When Mothers and Fathers Disagree:

Differences in Ratings of Child Wellbeing among Parent Dyads

ABSTRACT

Prior research documenting differences in child wellbeing across family forms relies heavily on the ratings of one parent – overwhelmingly the child's mother. This over-reliance on a single-parent proxy ignores potentially important differences between fathers' and mothers' ratings of child outcomes. Using father-mother dyads from the Fragile Families and Child Wellbeing Study, this study examines the factors that predict the difference in father and mother reports of poor child health, internalizing problem behavior, and externalizing problem behavior. This study finds that ratings of the same child's health and problem behavior at age 5 differed between parents and that these discrepancies were better explained by the characteristics of the parents and their relationship with each other than those of the child. In general, as parents' ratings of their relationship quality and coparenting diverge, the discrepancies in their reports of child wellbeing also grow wider.

Keywords: behavior, child wellbeing, health, measurement, parents, relationships

The American family has undergone massive change in the last fifty years (Furstenberg, 2014). High rates of non-marital births, divorce, and multi-partnered fertility have contributed to increasingly diverse and complex family forms (McLanahan & Jacobsen, 2015). Given the importance of families for children's healthy development, there is increasing interest in the ways in which changing family structures have implications for child wellbeing.

The extant research linking family context to child wellbeing, however, relies heavily on outcome measures reported by proxy. Traditionally, researchers focused on the role of mothers in child development. Yet, the nuclear-family household with the mother as the primary caregiver and father as the provider is no longer the dominant model (Grall, 2016; Meyer & Carlson, 2014). Despite acknowledging shifting family arrangements, survey data is still typically only collected from one parent, most often the child's mother. Given the increasing ambiguity in parenting roles, studying children solely through the perspectives of their mothers and ignoring other caretakers, particularly fathers, can no longer be considered adequate. Furthermore, the burgeoning scholarship on the influence of fathers on child development demonstrates discrepancies between parental reports across a range of predictors such as residential status and father involvement (Mikelson, 2008; Waller & Jones, 2014). Therefore, it is reasonable to suspect that parents may also differ in their perceptions of frequently assessed child wellbeing measures including the child's health status and behavior.

The current study uses data from the Fragile Families and Child Wellbeing Study (FFCWS) to address these gaps within the existing literature. This is a unique dataset and particularly well suited for this study, because both mothers and fathers were interviewed at baseline and at each wave with follow-up surveys. The sample includes an oversample of births to unmarried parents and interviews were conducted with both residential and non-residential

biological fathers. The data provide information regarding relationship quality between parents and their cooperation in parenting to explain differences in parent-rated child wellbeing measures. First, this study compares parent concordance on parent-rated child health, internalizing problem behavior, and externalizing problem behavior when the focal child is age 5 to determine if there are differences. Second, it examines the factors that predict the discrepancy between father's and mother's reports. This study makes a methodological contribution by suggesting that researchers consider both mother- and father-rated child outcomes in future analyses. Substantively it contributes to the growing literature about the changing nature of American families and its implications for child wellbeing. In particular, discrepant assessments have implications for anyone interested in child wellbeing, as efforts to improve health and behavior may be hindered by parents who disagree on how their child is faring.

BACKGROUND

Family systems theory is an interdisciplinary framework that captures the dynamic role of dyadic (i.e. parent-child, mother-father) and triadic (mother-father-child) relationships on individual-level outcomes (Minuchin, 1974). From this perspective, child development occurs across multiple levels of the family system (Cox & Paley, 2003). While previous research focuses on the mother-child relationship, more recent work advances our understanding of child wellbeing by considering other individuals within larger family systems. Considering a broader family context is important because these relationships are interdependent.

Among family relationships, the marital relationship is historically viewed as central to nuclear family dynamics (Cummings & O'Reilly, 1997). Marital and parent-child relationships are interrelated and poor parent-child relationships often develop in the context of distressed marriages (Cox & Paley, 2003). Marital distress is negatively linked to parenting, as this tension spills over into parents' interactions with children (Cummings & Davies, 2002). More recently,

studies including unmarried parents add support for the spillover hypothesis – better relationship quality leads to more positive parenting (Carlson & McLanahan, 2006; Carlson, Pilkauskas, McLanahan, & Brooks-Gunn, 2011; Ryan, Kalil, & Ziol-Guest, 2008). Furthermore, relationship quality may be particularly important among nonmarried couples as a high-quality couple relationship can be essential for connecting fathers to their children (Carlson et al., 2011). Moreover, positive associations exist between parental relationship quality and child development (Cummings & Davies, 2002; Goldberg & Carlson, 2014). For example, poor parental relationship quality is related to lower parent-child engagement and parental conflict intensifies aggressive behavior in children (Fomby & Osborne, 2010) while greater couple supportiveness is related to lower levels of both externalizing and internalizing behavioral problems among young children (Goldberg & Carlson, 2014).

Coparenting, or the coordination of efforts by parents to raise a common child, is conceptually distinct from parents' relationship quality (Feinberg, 2003). How parents interact together with their child is predictive of adjustment, even after controlling for parents' relationship quality and their individual parent-child relationships (Mchale & Rasmussen, 1998). Successful coparenting is related to positive parenting and child adjustment (Hohmann-Marriott, 2011), while coparenting conflict predicts poor parenting and disruptive child behavior (Feinberg, Kan, & Hetherington, 2007). Therefore, cooperation in parenting provides additional information that is important for understanding child wellbeing.

In a world of increasingly fluid family forms, the resources available to support parenting vary as partners enter and exit family life, creating tension in the family system. Living with married parents at age 5 is associated with significant advantages in both behavioral and health outcomes and children living with parents stably married since birth exhibit the lowest level of

problem behavior (Bzostek & Beck, 2011; Craigie, Brooks-Gunn, & Waldfogel, 2012). By contrast, cohabitating and dating mothers experiencing greater instability in their relationships report more stress and engage in harsher parenting practices (Beck, Cooper, McLanahan, & Brooks-Gunn, 2010) and the number of entrances/exits by father figures is associated with poor child development (Fomby & Cherlin, 2007; Waldfogel, Craigie, & Brooks-Gunn, 2010). Among the fathers most at risk for low engagement are nonresident fathers who have ended their romantic relationships with their child's mother (Bronte-Tinkew, Horowitz, & Scott, 2009; Fagan & Palkovitz, 2011). Yet, cooperative parenting among nonresident fathers is positively associated with father-child contact and closeness (Carlson, McLanahan, & Brooks-Gunn, 2008). Therefore, maintaining high-quality parent relationships and cooperation in parenting seem to be especially important for nonresident father involvement and child wellbeing.

Theoretically, parents living in high-quality, stable relationships will combine their resources and work cooperatively to raise their child; whereas those in uncooperative relationships could put their child's wellbeing at risk. Empirical evidence supports these claims. Yet, there is a common limitation to much of this work: the data for the outcomes measuring child health and behavior at age 5 are collected from a single proxy – the child's mother.

Child Wellbeing

A life course perspective of human development includes *sensitive periods* when specific exposures have a stronger effect on health and well-being (Ben-Shlomo & Kuh, 2002). The transition from early to middle childhood (approximately age 5) is recognized as a sensitive period for shaping subsequent development (Duncan, Ludwig, and Magnuson, 2007). How children are doing at school entry is important because a successful transition lays the foundation for future success. Differences in temperament and disposition at the start of school are

remarkably persistent. Measures of children's socioemotional development are important indicators of school readiness and strongly correlated with school performance, adolescent adjustment, and adult outcomes (Duncan & Magnuson, 2011, Entwisle, Alexander, and Steffel Olson 2005). The social contexts of home and family are the most prominent influences in young children's lives and shape first experiences of learning and socialization (Eccles, 1999). Parental relationship and coparenting quality likely play key roles in this stage of development.

Despite the importance of measuring children's wellbeing accurately, the extant research linking family context to child wellbeing relies heavily on child measures reported by proxy. Common survey methods of self-assessment used among adults cannot be employed with 5-year-old children who lack the necessary language skills and cognitive abilities to answer the questions (Eiser & Morse, 2001; Waters et al., 2000). Therefore, survey professionals must rely on proxies to assess children. Yet, questions remain as to who is the best proxy and whether a single proxy should ever be considered adequate.

Frequently, researchers only collect data from one parent or guardian – most often the child's mother. There may be good arguments for using maternal ratings. Complex families are becoming increasingly matriarchal as the vast majority of children live with their biological mother after their parents' relationship dissolution (Meyer & Carlson, 2014). Yet, most custodial parents report contact with the other biological parent in the last year and father-headed single-parent families are growing (Grall, 2016; Meyer & Carlson, 2014). Recent estimates suggest that 17.5% of custodial parents are fathers, with approximately 26% of custodial parents reporting court ordered physical or legal joint custody (Grall, 2016).

An over-reliance on single-parent proxies ignores some important questions. Given the same child, would mothers and fathers agree? If not, what predicts these differences? Are the

differences best explained by characteristics of the child? The parents? Or the dynamics of the relationship between the parents?

It is reasonable to suspect that parents may disagree on child wellbeing, as there are documented discrepancies between parent reports across a range of measures. For instance, divorced parents give inconsistent reports of where their children live (Cork & Voss 2006, Lin et al. 2004). Following a non-marital birth, over one-third of matched mother-father pairs disagreed about who their child lived with at age five (Waller & Jones, 2014). These discrepancies in reports of children's residence are attributed to complexity and ambiguity in living situations, rather than the quality of the parents' relationship with each other (Waller & Jones, 2014). By contrast, lower quality parental relationships may contribute to discrepancies in measuring father involvement with children. For instance, when the relationship is poor, mothers may underestimate (or fathers may overestimate) the amount of time fathers spend with children (Coley and Morris 2002; Mikelson 2008).

Both motivational and non-motivational factors may lead to inconsistencies in parent's survey reports of children's behavior and health status. Given the challenges in measuring other important variables in complex families, discrepancies in child wellbeing measures may not be surprising. It is likely that parents who live apart and/or in uncooperative relationships will give inconsistent reports of how their children are doing. Therefore, these factors – if they influence parental ratings of child wellbeing - may cloud researchers' ability to properly assess child health and behavior across family types.

Current Outcome Measures

In terms of behavior, the Child Behavior Checklist (CBCL) is a popular standardized measure in child psychology for assessing maladaptive behavior in children (Achenbach and

Ruffle 2000). It utilizes a questionnaire in which the parent rates the child on various behavioral and emotional problems, assessing both internalizing (i.e., anxious, depressive) and externalizing (i.e., hyperactivity, temper tantrums) behaviors (Achenbach and Ruffle 2000). Agreement between mothers and fathers tends to be only moderate (Achenbach, McConaughy, and Howell 1987; Duhig et al. 2000). A meta-analysis considering 60 studies found mother-father agreement on ratings of behavior problems were far from concordant (r = .61) (Duhig et al. 2000). Overall, agreement appeared to be higher for externalizing behaviors relative to internalizing behaviors (Achenbach et al. 1987; Duhig et al. 2000). Also, mothers have been shown to rate externalizing behaviors worse than fathers (Duhig et al. 2000). Explanations for these differences suggest that externalizing behaviors are overt by nature and therefore more observable and mothers spend more time observing their children (Achenbach et al. 1987). These conclusions, however, assume that parents are observing and rating the same behavior. In reality, it is also possible that children behave differently around different parents. It is also reasonable to hypothesize that parents who live together and spend more shared time with their child are more likely to observe the same behavior. Likewise, parents who live apart and spend more time with the child individually would be more likely to provide divergent reports. Yet, to my knowledge, there are no published studies which take into account parent residential status when comparing ratings.

In terms of health, single-item self-rated health (SRH) measures are considered robust indicators of general health status and valid predictors of acute and chronic illness, disability, and mortality among adults across racial and ethnic groups (Browning, Cagney, & Wen, 2003; Idler & Benyamini, 1997). SRH is an integrated assessment of numerous health domains, providing a comprehensive image of an individual's health, rather than specific determinations of health outcomes. It does not rely on strict diagnostic criteria or require access to formal healthcare

providers for judgment. As a result, a single question asking people to rate their health ("Overall, how would you rate your health?) in five categories ("Excellent, very good, good, fair or poor?") has become one of the most extensively used indicators of health status.

Parent-rated child health is similarly one of the most commonly used measures of children's health in social science research today. Despite its popularity, validation studies comparable to those conducted for adult SRH have not been performed. Previous research does suggest that parental gender should be considered as a potential factor affecting the reporting of child health. For example, one study found that a mother's self-reported health was strongly associated with her reporting of her child's health; however, this was not observed for fathers (Waters et al., 2000). Yet, two major limitations of this study were that it did not compare mothers and fathers of the same child and the father sample could have been too small to detect differences. Thus, a review of parent-rated child health strongly argued for future studies to obtain information from both parents whenever possible (Eiser & Morse, 2001). Yet, there are no published studies which take both parent ratings of child health status into consideration.

Increasingly studies are starting to recognize the importance of gathering data from both mothers and fathers. The Early Childhood Longitudinal Study, Birth Cohort (ECLS-B) a longitudinal study similar to FFCWS, followed children born in 2001 through kindergarten to provide detailed information about children's early life experiences (Flanagan & McPhee, 2009). Residential and non-residential fathers were surveyed about themselves and their role in children's lives at the baseline 9-month and 2-year follow-up data collections. At the 2-year follow-up response rates for non-residential fathers dropped to 39% and at the subsequent pre-school collection only residential fathers were interviewed. By the time the children reached

kindergarten in 2006 and 2007, fathers were no longer separately surveyed and overwhelmingly the "parent respondent" was the child's mother (94 and 92%).

Generalizing mother ratings as representative of a child's objective wellbeing without accounting for other members of the family system threatens the validity of the conclusions that can be drawn from such work. While some attention has been given to the discrepancies in the predictors of child wellbeing, a historical reliance on single-parent proxy outcome measures has prevented exploration into important differences between mother and father ratings. This has led to a gap in the literature on the role of family context in child wellbeing. It seems probable that parents who live apart or are in poor and uncooperative relationships with each other may give inconsistent reports on how their child is doing.

Research Questions

1) When considering the same child, to what extent do parents agree on ratings of child health and problem behavior?
2) Does the amount of time a father lives with the child predict discrepancies between father and mother reports?
3) How are ratings of parental relationship quality and cooperation in parenting related to differences in child wellbeing assessments?

Hypotheses

1) Parent concordance will be higher for health and lower for problem behavior, with parents more likely to agree on externalizing problem behavior than internalizing problem behavior.

2) The amount of time a father lives with the child will predict discrepancies between father and mother ratings for health and problem behaviors, with part-time and non-residential fathers having larger discrepancies due to less time spent with the child and mother.
3) Parents who report better relationship quality and cooperation in parenting will rate child wellbeing higher relative to their partner across all three outcomes. As mother-father ratings of relationship quality and cooperation in parenting diverge, the discrepancies in mother-father reports of child wellbeing outcomes will also grow wider.

METHOD

Data

Data for this project come from the Fragile Families and Child Wellbeing Study (FFCWS), a longitudinal birth cohort study of children born between 1998 and 2000 in 20 U.S. cities. The children come from diverse socioeconomic and racial/ethnic backgrounds, with an oversample of births to unmarried parents. This is a unique dataset and particularly well suited for this study, because both mothers and fathers were interviewed at baseline and at each wave with follow-up surveys. Special attention was taken to prevent attrition and include both residential and non-residential biological fathers at each wave. As a result, completion rates for the follow-up survey waves (ages 1, 3, and 5) were substantially higher than previous studies with 89%, 86%, and 85% for mothers and 69%, 65%, and 64% for fathers.

For this study, I focus on the fourth wave of data collection, when the focal child is 5 years old. The sample used in these analyses includes matched father-mother dyads (n=2,971). To be part of the matched pair sample, both biological parents rated each outcome measure in the 5-year survey. To address missing data, I use Stata's ICE command to execute multiple imputation (Royston 2009). I include both independent and dependent measures in the imputation equation but do not use imputed outcomes in my analyses (von Hippel 2007). I

estimate 5 complete data sets for each outcome. The sample was further restricted to children who lived at least half of the time with one of their biological parents (n=2,934). To ensure that any difference in parent ratings were not due to issues in translation, the sample was limited to parents who completed the interview in the same language (n=2,846). While all parents surveyed were asked to rate their child's overall health status, only those parents who reported seeing the child at least twice in the last thirty days were asked to rate the child's behavior. This resulted in the exclusion of approximately 750 children in the problem behavior subsamples. Therefore, the analytic sample for father-mother dyads on child health (n=2,846) was larger than for internalizing (n=2,096) and externalizing (n=2,119) problem behavior.

Measures

Child Outcomes

This study examines the differences across matched pairs of biological father and mothers, in their rating of the same focal child. For ease of interpretation and comparison across the three outcomes, each was constructed as a negative child outcome with higher values indicating poor health, internalizing problem behavior, and externalizing problem behavior.

Child health status. Child's overall health status is measured through parent report as "excellent (=1), very good, good, fair, or poor (=5)".

Child Problem Behavior. Two different measures of child behavior were selected: internalizing problem behavior and externalizing problem behavior. Parents who reported seeing their child at least twice in the last thirty days were asked to select "very true or often true" (=2), "somewhat or sometimes true" (=1), or "not true" (=0) in response to descriptions of specific behaviors. The internalizing problem behavior subscales ($\alpha_{mother} = .62$, $\alpha_{father} = .60$) consisted of six items: "child is unhappy, sad, or depressed", "child is withdrawn, doesn't get involved with

others", "child cries a lot", "child feels worthless or inferior", "child is nervous, high strung, or tense", and "child is too fearful or anxious." Total internalizing problem behavior scores were calculated by adding the scores from each of the six items (range: 0-12). The externalizing problem behavior subscale ($\alpha_{mother} = .68$, $\alpha_{father} = .65$) consisted of five items: "child demands a lot of attention", "child is stubborn, sullen, or irritable", "child has sudden change in mood or feelings", "child has temper tantrums or hot temper", "child does not seem to feel guilty after misbehaving." Total externalizing problem behavior scores were calculated by adding the scores from each of the five items (range: 0-10).

Each dependent variable was constructed as a value equal to the difference between the father and mother rating. For example, if the father said the child's health was poor (5), but the mother said the child's health was excellent (1), the value of difference would be 4. Therefore, positive values indicate that for each measure of child wellbeing, the father rated the child worse than the mother. Alternatively, negative values signify that the mother rated the child worse than the father. A value of zero indicates exact agreement between mother and father ratings.

Predictors

Child Characteristics. Child sex and low birth weight were variables constructed by the FFCWS team using medical records at the time of the child's birth. Sex is a categorical variable with two categories: boy and girl. Low birth weight is a dichotomous measure (1=yes). Child age at the time of the mother's 5-year interview was a constructed variable reported in months.

Parent Demographic Characteristics. Mothers reported their own demographic characteristics as well as many of the demographic characteristics of the fathers. When surveyed, fathers also reported their own demographic characteristics. The FFWCS team used this information to construct variables for father and mother characteristics including

race/ethnicity, nativity, and education. To address issues of multi-collinearity, father's race/ethnicity was included as a dummy variable when different from the mother's race/ethnicity. Similarly, nativity was measured as the number of parents foreign-born. Household measures included the number of children living in the mother's household with the child and the household poverty ratio. Mothers and fathers reported on their own general health status at the 5-year interview, using a 5 point scale similar to that used to report their child's health, *excellent* (5), very good, good, fair, or *poor* (1); however, this was reverse coded for ease of interpretation, such that higher ratings should be interpreted as better health.

Father Residential Status. To consider whether differences in mother and father ratings were not due to the differences in the father's presence in the child's life, categorical variables were created to measure the child's residential status with regards to the father. The amount of time a child lives with the father (based on the father's report) has three categories: all/most of the time, some of the time, and none of the time.

Parent Relationship Quality. Each parent was independently asked to rate their relationship quality with the other biological parent. Respondents were asked "In general, would you say that your relationship with (her/him) is *excellent* (5), very good, good, fair, or *poor* (1)?"

Cooperation in Parenting. Both biological mothers and fathers were also asked to rate eight different items to determine co-parenting quality. Each item was assessed on a 0- to 3-point scale. The response options were "always true" (=3), "sometimes true" (=2), "rarely true" (=1) or "never true" (=0). Each parent reported the extent to which the other parent acts like the kind of parent he/she wants for the child, can be trusted to take good care of the child, respects the parent's schedules and rules for the child, supports the parent in the way he/she wants to raise the child, talks with the parent about problems that come up with raising the child, can be

counted on to look after the child for a few hours, respects the parent's wishes about how the child should be raised. Finally, each parent was asked to rate themselves on how critical they are of the things the other parent does. This was rated on the same 4-point scale but was reverse coded, *always true* (=0) to *never true* (=3), such that higher ratings would indicate higher levels of cooperation. Total cooperation in parenting scores were calculated by adding the scores from each of the 8 items (range: 0-24). A factor analysis confirmed that the items loaded on a single factor ($\alpha_{mother} = .85$, $\alpha_{father} = .78$).

Analysis

All analyses were conducted using Stata 15. Descriptive statistics were generated for each of the three analytic samples. Similarly, summary statistics were generated to compare father and mother ratings for each child wellbeing outcome. Multivariate analyses consisted of OLS models predicting the discrepancy between father and mother ratings. Model 1 included the predictor variables capturing characteristics of the child including sex, age, and low birth weight. Model 2 added demographic characteristics of the child's family including number of children in the household and level of poverty as well as their parents' race/ethnicity, nativity, education, and self-rated health. Model 3 added the amount of time the father lives with the focal child. Model 4 added the relationship quality between the biological fathers and mothers, while Model 5 considered each parent's rating of their partner's cooperation in parenting.

RESULTS

Table 1 presents descriptive statistics for the analytic samples, for each child well-being outcome. Overall, in the largest sample for the health outcome, slightly more than half of the children were boys, with an average age of 5 years, and 8% were born low birth weight. The average focal child shared their mother's household with at least one other child. Almost half of the mothers identified their race/ethnicity as Non-Hispanic Black, with roughly one- identifying

as Non-Hispanic White and Hispanic. Most of the fathers reported the same race/ethnicity as the mothers. The majority of parents were born in the United States, had at least a high school education, and reported being in good health; however, more than a quarter of the children in the study had a mother or father with less than a high school education and almost one third lived below the poverty line. The majority of fathers participating in the study lived with the child most of the time, with 1 in 5 reporting living with the child some of the time, and a small group (9%) of fathers living with the child none of the time. On average, the fathers rated their relationship quality with the mothers higher than the mothers rated those same relationships. Similarly, fathers rated mothers higher in parenting cooperation than mothers rated fathers.

There are several minor but notable differences across the three subsamples. Parents in the smaller behavior subsamples have higher levels of education, lower levels of household poverty, and tend to rate their relationship quality and cooperation higher than those in the larger health status sample. Compared to the children in the health status sample, there is a higher percentage of Non-Hispanic White and Black mothers with a lower percentage of Hispanic mothers in the problem behavior subsamples, as well as a lower proportion of children with foreign born parents. Finally, there is a greater proportion of residential fathers in the behavior subsamples. This suggests that children excluded from the analysis on problem behavior resulted in a sample of more advantaged families.

To answer the first research question, Table 2 compares father and mother ratings across the three different child well-being outcomes. The mean difference between father and mother ratings of child poor health is approximately zero (-0.01). More than half (54%) of fathers and mothers gave their child the exact same health rating with roughly equal proportions of fathers and mothers rating their child's health worse than their partner. Consistent with Hypothesis 1,

there was less concordance between fathers and mothers on problem behavior than health. Approximately 38% of parents agreed on their child's internalizing problem behavior, while fewer than 17% of parents agreed on their ratings of externalizing problem behavior. Additionally, the ways in which parents disagreed differed across problem behaviors. Fathers reported more internalizing problem behaviors relative to mothers with a mean difference of 0.11, whereas mothers reported more externalizing problem behaviors relative to fathers with a mean difference of -0.08. In summary, there is evidence in support of the first hypothesis which predicted that there would be higher concordance between parents with respect to ratings of child health than problem behavior. Yet, contrary to Hypothesis 1, parents were more likely to agree on internalizing than externalizing problem behavior.

Because the outcome is a measure of difference between two ratings, there are several different ways to interpret the coefficients of the regression results. Generally speaking, the outcome is a measure of the father's rating subtracting the mother's rating, with higher values indicating poorer health or more problem behavior. Thus, negative values can be interpreted to mean that relative to fathers, mothers are rating their child's health or behavior worse. Negative values also mean that relative to mothers, fathers are rating their child's health or behavior better. Conversely, positive values can be interpreted to mean that relative to fathers, mothers are rating their child's health or behavior better while also suggesting that relative to mothers, fathers are rating their child's health of behavior worse.

The results of the OLS regression predicting the discrepancy between father and mother ratings of poor child health are shown in Table 3. Across all 5 models, none of child characteristics (sex, age, or low birth weight) were significant predictors of the discrepancy in father and mother ratings of poor child health. In Model 2, some individual parent

characteristics did predict the difference in parent ratings. With regards to father's level of education, relative to fathers without a high school diploma, fathers with greater than a high school education rated their child's poor health 0.12 points lower than the child's mothers. This suggests that father's education has a positive effect on his rating of his child's health. Also, both father and mother self-rated health were significant predictors of the discrepancy in poor child health. The positive coefficient for mother's self-rated health indicates that on average, the better a mother rates her own health, the better she rates her child's health, relative to the father. Likewise, healthier fathers rated their child's health better than their mothers. The relationship is the same for both mothers and fathers – healthier parents report healthier children.

Even after controlling for a range of child and parent characteristics, Model 3 demonstrates that the amount of time the father reported living with the child was a significant predictor of the discrepancy in parent reports of child health status. Relative to fathers who live with the child most of the time, fathers who live with the child some or none of the time rated their child's health much worse than the child's mother, even after controlling for relationship quality (Model 4) and cooperation in parenting (Model 5). This evidence supports Hypothesis 2 that as the amount of time the father lives with the child decreases, the divergence in mother-father ratings increases with fathers perceiving their child's health to decline.

To address the final research question, Models 4 shows that both parents' ratings of relationship quality are statistically significant predictors of the difference in ratings. For every one unit increase in relationship quality reported by mothers, there is a 0.03 point decrease in mother-rated poor child health, relative to fathers. Meanwhile, for every one unit increase in relationship quality reported by fathers, there is a 0.05 decrease in father-rated poor child health, relative to mothers. More simply, mothers with higher ratings of relationship quality are more

likely to rate their child's health better relative to fathers and a similar pattern emerges with regards to the fathers. This also suggests that as mother-father ratings of their relationship quality diverge the differences in their ratings of child health become larger. These results support Hypothesis 3 that parents who report better relationship quality rate child health better and as disagreement increases between mothers and fathers regarding their relationship quality the discrepancies in their reports of child health also grow wider. Model 5 demonstrates a similar positive relationship between relative ratings of coparenting and child health, but only for fathers. Inconsistent with Hypothesis 3, there is no evidence for an association between mother ratings of coparenting and child health.

Table 4 displays the results of the OLS regression predicting the discrepancy between father and mother ratings of internalizing problem behavior. Similar to the results for health, none of the characteristics of the child help to explain the differences in father and mother reports for internalizing problem behavior. Parental education appears to once again help explain some of the difference, such that mothers and fathers with more education report lower levels of internalizing problem behavior relative to their partners. This supports the notion that education may have a salubrious effect on child well-being, or at least on parents' perceptions. Unlike the dual effect of mother and father self-rated health on child health, only mother self-rated health had a significant relationship with internalizing behavior. Nativity emerged as a novel significant predictor for internalizing problem behavior. Relative to children with native born parents, children with two foreign born parents had on average, mother ratings 0.39 points higher than father ratings. In other words, couples in which both parents were foreign born were more likely to disagree on their child's internalizing behavior, with mothers reporting significantly more problem behavior than fathers.

Contrary to Hypothesis 2, the amount of time the father lives with the child is not a significant predictor of differences in parent ratings of internalizing behavior. After controlling for child and family characteristics, Model 3 in Table 4 shows that fathers who live with the child some or none of the time rated their child's internalizing behavior better than the child's mother, yet these differences are not statistically significant. Therefore, unlike for parent-rated child health, there is no evidence that differences in mother-father ratings of internalizing problem behavior can be attributed to differences in father's residential status.

Models 4 and 5 in Table 4 show that both parents' ratings of relationship quality and cooperation in parenting were statistically significant predictors of the difference in ratings in internalizing problem behavior. The coefficients between mothers and fathers are similar in magnitude and in opposite directions. For every one unit increase in relationship quality reported by a parent, there is a 0.13 decrease in father-rated internalizing problem behavior, relative to mothers, and a 0.13 decrease in mother-rated poor child health, relative to fathers. There are smaller, but still statistically significant relationships observed between cooperation in parenting and parent ratings of child internalizing problem behavior. For every one unit increase in cooperating in parenting reported by each parent, there is a 0.05 decrease in father-rated poor child health, relative to mothers, compared to a 0.03 decrease in mother-rated poor child health, relative to fathers. In summary, parents in better relationships with higher levels of cooperation report having a child with fewer internalizing problems. Additionally, as mother-father ratings of their relationship quality or cooperation in parenting diverge the differences in their ratings of internalizing problem behavior become larger. Furthermore, the relationship between these two predictors to internalizing problem behavior is stronger than their association to parent-rated child health. This lends additional support for Hypothesis 3 that parents who report better

relationship quality and cooperation in parenting rate their child's wellbeing higher. Also, among mothers and fathers who disagree more on either their relationship quality or cooperation, the gap in their reports of their child's wellbeing gets larger.

The results for the analysis on externalizing problem behavior are in Table 5. Parent education and self-rated health are once again significant predictors for fathers and mothers. Household income was also a significant predictor of the discrepancy between mothers and fathers. Relative to children living below the poverty line, those above the poverty line had father ratings higher than mother ratings. In other words, children living in households with higher incomes had fathers reporting more externalizing problems relative to their mothers.

Table 5 Model 3 reveals inconsistent results with regards to the second research question on the role of father's residential status in predicting differences in father-mother reports of child externalizing behavior. Compared to fathers who lived with their child all of the time, non-residential fathers reported significantly less externalizing problem behavior relative to mothers; yet, there were no statistically significant differences for fathers who lived with their child some of the time. Furthermore, the amount of time the father lived with the child (Model 3) stopped being a significant predictor of difference when relationship quality (Model 4) or cooperation in parenting (Model 5) was added to the model. This suggests that the differences observed for non-residential fathers may be a spurious association confounding the true relationship between the predictors that better explain the differences in father-more reports for externalizing problem behavior – parent relationship quality and cooperation in parenting. In line with internalizing problem behavior, the amount of time the father lives with the child is not a significant predictor of differences in parent ratings of externalizing behavior. As a result, there is inconsistent support for Hypothesis 2. While there is evidence that father's residential status helps explain

differences in parent-rated child health, the amount of time the father lives with the child does not explain mother-father differences in reports of neither internalizing nor externalizing problem behavior.

Finally, Models 4 and 5 show that relationship quality and cooperation in parenting are statistically significant predictors of the difference in ratings in externalizing problem behavior. This demonstrates a consistent relationship to those observed for the internalizing problem behavior with one exception – only the mother's rating of partner relationship quality has a significant relationship with externalizing behavior. For every one unit increase in mother's rating of relationship quality, the difference between father and mother ratings increase by 0.18 units. This means that as mothers rated their relationships with the fathers higher, they report less externalizing problem behavior from their child relative to the fathers. Consistent with internalizing problem behavior, Model 5 shows that both father and mother reports of cooperation in parenting remain statistically significant predictors. Thus, in relative terms, fathers with higher ratings of mother cooperation, rate their child's externalizing behavior better and mothers with higher ratings of father cooperation do the same. In support of Hypothesis 3, mothers who report better relationship quality rate child wellbeing better across both behavior outcomes and mothers and fathers who report higher levels of parenting cooperation rate child wellbeing better across both behavior outcomes. Furthermore, as mother-father ratings of relationship quality and cooperation in parenting diverge, the discrepancies in mother-father reports of child externalizing problem behavior grow wider.

DISCUSSION

This study used data from the FFCWB and provides the first examination of differences in parent-rated child wellbeing outcomes between mothers and fathers of young children. The analyses suggest three primary conclusions. First, when referencing the same child, parents

often do not agree when reporting poor child health, internalizing problem behavior, and externalizing problem behavior. Parent concordance was higher for child health and lower for problem behavior. This is most likely due to the fact that children are generally healthy and the outcome consisted of a single-item measure with less variability than the problem behavior subscales. Consistent with previous research, mothers generally rated externalizing behaviors worse than fathers; yet, contrary to prior work (Achenbach et al. 1987; Duhig et al. 2000), the matched dyads in this study were more likely to agree on internalizing problem behavior than externalizing problem behavior. This may, in part, be due to a reluctance among parents to report externalizing problem behavior, as they may believe that this reflect poorly on their parenting.

Second, father's residential status helped explain the discrepancies between father and mother reports of child health status, however, it did not explain the differences in reports of problem behavior. Fathers who lived with their child some or none of the time rated their child's health worse relative to mothers. The opposite pattern is observed for problem behavior - fathers who live with the child some or none of the time rated their child's internalizing behavior and externalizing better than the child's mother, yet these differences were not statistically significant. This challenges explanations that differences in parent reports are primarily due to objectives differences like observing different behaviors and more related to subjective interpretations, or perceptions, of their child's wellbeing.

Finally, parents who report better relationship quality and higher levels of coparenting rate child wellbeing higher relative to their partner. This lends support to the family systems theory which posits that the relationships between parents shape the relationships parents have with their child and subsequent wellbeing (Cox & Paley, 2003; Minuchin, 1974). Difficulties in the parents' relationships could be reverberating through relationships with their children,

meaning that the consequences of parents' struggles could be negatively impacting their children resulting in poorer health and behavior. Alternatively, it could be that parents experiencing stress from their own relationships are extrapolating their own poor wellbeing onto their child.

Most interestingly, as mother-father ratings of relationship quality and coparenting diverge, the discrepancies in mother-father reports of child wellbeing also tend to grow wider. Therefore, generalizing single-parent ratings as representative of a child's objective wellbeing without accounting for the other parent potentially results in biased estimates. If poor parental relationships do negatively impact child wellbeing, by continuing to neglect the perspective of fathers, researchers are in danger of underestimating the impact of the spillover from fathers reporting poor relationships, when mothers are reporting that everything (from their perspective) is great. Therefore, when the data are available, researchers should consider utilizing both mother and father-rated measures, especially when testing their theories on the ways family-level processes impact child wellbeing. Furthermore, future survey design needs to include data collection protocols that include both parents.

Beyond the factors that contribute to these discrepancies in parent-rated assessments, these differences could have their own implications for child wellbeing. Parents who disagree on how their child is doing are likely to have different responses to efforts to improve health or behavior. This could be particularly important for parents of children at school-entry as they increasingly interact with agents of formal institutions outside of the home, with their own child assessments. Without a shared view of their child's wellbeing, parents may disagree on the appropriate course of action, how to allocate resources, etc. The lack of common ground could have its own impact on subsequent child development, worthy of future exploration.

Despite the contributions of this work, this study is not without limitations. To be part of the matched pair sample, both parents must have rated child health and behavior in the 5-year survey. This means the mother-father dyads included those individuals that were easiest to track and follow over time. In particular, it does not include a large number of children without fathers completing the survey. In order to increase participation and reduce interview burden, the number of questions included on both the mother and father surveys was small, relative to the number asked on the primary care giver instrument. As a result, the full CBCL subscales were not available. However, given the available data, reliable measures for both internalizing and externalizing problem behavior were constructed. In order to maximize the number of dyads and maintain a representative sample, all matched pairs were included in the analyses, regardless of whether or not they completed the In-Home component of the FFCWB. This prevented the inclusion of additional control variables that may have helped explain some of the differences in mother-father reports.

This study contributes substantively to the growing body of literature about the changing nature of American families and its implications for child wellbeing. It also makes a methodological contribution by considering what data researchers should use in future analyses when utilizing parent-rated child health and behavior measures. As the first to document differences in ratings between mothers and fathers across child outcomes, this study raises questions about the nature of studies that use survey data to document differences in child wellbeing across family forms without considering the perspectives of multiple caregivers. Now, more than ever, we must consider the views and roles of fathers, as well as other family members and guardians, on child outcomes.

Table 1. *Descriptive Statistics for Predictor Variables for each Child Well-Being Outcome sample*

Variables	Health (n=2,846) % or *M*	*SD*	Internalizing (n=2,096) % or *M*	*SD*	Externalizing (n=2,119) % or *M*	*SD*
Boy	.53		.52		.52	
Child Age (in Months)	61.57	2.75	61.02	2.41	61.02	2.40
Low Birth Weight	.08		.08		.08	
Number of Children in Household	2.50	1.27	2.50	1.29	2.49	1.28
Mother's Race:						
Non-Hispanic White	.27		.29		.29	
Non-Hispanic Black	.45		.46		.46	
Hispanic	.25		.22		.22	
Other	.04		.04		.04	
Father's Race/Ethnicity Different	.13		.12		.13	
Number of Parents Foreign Born:						
0	.82		.85		.85	
1 Parent Foreign Born	.07		.06		.06	
2 Parents Foreign Born	.11		.09		.09	
Mother's Education:						
<HS	.29		.26		.26	
High School	.29		.30		.30	
Greater than High School	.42		.44		.44	
Father's Education:						
<HS	.29		.27		.27	
High School	.33		.33		.33	
Greater than High School	.38		.40		.40	
Household Poverty Ratio:						
<100%	.33		.31		.31	
100-199%	.26		.25		.25	
200%+	.41		.44		.44	
Mother's Self-Rated Health	3.69	0.99	3.70	1.00	3.71	1.00
Father's Self-Rated Health	3.84	0.96	3.84	0.95	3.83	0.95
Time Father Lives with Child:						
All/Most	.70		.73		.73	
Some	.20		.21		.21	
None	.09		.06		.06	
Relationship Quality - Mother Rating	3.51	1.25	3.56	1.22	3.56	1.22
Relationship Quality - Father Rating	3.70	1.20	3.75	1.17	3.75	1.17
Cooperation - Mother Rating Father	19.53	4.70	19.74	4.46	19.73	4.47
Cooperation - Father Rating Mother	20.51	3.56	20.58	3.51	20.57	3.51
Observations	2,846		2,096		2,119	

Table 2. *Summary Comparing Father and Mother Ratings of Child Well-Being Measures*

	Difference Father-Mother				Father-Mother Agreement		
Outcome	Mean	SD	Min	Max	Exact Agreement	Father Higher	Mother Higher
Poor Child Health (n=2,846)	-0.01	0.89	-4	4	53.58%	23.14%	23.28%
Internalizing Problem Behavior (n=2,096)	0.11	1.83	-10	11	37.55%	34.08%	28.36%
Externalizing Problem Behavior (n=2,119)	-0.08	2.53	-9	9	16.53%	41.04%	42.43%

Note: Higher Values = Poorer Health, More Problem Behavior
Father Value – Mother Value = Difference
Father > Mother = Positive (+) Value – Interpretation: Mother Rating Child Better or Father Rating Child Worse
Father < Mother = Negative (-) Value – Interpretation: Father Rating Child Better or Mother Rating Child Worse

Table 3. *OLS Regression Results: Predicting the Discrepancy Between Father and Mother Ratings of Child Poor Health (n=2846)*

	Model 1		Model 2		Model 3		Model 4		Model 5	
Variables	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*
Boy	-0.05	0.04	-0.05	0.03	-0.05	0.03	-0.05	0.03	-0.06	0.04
Child Age (in Months)	-0.00	0.01	0.01	0.01	0.00	0.01	0.00	0.01	0.00	0.01
Low Birth Weight	-0.00	0.06	-0.01	0.06	-0.02	0.06	-0.02	0.06	-0.04	0.07
Number of Children in Household			-0.02	0.01	-0.01	0.01	-0.01	0.01	-0.01	0.02
Mother Race/Eth (vs. Non-H White)										
Non-Hispanic Black			-0.02	0.05	-0.06	0.05	-0.06	0.05	-0.06	0.05
Hispanic			-0.00	0.06	-0.01	0.06	-0.02	0.06	-0.01	0.06
Other			0.12	0.10	0.11	0.10	0.10	0.10	0.08	0.11
Father Race/Ethnicity Different			-0.02	0.05	-0.04	0.05	-0.04	0.05	-0.05	0.06
No. of Parents Foreign Born (vs. 0)										
1 Parent Foreign Born			0.03	0.07	0.05	0.05	0.06	0.07	0.06	0.08
2 Parents Foreign Born			-0.11	0.07	-0.05	0.07	-0.04	0.07	-0.02	0.07
Mother Education (vs. <HS)										
High School			0.03	0.05	0.03	0.05	0.03	0.05	0.04	0.05
Greater than High School			0.06	0.05	0.06	0.05	0.06	0.05	0.07	0.06
Father Education (vs. <HS)										
High School			-0.06	0.05	-0.07	0.05	-0.07	0.05	-0.07	0.05
Greater than High School			-0.12**	0.05	-0.11**	0.05	-0.11**	0.05	-0.10**	0.06
HH Poverty Ratio (vs. <100%)										
100-199%			-0.04	0.05	-0.01	0.05	-0.01	0.05	-0.01	0.05
200%+			0.02	0.05	0.08	0.05	0.08	0.05	0.08	0.06
Mother Self-Rated Health			0.15***	0.02	0.15***	0.02	0.15***	0.02	0.15***	0.02
Father Self-Rated Health			-0.16***	0.02	-0.16***	0.02	-0.15***	0.02	-0.15***	0.02
Time Father Lives w Child (vs. Most)										
Some					0.20***	0.04	0.19***	0.05	0.18***	0.06
None					0.24***	0.05	0.22***	0.06	0.21***	0.07
Relationship Quality - Mother Rating							0.03**	0.02		
Relationship Quality - Father Rating							-0.05***	0.02		
Cooperation in Parenting - Mother Rating Father									0.00	0.00
Cooperation in Parenting - Father Rating Mother									-0.02***	0.01

Table 4. *OLS Regression Results: Predicting the Discrepancy Between Father and Mother Ratings of Child's Total Internalizing Problem Behavior Score (n=2,096)*

	Model 1		Model 2		Model 3		Model 4		Model 5	
Variables	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*
Boy	-0.01	0.08	-0.03	0.08	-0.03	0.08	-0.03	0.08	-0.03	0.08
Child Age (in Months)	-0.02	0.02	-0.02	0.02	-0.02	0.02	-0.02	0.02	-0.02	0.02
Low Birth Weight	0.08	0.15	-0.10	0.15	-0.11	0.15	-0.11	0.15	-0.08	0.15
Number of Children in Household			0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
Mother Race/Eth (vs. Non-H White)										
Non-Hispanic Black			-0.11	0.11	-0.09	0.11	-0.07	0.11	-0.09	0.11
Hispanic			0.11	0.13	0.11	0.13	0.09	0.13	0.09	0.13
Other			0.49**	0.24	0.49**	0.24	0.49**	0.24	0.45*	0.24
Father Race/Ethnicity Different			-0.08	0.13	-0.07	0.13	-0.05	0.13	-0.08	0.13
No. of Parents Foreign Born (vs. 0)										
1 Parent Foreign Born			0.01	0.20	-0.02	0.20	0.00	0.20	0.03	0.20
2 Parents Foreign Born			-0.39**	0.18	-0.41**	0.18	-0.40**	0.18	-0.36**	0.18
Mother Education (vs. <HS)										
High School			0.27**	0.11	0.27**	0.11	0.25**	0.11	0.28**	0.11
Greater than High School			0.41***	0.12	0.42***	0.12	0.40**	0.12	0.43**	0.11
Father Education (vs. <HS)										
High School			-0.07	0.11	-0.06	0.11	-0.07	0.11	-0.06	0.11
Greater than High School			-0.25**	0.12	-0.26**	0.13	-0.27**	0.12	-0.25**	0.12
HH Poverty Ratio (vs. <100%)										
100-199%			-0.01	0.11	-0.03	0.11	-0.03	0.11	-0.04	0.11
200%+			0.07	0.12	0.04	0.12	0.05	0.12	0.04	0.12
Mother Self-Rated Health			0.15***	0.04	0.15***	0.04	0.12***	0.04	0.14***	0.04
Father Self-Rated Health			-0.07	0.04	-0.07	0.04	-0.04	0.04	-0.05	0.04
Time Father Lives w Child (vs. Most)										
Some					-0.11	0.10	-0.08	0.11	-0.08	0.11
None					-0.11	0.16	-0.11	0.17	-0.06	0.17
Relationship Quality - Mother Rating							0.13**	0.04		
Relationship Quality - Father Rating							-0.13***	0.04		
Cooperation in Parenting - Mother Rating Father									0.03***	0.01
Cooperation in Parenting - Father Rating Mother									-0.05***	0.01

Table 5. *OLS Regression Results: Predicting the Discrepancy Between Father and Mother Ratings of Child's Total Externalizing Problem Behavior Score (n=2,119)*

	Model 1		Model 2		Model 3		Model 4		Model 5	
Variables	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*	*B*	*SE*
Boy	0.10	0.11	0.08	0.11	0.08	0.11	0.08	0.11	0.09	0.11
Child Age (in Months)	0.01	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Low Birth Weight	0.16	0.21	0.22	0.21	0.24	0.21	0.25	0.21	0.21	0.21
Number of Children in Household			0.05	0.04	0.05	0.04	0.05	0.04	0.05	0.04
Mother Race/Eth (vs. Non-H White)										
Non-Hispanic Black			-0.24	0.15	-0.21	0.15	-0.18	0.15	-0.22	0.15
Hispanic			-0.08	0.18	-0.07	0.18	-0.08	0.18	-0.09	0.18
Other			0.17	0.32	0.17	0.32	0.17	0.32	0.11	0.32
Father Race/Ethnicity Different			-0.21	0.18	-0.19	0.18	-0.16	0.18	-0.19	0.18
No. of Parents Foreign Born (vs. 0)										
1 Parent Foreign Born			0.15	0.24	0.14	0.24	0.14	0.24	0.19	0.24
2 Parents Foreign Born			-0.33	0.24	-0.36	0.24	-0.37	0.24	-0.32	0.24
Mother Education (vs. <HS)										
High School			0.14	0.15	0.14	0.15	0.10	0.15	0.15	0.15
Greater than High School			0.38**	0.17	0.39**	0.17	0.36**	0.17	0.41**	0.17
Father Education (vs. <HS)										
High School			-0.06	0.15	-0.06	0.15	-0.07	0.15	-0.07	0.15
Greater than High School			-0.30*	0.17	-0.32*	0.17	-0.34**	0.17	-0.32*	0.17
HH Poverty Ratio (vs. <100%)										
100-199%			0.36**	0.15	0.33**	0.15	0.32**	0.15	0.32**	0.15
200%+			0.33**	0.16	0.30*	0.16	0.28*	0.16	0.30*	0.16
Mother Self-Rated Health			0.23***	0.06	0.22***	0.06	0.18***	0.06	0.21***	0.06
Father Self-Rated Health			-0.14***	0.06	-0.14***	0.06	-0.13**	0.06	-0.12***	0.06
Time Father Lives w Child (vs. Most)										
Some					-0.06	0.14	0.07	0.15	-0.02	0.15
None					-0.44*	0.23	-0.34	0.23	-0.35	0.23
Relationship Quality - Mother Rating							0.18***	0.06		
Relationship Quality - Father Rating							-0.08	0.06		
Cooperation in Parenting - Mother Rating Father									0.04***	0.01
Cooperation in Parenting - Father Rating Mother									-0.06***	0.02

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