

Perception and Internalization of Adoption Stigma among Gay, Lesbian, and Heterosexual Adoptive Parents

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Using data from 30 gay male, 45 lesbian, and 51 heterosexual couples who had recently adopted a child, the current study sought to (1) create and validate a measure that differentiated between perception of societal stigma about adoption and internalization of adoption stigma; (2) examine whether gender, sexual orientation, preferential adoption status, and transracial adoption status were associated with perception and internalization of adoption stigma; and (3) examine the association between adoption stigma and depression. Results indicated that the Feelings About Adoption Scale (FAAS) is a valid measure of perceived and internalized adoption stigma. Women perceived higher levels of stigma than men, and heterosexual in-racial adopters reported higher levels of internalized stigma than heterosexual transracial adopters, gay/lesbian transracial adopters, and gay/lesbian in-racial adopters. Participants who reported high levels of internalized stigma were more depressed. More research is needed to further validate the FAAS.

KEYWORDS *adoption, depression, gay, lesbian, race, stigma, transracial*

INTRODUCTION

The dominant North American family ideology has defined an allegedly true family as one that is biologically related (Andersen, 1991; Fisher, 2003). Indeed, biological ties are regarded as fundamental to family relations in the United States, and biological ties are privileged over social ties in the creation and maintenance of kin relations. This ideology has had notable

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consequences for the social institution of adoption and for the individuals most intimately affected by the social construction of adoption (Riley, 2009; Wegar, 2000). Specifically, this ideology is associated with several stigmatizing beliefs about adoption that may have implications for the experiences, attitudes, and well-being of adoptive parents and families (Kline, Karel, & Chatterjee, 2006). For example, one stigma is that adoptive family members lack the permanent blood relationships of genetically tied families and are therefore not as close or bonded to one another (Miall, 1996; Wegar, 2000). A related stigma is that adoptive parents are not true parents because they lack the required biological ties necessary for bonding and parenting (Miall, 1987).

According to Kline and colleagues (2006), Wegar (2000), and others, these stigmatizing beliefs may cause adoptive family members to feel socially marginalized and devalued; indeed, both adopted persons and adoptive mothers have reported feeling that others perceive them as abnormal or second rate (Hollingsworth, 2002; March, 1995; Miall, 1987, 1996). For example, in a study of infertile women who had adopted or who were in the process of adopting, women often felt that their emotions as parents and the validity of their parenting experience were regarded by the larger society as less authentic than those of biological mothers (Miall, 1987). Adoptive mothers are often described as feeling hurt and upset by the second-rate social status of adoptive motherhood (Miall, 1987; Wegar, 1997). For instance, two-thirds of the adoptive mothers in one study were disturbed by the dominant societal belief that adoptive motherhood is inferior to biological motherhood (Miall, 1987). Similarly, Daniluk and Hurtig-Mitchell (2003) interviewed heterosexual infertile couples who adopted and found that most couples had encountered comments that revealed others' beliefs that adoptive parenthood was second rate or that they had a weaker connection to their child because they were adopted. In addition to worrying about stigma from society in general, some of these couples were particularly fearful about possible stigmatization by family members, whom they worried might not perceive their adopted child as a legitimate member of their families.

Notably, in recent years, postmodern shifts in thinking about family forms and processes have given way to increasing acceptance of adoption as an alternative means of establishing kinship (Kline et al., 2006). Such shifts are reflected in increasingly positive news and media coverage of adoptive families over the past several decades. As Kline and colleagues (2006) report, although news stories have continued to depict adoptive families and adopted persons in negative ways, positive portrayals of adoptive families and adoption in general are increasingly present in mainstream media.

Survey data also point to shifts in attitudes toward adoption. Miall (1996) surveyed men and women and found that 61% of both males and females rejected the notion that biological mothers feel differently about their children from adoptive mothers (e.g., because of the physical bonding that occurred during pregnancy). Similarly, 74% of men and 70% of women rejected the

idea that biological fathers feel differently about their children from adoptive fathers. The majority of males (67%) and females (69%) felt that there was no greater risk in adopting a child than in having one by birth; those men and women who did perceive more of a risk felt that this greater risk was linked to an adopted child's unknown past and problematic background.

Findings from the 2002 National Adoption Attitudes Survey suggest continued trends toward overwhelmingly positive attitudes toward adoption (Evan B. Donaldson Adoption Institute, 2002). In 1997, 56% of Americans surveyed had a "very favorable" opinion about adoption, whereas in 2002, 63% did. Furthermore, the 2002 survey found that 75% of Americans believe that adoptive parents are very likely to love their adoptive children as much as children born to them.

Yet, paradoxically, at the same time that adoptive family relationships appear to be less scrutinized, some scholars (e.g., Howell, 2006) have argued that the recent advances in reproductive technology, genetics, and medical science have contributed to an increased emphasis on and valuing of biogenetic relationships as fundamental to kinship. Infertility continues to be constructed as a problem to be solved through the use of high-technology medical treatments such as in vitro fertilization (Miall, 1996), and couples who are unable to conceive often experience a profound grieving process that is not immediately or easily alleviated by the promise of adoption (Daniluk & Hurtig-Mitchell, 2003). Tellingly, Miall (1996) found that 73% of women and 51% of males surveyed supported the use of reproductive technologies without donors over adoption. Thus, survey data suggest that while the majority of Americans do not acknowledge pejorative feelings towards adoption, at the same time they demonstrate a preference for biological families over families built through adoption.

Couples who adopt likely become increasingly aware of the persistence of stigmatizing beliefs about adoption and adoptive families as they bring their children home and begin their lives together as a family. For example, they may look to friends, families, and coworkers as sources of support, only to find that some of these individuals hold stigmatizing beliefs about adoption (Johnson & O'Connor, 2002). Furthermore, adoptive parents may encounter insensitive or stigmatizing remarks from strangers, who, for example, may comment on the fact that they do not appear to be biologically related to their child. Stigmatizing beliefs may also be encountered in the school system via assignments that reinforce depictions of biologically related nuclear families (i.e., drawing and labeling the family tree). Thus, adoptive parents may perceive some degree of adoption stigma in their social environments, although the degree to which they perceive such stigma is likely dependent on a variety of factors.

The current study explores both perceptions of adoption stigma and internalization of adoption stigma in a sample of gay, lesbian, and heterosexual adoptive couples who had recently adopted a child. Of particular interest

was (1) whether certain individual characteristics might determine which parents were most affected by such stigmas and (2) whether perceived stigma and internalized stigma were related to adoptive parents' mental health. In this study, depression was used as an index of mental health given the established link between other types of internalized stigmas and depression. For example, internalized stigma about homosexuality (i.e., internalized homophobia) is consistently related to higher levels of depression in gay men and lesbians (Frost & Meyer, 2009; Meyer, 1995). In addition, depression was selected as an indicator of mental health in light of much research showing that depression has important implications for parenting quality and child outcomes (England & Sim, 2009). Thus, a better understanding of the factors associated with parental depression can ideally inform prevention and intervention efforts aimed at the entire adoptive family.

Adoption Stigma: Who Is Most Affected?

Some individuals are likely to be more affected by adoption-related stigma than others. For instance, biological ties are often regarded as fundamental to motherhood in particular (Freeark et al., 2005). The experiences of pregnancy and childbirth are regarded as important aspects of motherhood and the mother-child bond. Both the scholarly and clinical literatures on adoption tend to frame motherhood in predominantly biological terms (Riley, 2009; Wegar, 1997). Furthermore, biological motherhood is viewed as an essential aspect of women's identity and childbearing as well as the primary source of mature femininity; in turn, failure to achieve biological motherhood is regarded as a profound violation of prescribed gender roles (Freeark et al., 2005; Wegar, 1997). Therefore, women in particular may mourn the loss of a biological child as a role failure (Nachtigall, Becker, & Wozny, 1992).

Biological fatherhood is regarded as an important role for men, but it is not synonymous with a healthy gender identity in the same way that biological motherhood is for women (Freeark et al., 2005). In turn, men generally tend to be less upset by their infertility than women (Freeark et al., 2005; Zoldbrod, 1993). These gender differences are reflected in Miall's (1996) findings: significantly more women (73%) than men (51%) supported the use of reproductive technologies without donors over adoption, suggesting a greater valuing of biological relatedness between parent and child. Thus, it is possible that women are more sensitive to the stigmas associated with adoption and more likely to internalize them as compared to men. However, this heightened sensitivity may only apply to heterosexual women, given that lesbians (as discussed below) are to some extent released from societal expectations to reproduce.

Sexual orientation, in addition to gender, may impact the degree to which adoptive parents are sensitive to and tend to internalize adoption

stigma. Gay and lesbian adoptive parents challenge conventional, heteronormative notions of family in several ways. First, in that they are not heterosexual; second, in that they cannot reproduce within the context of same-sex relationships; and third, in that no biological bonds exist among family members (Goldberg, 2010; Hicks, 2006). In turn, because of the multiple ways in which they lie outside of the idealized norm and also because they may be rejected from their (biological) families of origin due to their sexual orientation, gay/lesbian persons in general and gay/lesbian parents more specifically are often described as having more flexible notions of family which encompass non-biologically related persons as kin (Oswald, 2002; Weston, 1991). It is possible, then, that gay and lesbian adoptive parents are less sensitive to adoption-related stigmas. That is, they may perceive society as being less stigmatizing of adoption and may in turn be less likely to internalize these stigmatizing beliefs, since (1) their reference point is not heterosexual biological nuclear families and (2) adoption is more the norm in the gay/lesbian community (Gates, Badgett, Macomber, & Chambers, 2007). Alternatively, gay and lesbian adoptive parents may actually be more sensitive to adoption-related stigmas. Specifically, they may possess a heightened awareness of difference due to their sexual minority status, which may prompt greater attentiveness to the multiple ways in which their families deviate from the heterosexual nuclear norm (i.e., with regards to their sexuality and adoptive status). Notably, though, this greater awareness may not necessarily translate or correspond to greater internalization of adoption stigma.

Factors other than gender and sexual orientation may also shape perception and internalization of adoption-related stigmas. For example, although most heterosexual couples who seek to adopt infants or young children do so because they were unsuccessful in conceiving, some couples electively pursue adoption (i.e., they choose to adopt) (these couples are sometimes called “preferential adopters”; Brodzinsky & Pinderhughes, 2002). The latter group tends to be motivated by altruistic reasons (e.g., they want to give a good home to an existing child), and, by virtue of electively pursuing adoption, appear to place less value on blood ties as the basis for familial relationships (Brodzinsky & Pinderhughes, 2002; Goldberg & Smith, 2009). Thus, it is possible that persons who tried to have a biological child may perceive heightened levels of adoption stigma than preferential adopters, inasmuch as trying to conceive implies some valuing of biological connections. Furthermore, it may be that some persons who tried to conceive are more sensitive to adoption stigma than others. Namely, heterosexual couples, and women in particular, may be more likely to perceive and internalize adoption stigma given that heterosexual parenthood and motherhood especially tend to be framed in biological terms by broader societal and cultural discourses.

The racial makeup of the adoptive family may also be related to perception and internalization of adoption-related stigmas. That is, individuals who

adopt a child of a race that is different from their own may encounter more stares and questions regarding their family structure than persons who adopt in-racially (Goldberg & Gianino, 2010). In turn, they may perceive higher levels of adoption-related stigmas (and may be more likely to internalize them) given that their families are more visible and therefore more vulnerable to questioning, discrimination, and reproach. Alternatively, it is quite possible that individuals who adopt in-racially choose to do so precisely because they perceive higher levels of adoption stigma. For example, they may be more sensitive to the societal belief that family members should be biogenetically related—or at least be physically (racially) similar. In this case, one would expect higher levels of perceived stigma and/or internalized stigma among in-racial adoptive couples—although this effect might be moderated by sexual orientation, in that same-sex couples cannot reproduce and may therefore be less concerned about physical similarities among family members.

Little research has focused on the role of social attitudes toward adoption and their impact on the adoptive family. As Miall (1987) notes, it may be that awareness of attitudes within the larger community toward adoption contributes to a sense of stigma among adoptive parents, which influences their perception of their families as real or genuine. In Miall's (1987) study of infertile women who adopted, she found that "although the respondents' perceptions of societal beliefs about adoption contained strong elements of stigmatization based on the absence of blood ties, this did not indicate that the respondents accepted these beliefs as personally stigmatizing" (p. 37). Thus, as Miall (1987) and others have pointed out, it is important to distinguish between perceptions of societal stigma related to adoption and acceptance or internalization of such stigmatizing beliefs. Some individuals may be aware of societal stigmas against their family, but may not accept or internalize these beliefs. In turn, these individuals would not necessarily be expected to suffer compromised well-being. On the other hand, individuals who internalize negative beliefs and stereotypes about adoptive families and adoption may suffer damage to their well-being and their sense of integrity as a family unit. Indeed, gay men and lesbians who internalize negative beliefs about homosexuality tend to experience more depressive symptoms (Frost & Meyer, 2009); it is expected that parallel processes may occur in adoptive couples.

The current project, which utilized data from 30 gay male, 45 lesbian, and 51 heterosexual couples who had recently adopted a child, had several goals:

1. to create and validate a measure that differentiates between perception of societal stigmas about adoption and internalization of these stigmas;
2. to examine whether certain characteristics of adoptive parents and the adoption process (i.e., gender, sexual orientation, preferential adoption

- status, and transracial adoption status) are associated with perception and internalization of adoption stigma; and
3. to examine the association between perception and internalization of adoption stigma and mental health (i.e., depression).

Goals 2 and 3 can be formulated as research questions with corresponding hypotheses. Specifically, we wondered:

- 1a. Are sexual orientation, gender, and their interaction related to perception and internalization of adoption stigma? Hypothesis: Existing research and theory suggest several competing hypotheses. One is that perception of societal stigma varies as a function of sexual orientation, such that persons in same-sex couples perceive higher levels of stigma (but internalize similar levels of stigma) compared to persons in heterosexual couples. Another, suggested by existing theory and research, is that perception and internalization of societal stigma vary as a function of both sexual orientation and gender, such that heterosexual women perceive and internalize the highest levels of stigma, as compared to all other groups.
- 1b. Is preferential adoption status related to perception and internalization of adoption stigma? Hypothesis: Preferential adoption status will be associated with both perceived stigma and internalized stigma, such that preferential adopters (i.e., persons who did not try to conceive) will report lower levels of stigma. (Gay men will not be included in these analyses given the rarity of conception attempts in this subsample.)
- 1c. Is transracial/in-racial adoption status related to perception and internalization of adoption stigma? Hypothesis: Transracial adoption status will be associated with both perceived and internalized stigma such that persons who choose to adopt in-racially report higher levels of both types of stigma. However, it is expected that this effect might be moderated by sexual orientation, such that heterosexual parents who adopted in-racially report the highest levels of stigma.
2. Are perceptions of adoption stigma and internalization of adoption stigma related to mental health? Hypothesis: Perception of stigma will be unrelated to depression, but internalization of stigma will be related to depression, such that persons with high levels of internalized stigma will experience more depressive symptoms.

METHOD

Data from 251 individuals (60 men in 30 gay male couples; 89 women in 45 lesbian couples; 51 women and 51 men in 51 heterosexual couples) were analyzed for the current study.

Recruitment and Procedures

Inclusion criteria were (1) couples must be adopting their first child and (2) both partners must be becoming parents for the first time. Participants were recruited during the pre-adoptive period. Adoption agencies throughout the United States were asked to provide study information to clients who had not yet adopted. Census data were utilized to identify states with a high percentage of same-sex couples (Gates & Ost, 2004), and effort was made to contact agencies in those states. More than 30 agencies provided information to their clients, and interested clients were asked to contact the principal investigator. Both heterosexual and same-sex couples were targeted through these agencies to facilitate similarity on geographical location and income. Because some same-sex couples may not be out to agencies about their sexual orientation, national gay/lesbian organizations also assisted with recruitment.

Participation entailed completion of a questionnaire packet and participation in a telephone interview three to four months after participants were placed with their first child. This time point was chosen because of our interest in studying early adaptation to the transition to adoptive parenthood. Couples were mailed two packets, two consent forms, and two stamped envelopes and were asked to return the consent form with the packet. Participants then completed individual semi-structured interviews separately from their partners, over the telephone. On average, interviews (which covered a range of topics, including but not limited to those discussed in the present study) lasted between one and one and a half hours.

Description of the Sample

The sample as a whole was financially affluent. The mean family incomes for gay, lesbian, and heterosexual couples, respectively, were \$104,747 ($SD = \$53,118$), \$178,843 ($SD = \$128,840$), and \$125,481 ($SD = \$61,484$). The sample was also relatively racially homogeneous. Among gay men, 82% were Caucasian, 5% were Latino/Hispanic, 3% were Asian, 2% were African American, and 8% were other/multiracial. Among lesbians, 86% were Caucasian, 7% were Latina/Hispanic, 2% were African American, 2% were Asian, and 3% were other/multiracial. Among heterosexual couples, 89% were Caucasian, 3% were Latino/Hispanic, 2% were Asian, 1% were African American, and 5% were other/multiracial. The mean ages of gay men, lesbians, heterosexual women, and heterosexual men, respectively, were 38.74 years ($SD = 4.45$), 39.09 years ($SD = 5.90$), 37.97 years ($SD = 5.01$), and 39.32 years ($SD = 5.70$). The average length of gay men's, lesbians', and heterosexual couples' current relationship was 8.25 years ($SD = 3.87$), 7.73 years ($SD = 3.70$), and 8.86 years ($SD = 3.95$), respectively.

Prior to pursuing adoption, 10% of gay male couples had tried to conceive (i.e., via surrogacy using one man's sperm), 66% of lesbian couples had tried to conceive (i.e., one or both partners tried to conceive via alternative insemination), and 80% of heterosexual couples had tried to conceive. With regards to the type of adoption pursued, 76% of gay male couples, 49% of lesbian couples, and 52% of heterosexual couples had private domestic open adoptions; 18% of gay male couples, 30% of lesbian couples, and 15% of heterosexual couples had adopted through the child welfare system (public domestic adoption); and 6% of gay male couples, 21% of lesbian couples, and 33% of heterosexual couples had adopted internationally. Regarding the race of children, among gay male couples, 50% of children were Caucasian, 15% were Latino/Hispanic, 15% were African American, 3% were Asian, and 17% were multiracial. Among lesbian couples, 22% of children were Caucasian, 17% were Guatemalan, 14% were African American, 12% were Latino/Hispanic (U.S.-born), 6% were Asian, and 29% were multiracial. Among heterosexual couples, 40% of children were Caucasian, 26% were Asian, 11% were Latino/Hispanic, 3% were African American, and 20% were multiracial.

Measures

PERCEIVED AND INTERNALIZED ADOPTION STIGMA (FEELINGS ABOUT ADOPTION SCALE–FAAS)

A scale designed to measure perception and internalization of adoption stigma, the Feelings About Adoption Scale (FAAS) was created specifically for this study. The original scale, which participants completed three to four months post-adoptive placement, contained 10 items, 8 of which were retained after conducting a confirmatory factors analysis (described in more detail in the Results section). For all items, participants indicated on a five-point scale the extent to which each item applied to them (1 = *not at all true* to 5 = *very true*). We describe here the items that were retained for each of the two scales. The following five items were retained in the *Perceptions of Adoption Stigma in Society (Perceived Stigma)* scale:

1. People have indicated to me that they feel that as an adoptive parent, I'm not a "real" parent.
2. People in society don't understand adoption.
3. People in society don't understand adoptive families.
4. People in society value biological ties over everything else in creating a family.
5. People seem less excited about our adoption than about other people's pregnancies/biological births.

These items were summed and averaged to create a mean score for each participant. This factor demonstrated moderate internal consistency, with overall Cronbach's alpha = .78. The group level alphas for this factor were .74 for gay men, .80 for lesbians, .74 for heterosexual women, and .81 for heterosexual men.

The following three items were retained in the Internalization of Adoption Stigma (Internalized Stigma) scale:

1. I have felt that being an adoptive parent is second rate (to being a biological parent).
2. I have felt that, as an adoptive parent, I am not a "real" parent.
3. Being a parent is what is most important, not biological ties. (Reverse scored)

Items were summed and averaged to create a mean score for each participant. This factor demonstrated low to moderate internal consistency, as indicated by an overall Cronbach's alpha of .47. The group level alphas for this factor were .69 for gay men, .22 for lesbians, .30 for heterosexual women, and .54 for heterosexual men. These low alphas reflect the fact that 85% to 90% of all participants reported "not at all true" for each of the items on this scale; therefore, there are attenuated correlations when calculating the alphas for these items, which artificially reduce the magnitude of the alphas. On such scales, low alphas should not necessarily be considered indicative of low reliability (Garson, 2009), since many factors can influence alphas. Given the results of our confirmatory factor analysis (see below), we feel that it is useful to use this scale (Shevlin, Miles, Davies, & Walker, 2000). Caution should be taken when interpreting the results, however, and replication with other samples of adoptive parents should be undertaken.

Depression: The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) is a Likert-type scale that assesses depressive symptoms (20 items). Post-adoptive placement, participants were asked to consider the previous week and to indicate how often they experienced different moods and thoughts. Using a 4-point scale ranging from 0 (*rarely or none of the time*) to 3 (*most or all of the time*), respondents estimated the frequency of feelings corresponding to statements such as "I was happy," and "I felt that people disliked me." Higher scores indicate more symptoms. The CES-D has established validity and good internal consistency. The depression variable was mean-centered. The alphas for depression were .86 for gay men, .83 for lesbians, .80 for heterosexual women, and .84 for heterosexual men.

GENDER

Gender was effects coded (1 = female, -1 = male).

SEXUAL ORIENTATION

Sexual orientation of the couple was effects coded (1 = same sex, -1 = heterosexual).

PREFERENTIAL ADOPTION STATUS

Participants were asked whether they had tried to have a biological child prior to pursuing adoption. Responses to this question (yes/no) were effects coded, whereby participants who had not attempted to have a biological child were coded as 1 (preferential adopters) and participants who had tried to have a biological child were coded as -1 (not preferential adopters).

TRANSRACIAL ADOPTION STATUS

Participants who adopted a child whose race was different from their own were coded as 1 (transracial adoption) and participants who adopted a child whose race was the same as their own were coded as -1 (in-racial adoption).

Data Analysis

Data were analyzed to ensure that they met the assumptions for multivariate analyses. Of the participants who completed the post-placement assessment, two failed to complete the FAAS and were removed from the data set. Of those remaining ($N = 264$), only one missing value was found. This value was replaced using mean substitution. To identify multivariate outliers, Mahalanobis distance was computed and a chi-square cutoff of $\chi^2 = 29.59$, $p < .001$ was used. Thirteen multivariate outliers—that is, participants who exhibited extreme scores across several FAAS items—were identified and excluded from subsequent analyses. Thus, the final sample N was 251. Normality was also assessed at the item level. Significant skewness (beyond ± 1.00) was found for 6 of the 10 FAAS items. In particular, 5 items (1, 2, 3, 4, and 9) were positively skewed, and 1 item (10) was negatively skewed. Significant kurtosis (beyond ± 1.00) was found in 5 of 10 FAAS items (1, 2, 3, 4, and 10). Data transformations were performed on six items to reduce skewness and kurtosis to acceptable levels.

Confirmatory factor analysis (CFA) using AMOS, Version 17.0 (Arbuckle, 2004) was used to address Goal 1 of the study. The goal of CFA is to validate the number of hypothesized factors and to assess the loadings of items to each factor for a given measure. Because the FAAS was developed with two factors in mind, *Perceived Stigma* and *Internalized Stigma*, indicator variables were examined using a two-factor model (Figure 1). Because data were adequately screened and deemed fit for CFA, the standard input matrix (variance-covariance) was used, and maximum likelihood was chosen as the estimation method.

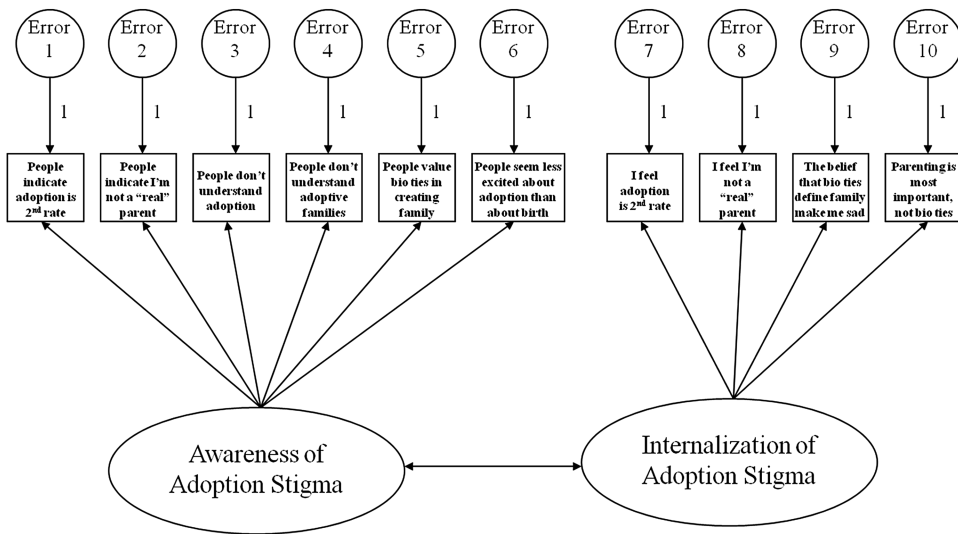


FIGURE 1 Two-factor model of perceived adoption stigma and internalized adoption stigma.

The model was evaluated using four fit measures. These measures were chosen based on Jaccard and Wan's (1996) recommendation to report at least three fit tests—one absolute fit measure (comparing correlation/covariance of the hypothesized model to that of the observed data), one relative fit measure (comparing fit against an independence model and a saturated model), and one parsimonious fit measure (evaluating the fit of the model versus the number of estimated coefficients needed to achieve that level of fit). The chi-square goodness of fit and the root mean square error of approximation (RMSEA) were used as absolute fit measures. The Bentler-Bonett normed fit index (NFI) was used as the relative fit measure, and the parsimony normed comparative fit index (PCFI) was chosen as the parsimonious fit measure. This method ensures that a model fit is tested from several different perspectives, so as to detect a true fit (Meyers, Gamst, & Guarino, 2006).

Multilevel modeling (MLM) was used to address Goals 2 and 3. MLM enables the examination of partners who are nested in couples, accounting for the lack of independence in their outcome scores (Sayer & Klute, 2005). MLM permits examination of the effects of individual and dyad level variables, accounts for the extent of the shared variance, provides accurate standard errors for testing the regression coefficients relating predictors to outcome scores, and accounts for missing data in the outcome.

An additional methodological challenge is introduced in the study of dyads when there is no meaningful way to differentiate the two dyad members (e.g., male/female). In this case, dyad members are considered to be exchangeable or interchangeable (Kashy & Kenny, 2000). The multilevel models tested were two-level random intercept models such that individual

partners (Level 1) were nested in couples (Level 2). The Level 1 model was a within-couples model that used information from both members of the couple to define one parameter—an intercept, or average score—for each couple. This intercept is a random variable that is treated as an outcome variable at Level 2. The Level 2 model was a between-couples model that tested the significance of couple-level predictors such as sexual orientation.

The unconditional model with no predictors is:

Level 1 (within couples):

$$Y_{ijk} = \beta_{0j} + r_{ij}$$

Level 2 (between couples):

$$\beta_{0j} = \gamma_{00} + u_{0j}$$

where Y_{ijk} represents the adoption stigma score of partner i in dyad j , where $i = 1, 2$ for the two members of the dyad.

RESULTS

Goal 1: Creation and Validation of Feelings About Adoption Scale (FAAS)

The first goal of the study was to create and validate a measure that differentiated between perception and internalization of adoption stigma. All obtained factor loading items were significantly different from zero ($p \leq .001$; see Figure 2 for standardized factor loadings) except one (Item 10). The factors were not significantly correlated ($r = .23, p > .05$). The two-factor model did not generally meet conventional standards for a good model fit. The chi-square goodness of fit test was significant, indicating a significant difference between the proposed and observed model, $\chi^2(34) = 280.76, p < .001$. In addition, the RMSEA was .17, whereas values greater than .10 are generally unacceptable and considered a poor fit (Byrne, 1998). The model produced an NFI of .70 (NFIs $> .90$ are indicative of a good fit; Tabachnick & Fidell, 2001) and a PCFI of .55 (ideally PCFI values greater than .90 are the goal, although values $> .50$ are deemed acceptable; Mulaik et al., 1989).

Based on the above tests, which suggested an unacceptable model fit, the model structure was revisited and two items were deleted on a theoretical basis. Item 8, "The societal belief that biological ties define a family has caused me to feel sad, frustrated and/or bad," was not theoretically or structurally similar to the other items in the *Internalized Stigma* factor. The structure of this question is problematic in that it only applies to those who believe that said societal belief exists. Indeed, the distribution of responses to this question, when compared to other questions measuring this factor, was dissimilar. Therefore it was agreed that this item was not measuring the

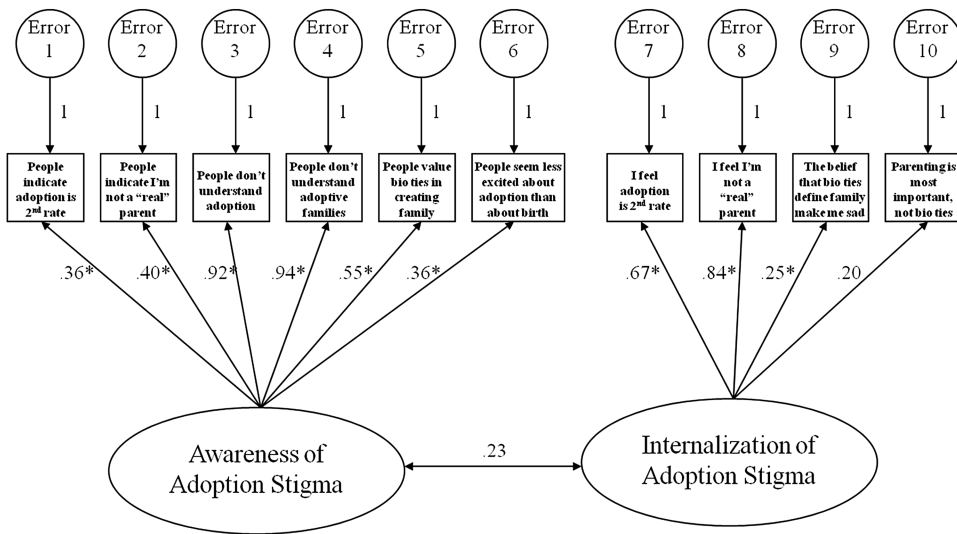


FIGURE 2 Two-factor model of perceived adoption stigma and internalized adoption stigma with standardized factor loadings. *The structure coefficient achieved statistical significance ($p < .05$).

desired constructs for the FAAS questionnaire, and it was deleted. Item 1, "People have indicated to me that they feel that being an adoptive parent is second rate," was also deleted. This item correlated too highly with Item 3, "People have indicated to me that they feel that as an adoptive parent, I'm not a 'real' parent" ($r = .68, p < .001$). These two items yielded very similar answers from participants. Therefore, Item 1 yielded almost no unique variance within the factor, and was thus deleted because of redundancy.

The new model is presented in Figure 3. This model was tested using the same procedures used for the original model. All obtained loadings were significantly different from zero ($p \leq .001$; see Figure 4 for factor loadings and exogenous variable variances). The factors were not significantly correlated ($r = .20, p > .05$). The revised two-factor model generally met conventional standards for a moderate-to-good model fit, although the chi-square goodness-of-fit test was significant, $\chi^2(17) = 64.30, p < .001$. The RMSEA was .09, indicating an adequate fit ($>.10$ is considered a poor fit; Byrne, 1998). The model produced an NFI of .90 ($>.90$ is indicative of a good fit; Tabachnick & Fidell, 2001) and a PCFI value of .63 ($>.50$ is deemed acceptable; Mulaik et al., 1989). Thus, overall the model was an acceptable fit.

Question 2a: Do Gender and Sexual Orientation Predict Adoption Stigma?

A second goal of the current study was to examine whether gender, sexual orientation, and their interaction predicted perceptions of societal stigmas

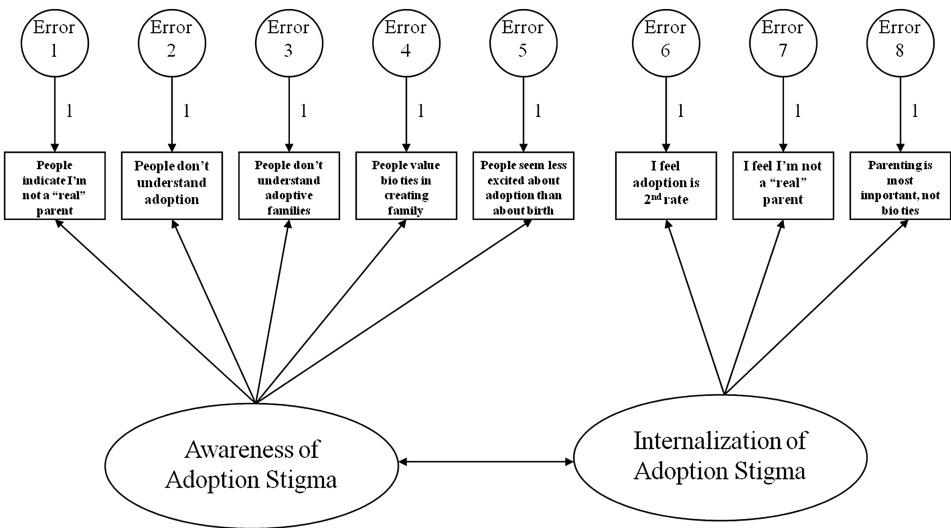


FIGURE 3 Final two-factor model of perceived adoption stigma and internalized adoption stigma.

about adoption (i.e., Perceived Stigma) and internalization of societal stigmas about adoption (i.e., Internalized Stigma). MLM was used to accomplish this goal. First, unconditional (baseline) models were fit with perceived stigma and internalized stigma as the outcomes. Three months post-adoption, the

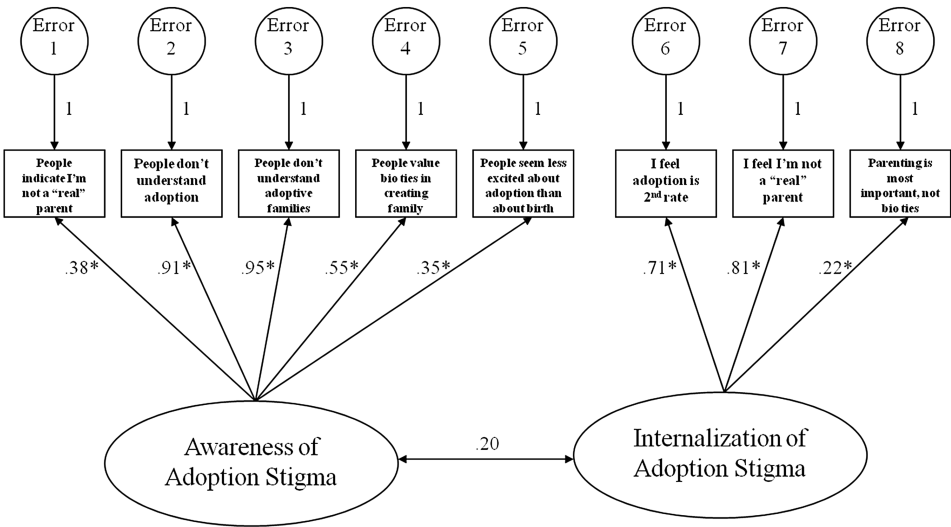


FIGURE 4 Final two-factor model of perceived adoption stigma and internalized adoption stigma with standardized factor loadings. *The structure coefficient achieved statistical significance ($p < .05$).

TABLE 1 Perceived Adoption Stigma, Internalized Adoption Stigma, and Depression, by Group

	Lesbians (<i>M</i> , <i>SD</i>)	Gay Men (<i>M</i> , <i>SD</i>)	Heterosexual Women (<i>M</i> , <i>SD</i>)	Heterosexual Men (<i>M</i> , <i>SD</i>)
Perceived Stigma	2.75 (.08)	2.55 (.10)	2.95 (.11)	2.68 (.11)
Internalized Stigma	1.16 (.05)	1.23 (.06)	1.27 (.06)	1.27 (.07)
Depression	.48 (.05)	.56 (.07)	.43 (.06)	.48 (.06)

average perceived stigma score was 2.73, $SE = .05$, $t(126) = 52.21$, $p < .001$, and the average internalized stigma score was 1.22, $SE = .03$, $t(126) = 41.46$, $p < .00$. Average stigma scores by group (gay, lesbian, heterosexual women, heterosexual men) appear in Table 1.

Next, a series of multilevel models were conducted to determine mean differences by gender, sexual orientation, and their interaction in the outcome variables. With regard to perceived stigma, when entered alone, gender emerged as a significant predictor, $\gamma = .11$, $SE = .05$, $t(126) = 2.33$, $p < .05$. Sexual orientation was nonsignificant when entered alone. The effect of gender was retained in the model with gender, sexual orientation, and the gender by sexual orientation interaction, $\gamma = .12$, $SE = .05$, $t(126) = 2.44$, $p < .05$, such that women perceived higher levels of stigma three months post-adoption. Neither sexual orientation nor the gender by sexual orientation interaction was significant. In predicting internalized stigma, gender, sexual orientation, and the interaction between gender and sexual orientation were all nonsignificant, both when tested alone and in combination.

Question 2b: Does Preferential Adopter Status Predict Adoption Stigma?

A series of multilevel models were then conducted to determine mean differences by preferential adoption status in the outcome variables. These analyses were limited to lesbian and heterosexual couples given that only three gay male couples in the sample attempted to conceive (i.e., by surrogacy) whereas there was notable variability among both heterosexual and lesbian couples (80% of heterosexual couples had tried to conceive, whereas in 66% of lesbian couples, at least one partner had tried to conceive). Preferential adoption status was first considered alone as a predictor of perceived and internalized stigma, and then, interactions between preferential adoption status, gender, and sexual orientation were examined. The effects were all nonsignificant, both when tested alone, and in combination.

Question 2c: Does Transracial/In-Racial Adoption Status Predict Adoption Stigma?

In predicting perceived stigma, transracial/in-racial adoption status was first entered alone as a predictor, then with gender, then with sexual orientation,

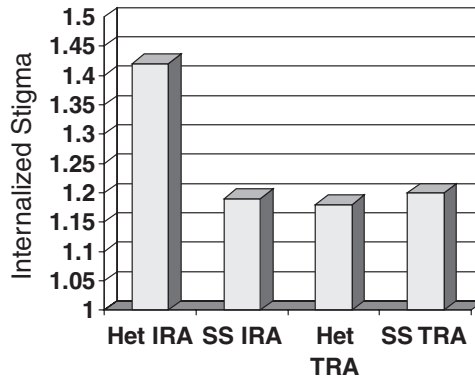


FIGURE 5 Internalized adoption stigma levels for heterosexual in-racial, same-sex in-racial, heterosexual transracial, and same-sex transracial adoptive parents.

and finally with both gender and sexual orientation, in order to explore all possible interactions. None of the effects were significant. In predicting internalized stigma, when entered alone, transracial/in-racial adoption status emerged as a significant predictor, at the level of a trend, $\gamma = -.06$, $SE = .03$, $t(126) = -1.81$, $p = .07$, although this effect disappeared when entered with gender. When entered with sexual orientation, transracial/in-racial adoption status continued to emerge as significant, $\gamma = -.06$, $SE = .03$, $t(126) = -2.04$, $p < .05$, and the interaction between transracial/in-racial adoption status and sexual orientation was significant, at the level of a trend, $\gamma = .06$, $SE = .03$, $t(126) = 1.88$, $p = .06$. When entered with gender, sexual orientation, and the gender by sexual orientation interaction, the main effect for transracial/in-racial adoption continued to emerge, at the level of a trend, $\gamma = -.04$, $SE = .03$, $t(126) = -1.68$, $p = .09$, and the interaction between transracial/in-racial adoption status and sexual orientation was significant, $\gamma = .07$, $SE = .03$, $t(137) = 2.20$, $p < .05$. Examination of the observed means revealed that heterosexual adopters who adopted in-racially reported higher levels of internalized stigma than any other group (Figure 5). Namely, in-racial heterosexual adopters had a mean internalized stigma score of 1.42 ($SE = .07$), whereas the scores for transracial heterosexual adopters, same-sex transracial adopters, and same-sex in-racial adopters were 1.18 ($SE = .06$), 1.20 ($SE = .06$), and 1.19 ($SE = .05$), respectively.

Question 3: Are Adoption Stigmas Related to Well-Being?

A third goal of the study was to examine whether perception of stigma and internalization of stigma were related to adoptive parents' mental health (i.e., depression). To accomplish this goal, two multilevel models were fit, both with depression as the outcome. In the first, perceived stigma was

examined as a predictor, and in the second, internalized stigma was examined as a predictor. Analysis showed that perceptions of societal stigma regarding adoption were not related to adoptive parents' depression, three months post-adoptive placement. However, internalized adoption stigma was related to depression, such that persons who reported higher levels of stigma reported higher levels of depression, $\gamma = .25$, $SE = .05$, $t(126) = 2.44$, $p < .001$.

DISCUSSION

The current study, which is the first to examine both perceived and internalized adoption stigma among gay, lesbian, and heterosexual adoptive parents, makes several important contributions. First, the findings highlight the importance of distinguishing between perceptions of stigma and internalization of stigma. For example, these two forms of stigma were differentially related to depression in the current sample. Second, the findings highlight several important factors, including gender, sexual orientation, and transracial/in-racial adoptive status, which may interact to shape perceptions and experiences of adoption stigma.

The first goal of the study was to create and validate a measure of adoption stigmas. The final FAAS was found to be a valid measure of perceived and internalized adoption stigma. Specifically, confirmatory factor analysis verified a moderate to good fitting two-factor model, with items pertaining to participants' perceptions of society's attitudes about adoption (e.g., "people say that I'm not a real parent"; "people value biological ties in creating families") as indicators of Perceived Stigma, and the participants' internalization of society's attitudes about adoption (e.g., "I feel that adoption is second rate"; "parenting is most important, not biological ties"; reverse coded) as indicators of Internalized Stigma. Contrary to our prediction, these two scales were not significantly correlated, and further analyses (not shown) showed that they were not significantly correlated for any of the groups in this study (i.e., gay men, lesbian women, heterosexual women, heterosexual men). Thus, it seems that at least for this sample, perceiving the existence of societal stigmas surrounding adoption does not necessarily translate into internalization of such beliefs. This finding has practical utility, inasmuch as it suggests that adoptive parents who encounter adoption stigma (e.g., in their immediate family, or in their child's school) are not necessarily vulnerable to internalizing such beliefs. Furthermore, it suggests that raising adoptive parents' consciousness of adoption stigma (e.g., in the context of adoption preparedness training) will not necessarily cause them to internalize such stigmas.

The finding that the Internalized Stigma factor of the FAAS was significantly associated with depressive symptoms in adoptive parents indicates

that this scale may be a useful tool for researchers who study adoptive families, particularly those who focus on mental health and adjustment in adoptive parents. Although we believe the FAAS to be a reliable measure despite the low Cronbach's alpha for the Internalized Stigma factor, researchers using this measure should consider testing response variability for the items that make up this factor to confirm a similar pattern of skewed responses. Additional factor analyses on adoptive parents using even larger sample sizes would be useful in further validating the scale.

The second goal of the study was to determine whether certain factors, such as sexual orientation, gender, preferential adoptive status, and transracial/in-racial adoptive status, differentiated individuals' reports of adoption stigma. We hypothesized that heterosexual women should report the highest levels of both perceived and internalized stigma; however, interestingly, we found that all women, regardless of sexual orientation, reported higher levels of perceived stigma, although there were no gender differences in reports of internalized stigma. Thus, lesbian women appear to be equally sensitive to fundamental assumptions and norms about the nuclear family as heterosexual women. Perhaps this finding reflects women's shared female socialization; that is, all women, regardless of their adult roles and associated expectations, are sensitized to social constructions of motherhood and femininity as inextricably tied to pregnancy and biology (Freeark et al., 2005; Goldberg, 2010).

Importantly, sexual orientation by itself did not impact perception or internalization of adoption stigma; that is, there were no differences between same-sex and heterosexual couples in their scores on the two subscales. One potential explanation for this is that same-sex couples who adopt may easily differentiate between stigma that they perceive in the environment due to their same-sex status and stigma that they perceive due to their adoptive parent status. Furthermore, same-sex couples in our sample were largely concentrated in urban areas, where alternative family structures are typically more common (Gates et al., 2007); therefore, differing levels of perceived stigma due to sexual orientation and adoptive status may not have been experienced for these couples.

Contrary to expectation, preferential adoption status was unrelated to perceived or internalized adoption stigma. In other words, individuals who had tried to conceive did not report higher levels of adoption stigma. Perhaps what is more important than whether couples had tried to conceive is the extent of their conception efforts. That is, it is possible that couples who pursue extensive and expensive fertility treatments—which would seem to reflect a significant investment in a biological child—experience higher levels of adoption stigma. Future research can explore this possibility.

Consistent with our hypothesis, heterosexual parents who adopted in-racially reported the highest level of internalized stigma compared to all other groups—although they did not report higher levels of perceived stigma.

That is, all participants, regardless of sexual orientation and racial makeup of their family, were similarly aware of societal adoption stigma; however, heterosexual persons who adopted in-racially were the only ones to report high levels of internalized stigma. This finding is important, and underscores the importance of differentiating between perceived and internalized stigma. Indeed, it appears likely that heterosexual persons who had internalized beliefs about the importance of biological ties to family relationships were in turn more likely to prefer a same-race child, as a means of mirroring the biogenetically related nuclear family as closely as possible. That this finding was present in heterosexual persons only is notable. Indeed, gay/lesbian parents' reasons for pursuing an in-racial placement as opposed to a transracial placement may be less motivated by a desire to simulate the biogenetically nuclear family (which they already do not conform to), but may reflect other concerns such as worries about being further rejected by family of origin (Goldberg, 2009). It is possible, then, that assessment of internalized stigma may be useful in the preadoptive period, inasmuch as it may serve as a guide for understanding adopters'—particularly heterosexual adopters'—racial preferences and adoption choices.

Finally, consistent with our expectation, internalized adoption stigma (but not perception of adoption stigma) was related to depression, such that persons who reported greater internalization of stigma reported higher levels of depression. This finding again points to the importance of distinguishing between perception and internalization of stigma. Notably, the fact that depression was not correlated with perceived societal stigma provides tentative support for the proposed directionality of effects (i.e., the notion that internalized stigma increases depression, as opposed to depression affecting reporting of stigma). Therefore, assessment of internalized stigma may be useful in identifying adoptive parents at risk for depression. Specifically, adoption practitioners may wish to formally or informally assess for the presence of internalized stigma among adoption applicants, inasmuch as this may represent a risk factor for depressive symptoms. Likewise, mental health practitioners who work with depressed adoptive parents should consider whether internalized stigmas about adoption may be implicated. In turn, adoption and mental health practitioners who suspect that internalized stigma may be affecting their clients' well-being can aim to combat internalized stigma, for example, by helping adoptive parents to see how their feelings of frustration and shame may in part be related to societal attitudes about adoption. Presumably, clients' increased understanding of these processes might help to facilitate their psychological growth and well-being.

The limitations of this study should be considered in future research. First, it is a cross-sectional study, precluding firm conclusions about the directionality of effects. Second, we did not explore the role of geographical context in perceptions of stigma. Perceived societal stigma may vary according to couples' geographical location, in that less stigma may be

experienced when living in diverse areas where alternative family structures are often more prevalent (Gates et al., 2007) and perhaps less stigmatized. A third limitation is that adoptive parents in this study were interviewed three to four months post-placement; it is possible that the findings might be different at other assessment points (e.g., as time passes and family relationships become increasingly close and solidified, patterns of perceived and internalized stigma may shift). That said, these findings have important implications for the transitional period of adoption: that is, adoptive parents may still be adjusting to their own—and others'—conceptualizations of their new family. In turn, perceptions and internalization of stigma may be more heightened during this period, as new adoptive parents adjust to their identity as an adoptive family. As adoptions become legalized and familial attachments grow stronger, levels of internalized stigma may decrease. Alternatively, it is possible that adoptive parents' perceptions of adoption stigma developed long before they even chose to adopt (via exposure to messages in the media, etc.) and may be relatively stable across the family life cycle. Further assessment of perceived and internalized adoption stigma is needed to broaden our understanding of their meaning and impact at various stages of the family life cycle.

Despite these limitations, the current study provides some important insights into the nature and implications of perceived and internalized adoption stigma among both heterosexual and same-sex couples. It also provides preliminary data on a potentially useful research tool for assessing adoption stigma, the FAAS.

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