Been thinking of yourself as a worthless person?
Social dysfunction	(1) Been able to concentrate on whatever you are doing? (3) Felt that you were playing a useful part in things? (4) Felt capable of making decisions about things? (7) Been able to enjoy your normal day-to-day activities? (8) Been able to face up to your problems? (12) Been feeling reasonably happy, all things considered?

Notes. This table shows the categorization of the GHQ-12 items into the facets of anxiety and depression, social dysfunction, and loss of confidence, as identified by Graetz (1991).

Table A.5
Experiment comprehension by age group and survey wave.

	Age ≤ 10			Age 11–13			Age > 13		
	2018	2019/20	2022	2018	2019/20	2022	2018	2019/20	2022
Patience	87.26	99.81	99.15	90.80	99.94	99.44	91.20	99.92	99.71
Risk	92.07	99.69	98.72	93.67	99.77	99.68	97.42	99.76	99.76
Prosociality	95.91	99.94	100.00	96.76	100.00	99.60	97.85	99.84	99.88

Notes. Cell entries show the share of children who did not fail to understand the experimental tasks after three explanations. In the estimation sample, children who failed to understand the experimental procedure after the third explanation in waves 2019/20 and 2022 are excluded.

Table A.6
Number of explanations required for task comprehension by survey wave.

	2018				2019/20				2022			
	1st	2nd	3rd	Failed	1st	2nd	3rd	Failed	1st	2nd	3rd	Failed
Patience												
Control Q 1	10.96	40.01	39.43	9.61	31.96	59.51	8.46	0.07	26.86	54.21	18.57	0.36
Control Q 2	28.29	45.99	23.82	1.91	48.84	47.64	3.48	0.04	45.92	46.73	7.33	0.03
Control Q 3	35.09	45.86	17.70	1.35	54.01	42.81	3.13	0.04	57.24	38.39	4.32	0.05
Control Q 4	38.82	44.03	15.43	1.72	50.51	44.99	4.41	0.09	65.30	31.09	3.56	0.05
Risk	11.17	41.17	40.96	6.69	21.83	59.64	18.26	0.26	22.82	60.34	16.51	0.33
Prosociality	17.09	51.15	28.21	3.55	30.83	59.36	9.74	0.07	31.57	58.03	10.20	0.20

Notes. Cell entries show the share of children (in percent) who understood the experimental task after the 1st, 2nd, or 3rd explanation, or who failed to understand it after three explanations. Patience comprehension was assessed using four separate control questions. In the estimation sample, children who failed to understand the experimental procedure after the third explanation in waves 2019/20 and 2022 are excluded.

Table A.7
Number of explanations required for task comprehension by age group.

	Age ≤ 10				Age 11–13				Age > 13			
	1st	2nd	3rd	Failed	1st	2nd	3rd	Failed	1st	2nd	3rd	Failed
Patience												
Control Q 1	17.31	49.15	27.77	5.77	23.61	51.30	22.42	2.67	30.16	54.83	13.94	1.08
Control Q 2	34.60	47.06	16.94	1.40	40.06	48.61	10.99	0.34	49.58	44.79	5.46	0.17
Control Q 3	41.03	44.60	13.45	0.93	47.42	44.88	7.40	0.30	58.60	37.59	3.63	0.17
Control Q 4	40.92	45.74	12.10	1.24	51.17	41.16	7.31	0.37	61.90	34.32	3.59	0.19
Risk	12.78	48.54	34.36	4.31	18.65	53.70	25.50	2.15	24.65	59.86	14.99	0.51
Prosociality	19.98	54.79	23.08	2.14	25.94	57.02	15.93	1.12	34.06	57.26	8.33	0.36

Notes. Cell entries show the share of children (in percent) who understood the experimental task after the 1st, 2nd, or 3rd explanation, or who failed to understand it after three explanations. Patience comprehension was assessed using four separate control questions. In the estimation sample, children who failed to understand the experimental procedure after the third explanation in waves 2019/20 and 2022 are excluded.

Table A.8
Summary statistics of economic preferences by survey wave and age group.

	Age ≤ 10			Age 11–13			Age > 13		
	Obs.	Mean	Std. dev.	Obs.	Mean	Std. dev.	Obs.	Mean	Std. dev.
2018									
Prosociality	1955	−0.089	1.004	1359	−0.108	1.028	466	−0.056	1.065
Patience	1955	0.162	1.053	1359	0.051	1.050	466	−0.056	0.990
Risk Attitudes	1955	0.065	1.130	1359	0.191	1.014	466	0.137	0.982
2019/20									
Prosociality	1583	−0.140	1.020	1772	−0.050	1.012	1230	0.015	1.019
Patience	1583	0.065	1.051	1772	−0.097	1.016	1230	−0.109	0.985
Risk Attitudes	1583	−0.053	1.035	1772	0.044	0.954	1230	−0.055	0.932
2022									
Prosociality	230	−0.029	0.926	1226	0.138	0.921	2444	0.195	0.943
Patience	230	0.187	0.948	1226	0.000	0.942	2444	−0.081	0.897
Risk Attitudes	230	−0.127	1.079	1226	−0.048	0.972	2444	−0.118	0.906

Notes. The table presents summary statistics for the sample, consisting of children with complete data on economic preferences and baseline controls (SES, age, gender, and district). Economic preferences are standardized to a mean of zero and a standard deviation of one across the pooled sample.

Table A.9
Summary statistics of the positive parenting measure.

Variable	Obs.	Mean	Std. dev.	Min.	Max.
I use words and gestures to show my child that I love her/him.	11,877	3.754	0.968	1	5
I comfort my child when s/he feels sad.	11,877	3.151	1.011	1	5
I praise my child.	11,877	3.251	0.958	1	5
I try to actively influence my child's circle of friends.	11,877	2.155	1.036	1	5
I talk to my child about things s/he has done, seen, or experienced.	11,877	3.112	0.965	1	5
When my child is outside the home, I know exactly where s/he is.	11,877	3.580	1.034	1	5

Notes. Mothers assessed their parenting style by rating each item on a five-point Likert scale ranging from "never" to "very frequently." The six items elicit the parenting style dimensions emotional warmth (items one to three) and monitoring (items four to six) from Thönnissen et al. (2023). The items were answered once per household, resulting in identical values for siblings. As a measure of latent positive parenting, we use the first principal component extracted from a PCA conducted on the six items.

Table A.10
Factor loadings for PCA underlying positive parenting measure.

Item	Factor loading
I use words and gestures to show my child that I love her/him.	0.483
I comfort my child when s/he feels sad.	0.415
I praise my child.	0.441
I try to actively influence my child's circle of friends.	0.136
I talk to my child about things s/he has done, seen, or experienced when s/he was out.	0.480
When my child is outside the home, I know exactly where s/he is.	0.390

Notes. This information was provided by the mother, who was asked to assess her parenting style for the children. Summary statistics of the items used are provided in Table A.9.

Table A.11
Summary statistics of the maternal involvement measure (wave 2022).

Variable	Obs.	Mean	Std. dev.	Min.	Max.
Discuss managing anger and strong feelings	2970	2.954	0.996	1	5
Discuss working cooperatively	2978	3.155	0.963	1	5
Discuss making good decisions	2980	3.135	0.953	1	5
Discuss dealing with bullying	2979	2.639	1.086	1	5
Having joint meals	3002	4.352	1.122	1	5
Talking about her/his school day	2639	3.412	1.263	1	5
Doing homework together	2668	2.416	1.407	1	5
Discussing challenges and decisions	3002	2.523	1.179	1	5

Notes. This table reports summary statistics of the following set of questions from the 2022 wave. Mothers were asked how often they discussed with their child what they had learned at school about how to manage anger and strong feelings, work cooperatively, make good decisions, and deal with bullying. Possible answers were: 1 = never; 2 = seldom; 3 = sometimes; 4 = frequently; 5 = very frequently. In addition, they were asked how often they engaged in the following activities with their child during the past week: having joint meals, talking about their school day, doing homework together, and discussing important challenges and decisions in the child's life. Possible answers were: 1 = never; 2 = less than once per week; 3 = once or twice per week; 4 = three or four times per week; 5 = more than four times per week.

Table A.12
Summary statistics of the paternal involvement measure (wave 2022).

Variable	Obs.	Mean	Std. dev.	Min.	Max.
Discuss managing anger and strong feelings	3592	3.242	0.946	1	5
Discuss working cooperatively	3594	3.407	0.838	1	5
Discuss making good decisions	3597	3.423	0.855	1	5
Discuss dealing with bullying	3596	2.872	1.050	1	5
Having joint meals	3613	4.571	0.981	1	5
Talking about her/his school day	3202	3.922	1.174	1	5
Doing homework together	3226	2.743	1.605	1	5
Discussing challenges and decisions	3613	2.872	1.199	1	5

Notes. This table reports summary statistics of the following set of questions from the 2022 wave. Fathers were asked how often they discussed with their child what they had learned at school about how to manage anger and strong feelings, work cooperatively, make good decisions, and deal with bullying. Possible answers were: 1 = never; 2 = seldom; 3 = sometimes; 4 = frequently; 5 = very frequently. In addition, they were asked how often they engaged in the following activities with their child during the past week: having joint meals, talking about their school day, doing homework together, and discussing important challenges and decisions in the child's life. Possible answers were: 1 = never; 2 = less than once per week; 3 = once or twice per week; 4 = three or four times per week; 5 = more than four times per week.

Table A.13
Factor loadings for PCA underlying maternal involvement measure.

Item	Factor loading
Discuss managing anger and strong feelings	0.424
Discuss working cooperatively	0.445
Discuss making good decisions	0.437
Discuss dealing with bullying	0.387
Having joint meals	0.174
Talking about her/his school day	0.288
Doing homework together	0.252
Discussing challenges and decisions	0.324

Notes. This information was provided by the mother, who was asked to assess her interaction with the children. Summary statistics of the items used are provided in Table A.11.

Table A.14
Factor loadings for PCA paternal involvement measure.

Item	Factor loading
Discuss managing anger and strong feelings	0.438
Discuss working cooperatively	0.468
Discuss making good decisions	0.442
Discuss dealing with bullying	0.397
Having joint meals	0.122
Talking about her/his school day	0.292
Doing homework together	0.212
Discussing challenges and decisions	0.302

Notes. This information was provided by the father, who was asked to assess his interaction with the children. Summary statistics of the items used are provided in Table A.12.

Table A.15
Summary statistics of the atmosphere at home items.

Variable	Obs.	Mean	Std. dev.	Min.	Max.
Panel A: Mother's assessment					
We regularly help one another.	3615	5.988	1.096	1	7
We show respect for each other's feelings about an issue.	3615	5.601	1.121	1	7
We show care for each other even though we disagree.	3615	5.306	1.306	1	7
We stomp out of the room during a disagreement. *(reversed)*	3615	5.782	1.592	1	7
We insult each other or swear at each other. *(reversed)*	3615	5.635	1.350	1	7
We explain our sides of disagreement to each other.	3615	4.003	1.502	1	7
We suggest a compromise to a disagreement.	3615	4.837	1.476	1	7
We shout and yell at each other. *(reversed)*	3615	5.162	1.458	1	7
We throw something at each other that could hurt. *(reversed)*	3615	6.420	1.120	1	7
We put our own needs aside to support other family members.	3615	5.591	1.324	1	7
We collaborate with one another.	3615	6.093	1.101	1	7
Panel B: Father's assessment					
We regularly help one another.	3003	5.982	1.131	1	7
We show respect for each other's feelings about an issue.	3003	5.690	1.173	1	7
We show care for each other even though we disagree.	3003	5.403	1.345	1	7
We stomp out of the room during a disagreement. *(reversed)*	3003	5.966	1.408	1	7
We insult each other or swear at each other. *(reversed)*	3003	5.825	1.309	1	7
We explain our sides of disagreement to each other.	3003	4.251	1.668	1	7
We suggest a compromise to a disagreement.	3003	4.974	1.536	1	7
We shout and yell at each other. *(reversed)*	3003	5.653	1.384	1	7
We throw something at each other that could hurt. *(reversed)*	3003	6.592	0.876	1	7
We put our own needs aside to support other family members.	3003	5.821	1.260	1	7
We collaborate with one another.	3003	6.157	1.101	1	7

Notes. This table lists the components of the atmosphere at home index, as included in the 2022 survey wave. Parents rated the listed statements from 1 = "never" to 7 = "very often." Items marked with *(reversed)* are reverse-coded for scoring purposes.

Table A.16
Summary statistics of items for the SES index (wave 2019/20).

Variable	Obs.	Mean	Std. dev.	Min.	Max.
Panel A: Housing and land ownership					
Square feet of main living room	4537	170.355	116.466	24	2400
Number of rooms	4537	1.307	0.714	1	11
Area of the house (in decimal)	4526	9.932	10.444	0.1	110
Construction material (from jute stick to cement)	4541	3.449	1.067	1	6
Electricity connection (yes/no)	4562	0.968	0.175	0	1
Tubewell (yes/no)	4562	0.566	0.496	0	1
Homestead land owned (in decimal)	4562	9.141	11.465	0	330
Cultivable land owned (in decimal)	4562	41.906	98.921	0	1510
Panel B: Household assets (quantity)					
Metal cooking pot (aluminium made)	4562	23.980	13.674	0	95
Sewing machine	4562	0.115	0.360	0	8
Wall clock/wrist watch	4562	0.715	1.019	0	10
Bicycle	4562	0.256	0.499	0	8
Boat (without an engine)	4562	0.127	0.386	0	8
Other valuables (above 100 Taka)	4562	9.849	10.677	0	90
TV (color)	4562	0.347	0.513	0	8
Chair/table	4562	4.468	2.848	0	61
Bed-frame	4562	2.594	0.971	0	8
Almirah	4562	0.866	0.976	0	8
Table fan	4562	1.970	1.327	0	12
Refrigerator	4562	0.222	0.480	0	8
Mobile phone	4562	1.913	0.974	0	9
Ornament (gold)	4562	3.207	2.540	0	30
Ornament (silver)	4562	1.375	1.617	0	16

Notes. This table uses information provided by the household head in wave 2019/20. Area measurements in "decimal" refer to a traditional unit used in Bangladesh, where 1 decimal equals 1/100th of an acre or approximately 40.47 square meters. Monetary values are in Bangladeshi Taka, with 100 Taka approximately equivalent to 0.82 US-Dollar in January 2025. Construction material is scored on an ordinal scale, ranging from 1 (jute stick) to 6 (cement).

Table A.17
Factor loadings for PCA used to construct socio-economic status index.

Item	Factor loading
Square feet of main living room	0.187
Number of rooms	0.099
Area of the house (in decimal)	0.104
Construction material (from jute stick to cement)	0.214
Electricity connection (yes/no)	0.154
Tubewell (yes/no)	0.195
Homestead land owned (in decimal)	0.151
Cultivable land owned (in decimal)	0.192
Metal cooking pot (aluminium made)	0.148
Sewing machine	0.090
Wall clock/wrist watch	0.238
Bicycle	0.087
Boat (without an engine)	0.014
Other valuables (above 100 Taka)	0.112
TV (color)	0.205
Chair/table	0.324
Bed-frame	0.323
Almirah	0.260
Table fan	0.336
Refrigerator	0.226
Mobile phone	0.294
Ornament (gold)	0.290
Ornament (silver)	0.131

Notes. This table uses information provided by the household head in wave 2019/20. Summary statistics and further descriptions of the items used are provided in Table A.16.

Table A.18
Different facets of parental mental illness and children's economic preferences.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Panel A: Anxiety and depression (standardized)						
	−0.033***	−0.016	0.030**	0.055***	−0.001	0.007
	(0.012)	(0.016)	(0.012)	(0.016)	(0.012)	(0.015)
Observations	6984	4324	6984	4324	6984	4324
Panel B: Loss of confidence (standardized)						
	−0.011	−0.017	0.007	0.013	−0.001	−0.003
	(0.013)	(0.016)	(0.012)	(0.015)	(0.011)	(0.015)
Observations	6984	4324	6984	4324	6984	4324
Panel C: Social dysfunction (standardized)						
	−0.024**	−0.018	0.028**	0.046***	0.001	0.009
	(0.012)	(0.015)	(0.012)	(0.015)	(0.012)	(0.015)
Observations	6984	4324	6984	4324	6984	4324

Notes. This table employs the binary GHQ scoring method (0–0–1–1) described in Section 2.2 and disaggregates the overall GHQ measure into three distinct factors — anxiety and depression, social dysfunction, and loss of confidence — as identified by Graetz (1991), see Appendix Table A.4. Each of the three facets is standardized to a mean of zero and a standard deviation of one. Before standardization, the scales range from 0 to 4 for anxiety and depression, from 0 to 2 for loss of confidence, and from 0 to 6 for social dysfunction. Each entry stems from a separate regression, with the column header indicating the outcome variable. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. The controls include fixed effects for age, district, and survey year, along with variables for SES, gender, parental lagged preferences, and the child's lagged outcome value. Regressions are based on child outcomes from the 2019/20 and 2022 waves, and standard errors are clustered at the household level. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.19
SES and gender gaps in children's economic preferences.

	Prosociality	Patience	Risk attitudes
Panel A: Gaps by family SES			
SES index (median split)	−0.041**	0.038*	−0.002
	(0.020)	(0.021)	(0.019)
Observations	12,265	12,265	12,265
Panel B: Gaps by child's gender			
Female	0.006	0.070***	−0.072***
	(0.019)	(0.019)	(0.019)
Observations	12,265	12,265	12,265

Notes. Each entry corresponds to a separate regression, with the column header indicating the outcome variable. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. We perform a median split of the SES index described in Section 2.4, where 1 denotes above-median SES and 0 denotes below-median SES. Survey wave fixed effects are included as controls, and standard errors are clustered at the household level. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.20
Parental mental health and children's economic preferences: Correction for multiple hypothesis testing.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Coefficient	−0.068	−0.055	0.060	0.095	−0.019	−0.011
Standard p-values	0.004	0.073	0.014	0.002	0.418	0.700
Anderson p-values	0.014	0.079	0.015	0.007	0.163	0.305
Romano–Wolf p-values	0.011	0.157	0.029	0.009	0.419	0.692
Observations	6984	4324	6984	4324	6984	4324

Notes. The table presents coefficients and p-values, adjusted for multiple hypothesis testing, of the relation between parental mental health and children's economic preferences (as indicated in the column headings). The p-values include standard p-values clustered at the household level, sharpened False Discovery Rate (FDR, also called Anderson) p-values, as proposed by Benjamini et al. (2006) and implemented using the Stata code provided by Anderson (2008), and Romano–Wolf p-values as proposed by Romano and Wolf (2005a,b) and implemented using the Stata code from Clarke et al. (2020). The calculation of Romano–Wolf p-values requires the inclusion of the same control variables across all outcomes. We therefore include all three lagged economic preferences of children in each regression. Aside from this, the estimation equation follows the main specification in Table 4 and is described in equation (1). Note that Anderson p-values can be lower than unadjusted p-values when many hypotheses are rejected.

A.2. Supplementary analysis

Table A.21
Parental mental health and children's economic preferences: Robustness to varying measures of mental health.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Panel A: Main specification (more than 2 symptoms)						
	−0.069***	−0.056*	0.060**	0.095***	−0.019	−0.013
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Observations	6984	4324	6984	4324	6984	4324
Panel B: Stricter threshold (more than 4 symptoms)						
	−0.053*	−0.028	0.060**	0.133***	0.018	0.020
	(0.029)	(0.037)	(0.028)	(0.037)	(0.028)	(0.037)
Observations	6984	4324	6984	4324	6984	4324
Panel C: Continuous mental health measure (range: 0–12)						
	−0.011**	−0.007	0.012**	0.019***	−0.000	0.003
	(0.005)	(0.005)	(0.005)	(0.006)	(0.004)	(0.005)
Observations	6984	4324	6984	4324	6984	4324
Panel D: Likert-scale scoring method (threshold 16 or more out of 36)						
	−0.075**	−0.033	0.085***	0.072*	0.018	−0.006
	(0.032)	(0.041)	(0.032)	(0.041)	(0.031)	(0.042)
Observations	6988	4347	6988	4347	6988	4347

Notes. This table repeats the estimation equation of the main results from Table 4, using varying measures of parental mental health. Panel A presents the main specification, defining mental illness as the presence of more than two symptoms (i.e., having a score of 3 or higher on the 12-point scale), observed in 39.1 percent of fathers and 39.8 percent of mothers in our sample. In Panel B, we adopt a stricter threshold, defining mental illness as a score exceeding 4, which applies to 21.9 percent of fathers and 21.4 percent of mothers. In Panel C, we use the same mental health measure as a "continuous" variable, ranging from 0 (no indication of mental illness) to 12 (severe mental illness). In Panel D, we adopt an alternative scoring approach that aggregates individual item responses before applying a single cutoff. This approach is informed by statistics on diagnosed mental illness in Bangladesh (WHO, 2020) and corresponds closely to that in Haushofer et al. (2020). Using this criterion, 16.4 percent of fathers and 16.0 percent of mothers in our sample are classified as mentally ill. Each entry represents a separate regression, with the column header indicating the outcome variable. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, parental lagged preferences, and the child's lagged outcome value. Regressions are based on child outcomes from the 2019/20 and 2022 waves, and standard errors are clustered at the household level. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.22
Parental mental health and children's economic preferences: Robustness to excluding lagged child preferences.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Panel A: Baseline specification						
	−0.069***	−0.055*	0.059**	0.090***	−0.021	−0.016
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Observations	6984	4324	6984	4324	6984	4324
Panel B: Adding lagged family income and shocks as control variables						
	−0.065***	−0.050	0.063**	0.095***	−0.022	−0.015
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Observations	6982	4322	6982	4322	6982	4322

Notes. This table replicates the specifications from Table 4, Panels A and B, but excludes children's lagged preferences from the set of control variables. Each entry represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, and lagged parental economic preferences. Regressions are based on outcomes from the 2019/20 and 2022 waves. Panel B adds controls for household-level shocks and lagged family income. Standard errors clustered at the household level in parentheses. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.23
Parental mental health and children's economic preferences by child age.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Panel A: Children aged ≤ 13						
	−0.060*	−0.025	0.078**	0.082*	0.006	−0.007
	(0.033)	(0.042)	(0.034)	(0.044)	(0.033)	(0.044)
Observations	3855	2241	3855	2241	3855	2241
Panel B: Children aged > 13						
	−0.077**	−0.100**	0.026	0.091**	−0.051	−0.017
	(0.035)	(0.045)	(0.033)	(0.041)	(0.033)	(0.042)
Observations	3129	2083	3129	2083	3129	2083
p-value (equality)	0.812	0.204	0.108	0.905	0.198	0.917

Notes. This table repeats the estimation of the main results from Table 4, conducted separately by age group (median split). Each entry represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, parental lagged preferences, and the child's lagged outcome value. Regressions are based on child outcomes from the 2019/20 and 2022 waves, and standard errors are clustered at the household level. The *p*-values of *t*-tests testing for equality of coefficients are presented below the estimates. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.24
Parental mental health and children's economic preferences: Heterogeneity by SES.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Interaction with family SES (median split)						
Mental illness	−0.072**	−0.027	0.060*	0.070*	−0.018	−0.019
	(0.034)	(0.040)	(0.034)	(0.042)	(0.034)	(0.041)
Mental illness × Above-median SES	0.007	−0.063	0.000	0.054	−0.003	0.014
	(0.048)	(0.061)	(0.049)	(0.061)	(0.047)	(0.061)
Main effect + interaction	−0.065*	−0.090*	0.060*	0.124***	−0.021	−0.005
	(0.035)	(0.047)	(0.035)	(0.045)	(0.033)	(0.046)
Observations	6984	4324	6984	4324	6984	4324

Notes. This table examines heterogeneity in the relationship between indications of parental mental illness and children's economic preferences by family socio-economic status (SES). SES is measured using a household asset index and split at the median. Each column represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. The coefficient on mental illness refers to children from below-median SES households, the interaction term reflects the differential effect for children from above-median SES households, and the sum of both captures the total effect for above-median SES households. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, parental lagged preferences, and the child's lagged outcome value. Regressions are based on child outcomes from the 2019/20 and 2022 waves, and standard errors are clustered at the household level. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.25
Parental mental health, parental investments and children's responsibilities by age.

Outcome variable:	Parental involvement		Positive parenting	Atmosphere at home	
Mental illness:	Maternal	Paternal	Maternal	Maternal	Paternal
Child's age ≤ 13					
	−0.103	−0.063	−0.003	−0.289***	−0.025
	(0.071)	(0.071)	(0.030)	(0.061)	(0.065)
Observations	1014	1017	6690	1350	1103
Child's age > 13					
	−0.096*	−0.050	−0.028	−0.260***	0.000
	(0.055)	(0.059)	(0.035)	(0.045)	(0.050)
Observations	1458	1467	3,600	2265	1900
Outcome variable:	Child working for money		Child helps on family farm	No longer in school	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Child's age ≤ 13						
	0.011	0.015	0.046***	0.066***	0.003	−0.002
	(0.007)	(0.010)	(0.015)	(0.018)	(0.005)	(0.007)
Observations	4249	2758	3931	2575	4203	2728
Child's age > 13						
	0.034**	0.024	0.016	0.009	0.043***	0.024
	(0.014)	(0.016)	(0.012)	(0.013)	(0.014)	(0.017)
Observations	3377	2570	3191	2448	3316	2524

Notes. This table reports estimates from Table 6 separately by child age, using a median split at age 13. Each cell reports the coefficient from a separate OLS regression of the outcome variable on an indicator for parental mental illness. All regressions include child age, district, and survey wave fixed effects, and control for household socioeconomic status and child gender. Standard errors clustered at the household level are in parentheses. $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.26
Parental mental health, parental investments and children's responsibilities by school enrollment.

Outcome variable:	Parental involvement		Positive parenting	Atmosphere at home	
Mental illness:	Maternal	Paternal	Maternal	Maternal	Paternal
Enrolled in school					
	−0.102**	−0.046	−0.040	−0.276***	−0.028
	(0.049)	(0.049)	(0.028)	(0.044)	(0.049)
Observations	2276	2289	6670	2972	2447
Not enrolled in school					
	0.076	−0.089	−0.047	−0.225**	0.120
	(0.193)	(0.206)	(0.076)	(0.090)	(0.094)
Observations	115	112	691	544	464
Outcome variable:	Child working for money		Child helps on family farm		
Mental illness:	Maternal	Paternal	Maternal	Paternal	
Enrolled in school					
	0.018***	0.022**	0.036***	0.047***	
	(0.007)	(0.009)	(0.011)	(0.013)	
Observations	6798	4663	6354	4400	
Not enrolled in school					
	−0.008	−0.032	−0.021	−0.012	
	(0.029)	(0.031)	(0.022)	(0.022)	
Observations	721	589	667	552	

Notes. This table reports estimates from Table 6 separately by child school enrollment status (9.8 percent of children are not enrolled anymore). Each cell reports the coefficient from a separate OLS regression of the outcome variable on an indicator for parental mental illness. All regressions include child age, district, and survey wave fixed effects, and control for household socioeconomic status and child gender. Standard errors clustered at the household level are in parentheses. $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.27
Parental mental health, parental investments and children's responsibilities by number of siblings.

Outcome variable:	Parental involvement		Positive parenting	Atmosphere at home	
Mental illness:	Maternal	Paternal	Maternal	Maternal	Paternal
Siblings ≤ 2					
	−0.096	−0.041	−0.001	−0.304***	−0.030
	(0.064)	(0.067)	(0.033)	(0.057)	(0.064)
Observations	1367	1370	5888	1984	1579
Siblings > 2					
	−0.097	−0.059	−0.006	−0.225***	0.015
	(0.072)	(0.067)	(0.038)	(0.058)	(0.063)
Observations	1104	1113	4400	1630	1423

Outcome variable:	Child working for money		Child helps on family farm		No longer in school	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Siblings ≤ 2						
	0.026***	0.017	0.044***	0.052***	0.024***	0.001
	(0.010)	(0.013)	(0.014)	(0.016)	(0.008)	(0.010)
Observations	4256	2824	3931	2646	4217	2798
Siblings > 2						
	0.013	0.020	0.015	0.024	0.014	0.014
	(0.012)	(0.014)	(0.015)	(0.016)	(0.012)	(0.015)
Observations	3368	2502	3189	2375	3300	2452

Notes. This table reports estimates from Table 6 separately by number of siblings, using a median split at two siblings. Each cell reports the coefficient from a separate OLS regression of the outcome variable on an indicator for parental mental illness. All regressions include child age, district, and survey wave fixed effects, and control for household socioeconomic status and child gender. Standard errors clustered at the household level are in parentheses. $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.28
Parental mental health, parental investments and children's responsibilities by birth order.

Outcome variable:	Parental involvement		Positive parenting	Atmosphere at home	
Mental illness:	Maternal	Paternal	Maternal	Maternal	Paternal
Firstborn					
	−0.097	−0.047	0.004	−0.289***	−0.069
	(0.071)	(0.073)	(0.035)	(0.061)	(0.068)
Observations	820	826	3471	1231	961
Later-born					
	−0.095*	−0.050	−0.011	−0.265***	0.016
	(0.055)	(0.056)	(0.029)	(0.046)	(0.050)
Observations	1651	1657	6817	2383	2041

Outcome variable:	Child working for money		Child helps on family farm		No longer in school	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Firstborn						
	0.018	0.023	0.054***	0.060***	0.015	0.013
	(0.012)	(0.016)	(0.017)	(0.020)	(0.011)	(0.014)
Observations	2625	1717	2422	1611	2590	1695
Later-born						
	0.020**	0.017	0.021*	0.029**	0.019**	0.004
	(0.009)	(0.012)	(0.012)	(0.014)	(0.009)	(0.011)
Observations	4999	3609	4698	3410	4927	3555

Notes. This table reports estimates from Table 6 separately by birth order. Each cell reports the coefficient from a separate OLS regression of the outcome variable on an indicator for parental mental illness. All regressions include child age, district, and survey wave fixed effects, and control for household socioeconomic status and child gender. Standard errors clustered at the household level are in parentheses. $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.29
Parental mental health, positive parenting and children's responsibilities: Child fixed effects model.

Outcome variable:	Positive parenting	Work for money		Help on family farm		No longer in school	
Mental illness:	Maternal	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
	−0.036	0.025**	0.014	0.066***	0.071***	0.016*	−0.008
	(0.034)	(0.011)	(0.016)	(0.015)	(0.021)	(0.009)	(0.013)
Observations	9752	6568	3368	5758	3024	6424	3282

Notes. Each cell reports the coefficient from a separate OLS regression of the outcome variable on an indicator for parental mental illness. Unlike Table 6, these specifications include child fixed effects, identifying effects from within-child variation in parental mental health over time. Standard errors clustered at the household level are in parentheses. $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.30
Parental mental health and children's economic preferences: Accounting for previously run study.

	Prosociality		Patience		Risk attitudes	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
Panel A: Baseline specification						
	−0.068***	−0.055*	0.061**	0.095***	−0.019	−0.014
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Wald test (*p*-value)	[0.711]		[0.333]		[0.877]	
Observations	6984	4324	6984	4324	6984	4324
Panel B: Adding lagged family income and shocks as control variables						
	−0.065***	−0.051	0.064***	0.099***	−0.020	−0.013
	(0.024)	(0.031)	(0.025)	(0.031)	(0.024)	(0.031)
Wald test (*p*-value)	[0.691]		[0.319]		[0.853]	
Observations	6982	4322	6982	4322	6982	4322

Notes. Each entry represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. The outcome variables — prosociality, patience, and risk attitudes — are standardized to a mean of 0 and a standard deviation of 1 using all available observations. Controls include fixed effects for age, district, and survey year, as well as variables for SES, gender, lagged parental economic preferences and the child's lagged outcome variable in Panel A. Regressions are based on outcomes from the 2019/20 and 2022 waves. Panel B adds controls for household-level shocks and lagged family income. All specifications additionally include indicator variables for the three treatment arms (information treatment, filter cash treatment, filter credit treatment) of a prior study on arsenic water contamination, using the control villages with no repeated information campaign as baseline category. Standard errors clustered at the household level in parentheses. Unlike Table 4, no child fixed-effects specification is reported, as the time-invariant treatment indicators are absorbed by the individual fixed effects, yielding identical estimates. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

Table A.31
Parental mental health, parental investments and children's responsibilities: Accounting for previously run study.

Outcome variable:	Parental involvement		Positive parenting		Atmosphere at home	
Mental illness:	Maternal	Paternal	Maternal		Maternal	Paternal
	−0.098**	−0.058	−0.011		−0.272***	−0.010
	(0.048)	(0.048)	(0.025)		(0.041)	(0.045)
Wald test (*p*-value)	[0.545]				[0.000]	
Observations	2472	2484	10290		3615	3003
Outcome variable:	Child working for money		Child helps on family farm		No longer in school	
Mental illness:	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal
	0.022***	0.020**	0.033***	0.040***	0.020***	0.010
	(0.007)	(0.010)	(0.010)	(0.011)	(0.007)	(0.009)
Wald test (*p*-value)	[0.910]		[0.630]		[0.302]	
Observations	7626	5328	7122	5023	7519	5252

Notes. Each entry represents a separate regression, with the column header indicating the outcome variable. Maternal and paternal indications of mental illness are represented as binary variables, as described in Section 2.2. Controls include fixed effects for age, district, and survey year, as well as variables for SES and gender. Some outcome variables were not collected in all waves, leading to varying sample sizes. Specifically, the regressions draw on data from waves 2018, 2019/20, and 2022 for maternal positive parenting, from waves 2019/20 and 2022 for working for money, child helping on the family farm, and no longer in school, and from wave 2022 for paternal involvement, maternal involvement and atmosphere at home. Details on the construction of the indices for paternal and maternal involvement, positive parenting, and atmosphere at home are provided in Section 2.4. In the sample, 13.3 percent of children report working for money, while 66.4 percent help on the family farm, and 9.8 percent are no longer in school. All specifications additionally include indicator variables for the three treatment arms (information treatment, filter cash treatment, filter credit treatment) of a prior study on arsenic water contamination, using the control villages with no repeated information campaign as baseline category. Standard errors clustered at the household level in parentheses. Significance: $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$.

A.3. Robustness to previous arsenic water contamination study

Some of the households considered in our paper were exposed to a previous study on arsenic water contamination. We begin by briefly describing the study, before we demonstrate that the results reported in this paper remain unchanged when taking into account that a subsample of our sample was exposed to this randomized controlled trial (RCT).

Millions of rural households in Bangladesh regularly drink tubewell water as their main source of drinking water. Until the discovery of arsenic in the tubewell water in the mid-1990s, it was considered a safe and affordable option and was widely promoted by the Department of Public Health and Engineering (DPHE), with support from UNICEF, the World Bank, and similar organizations. Following the discovery of arsenic, the DPHE conducted a nationwide arsenic testing of all tubewells between 1999 and 2002. With support from NGOs, they labeled each tubewell as either green (indicating safe water) or red (indicating unsafe levels of arsenic) and launched a nationwide public information campaign.

Between 2014 and 2016, an RCT was conducted in the villages of our sample to assess the effectiveness of a public information campaign similar to the earlier DPHE campaign and the promotion of arsenic filters to encourage households to switch to arsenic-free drinking water, thereby possibly reducing their exposure to arsenic. All tubewells in the study villages were tested for arsenic and labeled either green or red again following the same protocol as the DPHE's nationwide campaign (which, according to regulations, should happen regularly anyhow but is not always enforced). In 23 percent of villages, households received information about the health risks of consuming arsenic-contaminated water (information treatment). In 22 percent of villages, this information was accompanied by an offer to purchase an arsenic water filter with cash on delivery (filter cash treatment). Households in another 22 percent of the villages received the same information, along with the option to buy the filter through a credit scheme (filter credit treatment).

Further details about this RCT can be found in the study's preregistration: https://www.socialscienceregistry.org/trials/11985/history/193353.

11.7 percent of the observations in our sample come from households that were exposed to one of the three treatments described above. From a conceptual point of view, there is little reason to expect that refreshing information on the consequences of drinking arsenic-contaminated water and a possible reduction of the contamination (if any) several years ago should influence parents' or their children's preferences that we study here. We demonstrate below that our main findings remain robust when controlling for exposure to the arsenic RCT (see Tables A.30 and A.31). The same holds for all other specifications, which are available upon request.

Appendix B. Experimental instructions and procedures

Supplementary material related to this article can be found online at https://doi.org/10.1016/j.jdeveco.2026.103785.

Data availability

Data will be made available on request.

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