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## Lesbian, Gay, and Heterosexual Adoptive Parents' Experiences with Pediatricians: A Mixed-Methods Study

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### ABSTRACT

Despite unique health risks and outcomes among adopted children, most pediatricians receive little training about this population. The current mixed-methods study explored lesbian, gay, and heterosexual adoptive parents' ( $n = 224$ , in 129 families) experiences with and perspectives on pediatricians. Parents in the study adopted via private domestic, public domestic, and international adoption. Parents who adopted via public domestic adoption were more likely to talk with pediatricians about adoption while parents who adopted internationally were most likely to feel positively about their pediatrician's adoption competence. Qualitative findings suggest that while parents did not look to pediatricians as sources of adoption expertise, they were disappointed when doctors did not take the adoption context into account when providing medical treatment. Findings hold implications for adoptive families, adoption practitioners, and health professionals, especially pediatricians.

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Pediatricians often serve as a first-contact and source of information for parents regarding their child's overall development and physical and mental health, as well as their own parenting choices and decisions. One population of children that is known to have specific health concerns and developmental considerations is adopted children, given their elevated risk of exposure to health risk factors, such as prenatal drug/alcohol exposure and preplacement deprivation (Keyes, Sharma, Elkins, Iacono, & McGue, 2008; Mason, Johnson, & Prock, 2014; Nadeem et al., 2017). Adopted children may also be at risk for emotional and behavioral problems, particularly in the context of early attachment disruptions, traumatic stress, abuse, or neglect (Keyes et al., 2008; Nadeem et al., 2017). Most medical professionals, however, receive little to no adoption-specific training (Henry, Pollack, &

Lazare, 2006; Koh, Kim, & McRoy, 2017). The current mixed-methods study examines predictors of whether lesbian, gay, and heterosexual adoptive parents (a) discuss adoption with pediatricians and (b) perceive pediatricians as adoption competent. This study also qualitatively explores parents' experiences with pediatricians, attending in particular to whether and how pediatricians are regarded as knowledgeable sources of adoption-related support. Findings have implications for adoptive families, adoption practitioners (who may refer families to health providers), and pediatricians and other health professionals.

### ***Adopted children and health***

According to the 2007 National Survey of Adoptive Parents, about 2% of children in the United States (US) were adopted—38% via foster care, 38% via private domestic adoption, and 25% via international adoption (Vandivere, Malm, & Radel, 2009). Children who are adopted have unique health concerns that are relevant to pediatricians (Mason et al., 2014). For example, adopted children are more likely than non-adopted children to have health problems, physical impairment, learning disabilities, developmental delays, and mental health difficulties (Bramlett, Radel, & Blumberg, 2007; Keyes et al., 2008; Nadeem et al., 2017). At the same time, adopted children are also more likely to have consistent health insurance and to receive preventive medical care (Bramlett et al., 2007) and mental health care (Keyes et al., 2008). Even when controlling for their greater risk for mental health issues, adopted children are more likely to be referred for and to receive treatment (Brodzinsky, 2013), perhaps reflecting their parents' higher income and educational levels compared to the general population (Vandivere et al., 2009), as well as greater sensitivity by providers and parents to the presence of mental health problems in adopted children.

Medical knowledge exists that can be pertinent to treating adopted children. Recent advances in developmental science highlight the adverse effects of chronic stress on physical and mental health (Shonkoff et al., 2012), which is especially relevant to youth adopted at older ages, who are more likely to be exposed to adverse early experiences (Goldberg, 2010). Youth adopted from foster care, especially those who have endured multiple foster care placements, have higher rates of medical and mental health challenges, which can in part be explained by their exposure to trauma (e.g. abuse; U.S. Department of Health & Human Services, 2015; Jones et al., 2012) and attachment-related challenges (e.g. grief and loss; Szilagyi, Rosen, Rubin, & Zlotnik, 2015). Children adopted internationally may also endure adverse early life experiences, including social and nutritional

deprivation (Weitzman & Albers, 2005), which may contribute to the mental health and medical issues (e.g. delayed growth) that are disproportionately observed in this group (Diamond et al., 2003).

Children adopted at birth via domestic private adoption are at elevated risk for mental health issues compared to non-adopted children (Keyes et al., 2008) but show lower risk than children adopted via foster care and internationally (Goldberg & Smith, 2013). This is likely due in part to a lack of exposure to adverse childhood circumstances. This lack of exposure may explain why there are no specific medical protocols for children adopted via domestic private adoption, whereas such protocols exist for children adopted via foster care and internationally (Borchers et al., 2003). This absence is concerning in that all adopted children are at higher risk for prenatal drug/alcohol exposure than non-adopted children (Davies & Bledsoe, 2005).

In addition to having children who may be at an elevated risk for certain physical and psychological difficulties, adoptive families are characterized by other unique characteristics that may be relevant in a pediatric context. For example, parents may not have complete medical history for their children (Goldberg, 2010). Children who are adopted are also connected to two families: their adoptive family and their birth family. In turn, adoptive families may or may not have contact with birth family members, the nature of which can have key implications for children's psychological adjustment and access to medical history (Brodzinsky, 2013, 2014).

### ***Pediatricians and adoption***

Pediatricians play a key role as family health advisors during the formative period of a child's development and during major developmental stages (Brodzinsky, 2014). They provide preventive care by assessing children's physical, behavioral, emotional, and developmental status, and, in the context of routine (i.e. well child) visits, have the opportunity to detect—and offer treatment options for—developmental and physical delays or disabilities (Child Trends, 2014). Yet pediatricians typically receive little exposure to adoption-specific curricula as part of their training (Henry et al., 2006; Koh et al., 2017). Medical students who do receive elective training about the ways that adoption and foster care may affect individuals throughout the life span tend to view the training as a valuable experience that contributes to good medical practice (Henry et al., 2006).

It is essential that pediatricians be familiar with the unique needs of adoptive families—both the medical and mental health issues that are seen at elevated rates in children, and the psychosocial and identity related concerns that may arise for these families (Jones et al., 2012). This type of

specific preparation is known as adoption competence: having the knowledge, skills, and values needed to provide appropriate treatment to people involved in adoption. Adoption competence encompasses knowledge about adoption practices and the impacts of adverse early experiences, skills to address the needs of individuals involved in adoption, cultural competency (e.g. familiarity with cross-cultural adoptions), and preparation to honor and support diversity (e.g. same-sex parent families; Atkinson, Gonet, Freundlich, & Riley, 2013; Brodzinsky, 2013 ). At a practical level, pediatricians should possess knowledge on how to interpret and utilize medical reports on adopted children (e.g. lab tests, birth information) in evaluating children's medical, developmental, and psychological functioning, as well how to support parents in developing appropriate expectations for children. Adoptive families may benefit from ongoing education and consultation in medical, neurological, and psychological domains, as well as guidance regarding referrals and resources, and pediatricians represent a key source of comfort, advocacy, and information over time (Brodzinsky, 2013, 2014, 2015; Jones et al., 2012).

### ***Adoptive families' experiences with pediatricians***

Little research has examined adoptive parents' experiences with health providers, with the exception of a few studies focused on international adoption (Lesens et al., 2012; Rykkje, 2007). The general research on parents' experiences with pediatric care suggests that parents are generally very satisfied with their pediatricians (Child Trends, 2014). Factors associated with satisfaction include longer well-visits and care occurring as scheduled (Halfon, Inkelas, Mistry, & Olson, 2004), interpersonal processes, including empathic communication and warmth (Galil et al., 2006; Gemmiti, Hamed, Lauber-Biason, et al., 2017; Gemmiti, Hamed, Wildhaber, Pharisa, & Klumb, 2017) and self-disclosure by pediatricians (Holmes, Harrington, & Parrish, 2010), and informational processes, including clarity and information giving (Galil et al., 2006). Yet despite relatively high satisfaction with pediatricians, parents often report wanting more information in the basic area of childrearing, including discipline and how to encourage learning (Schuster, Duan, Regalado, & Klein, 2000). For parents of children with special needs, the pediatrician's ability to connect the family with external services and the quality of their communication have been identified as important to parent satisfaction (Wood et al., 2009).

The few studies on adoptive parents' experiences with health providers find that families appreciate support, and may feel less supported when providers minimize differences or concerns and treat them as a biological family. A study of 13 Norwegian adoptive families with children ages

18 months to 14 years found that parents were generally satisfied but reported low confidence in providers' adoption competence (e.g. they felt that providers were not aware of adoption issues and minimized differences in between adopted and biological children; Rykkje, 2007). A study of 21 French families who had adopted internationally six years prior found that families appreciated support from providers during their children's transition to the family, and also valued medical consultations (Lesens et al., 2012). These studies were limited in that they focused on heterosexual parents from European countries who adopted internationally. Parents who are lesbian/gay (LG) or adopting domestically, for example, may have additional concerns or challenges.

In particular, LG parents who adopt may face unique challenges in relation to accessing health care for their children due to stigma. Providers may display insensitivity in the form of paperwork that inquires about "mother's" and "father's" employment and health history, confusion during in-person visits (e.g. "where is the mother?"), and providers who address one parent and exclude the other (Chapman et al., 2012; Goldberg, 2012). LG parents may also find that they must "educate" providers about their family constellation (Chapman et al., 2012; Goldberg, 2012). By contrast, LG parents appreciate when providers acknowledge and validate both parents as having an equal say in children's care (Chapman et al., 2012).

### ***Theoretical framework***

We draw from communication privacy management (CPM) theory (Petronio & Caughlin, 2006) and minority stress theory (Meyer, 1995) in framing this study. CPM theory recognizes that in making a decision about sharing private information, people find themselves balancing their desire for privacy with their need to share and receive information, advice, and support (Petronio, 2010). Sharing information (e.g. a child's adoption; details of their early life experiences) may be beneficial to the child, parent(s), or family in some situations but detrimental in others (Petronio & Caughlin, 2006). Families and individuals ultimately develop privacy rules for the revealing of information, which include criteria for how much, to whom, and when to disclose (Petronio, 2010). These rules, which are typically set by parents, may shift and change over time, in response to individual family members' needs, as well as experiences with disclosure (e.g. positive or negative; Docan-Morgan, 2010). In deciding whether to disclose private information—such as details about a child's adoption to a pediatrician—individuals consider the trustworthiness of the recipient and the possible outcomes of disclosure, including potential benefits and drawbacks (Docan-Morgan, 2010). In the pediatric context, parents likely

evaluate the ratio of risks to benefits of sharing adoption-related information, as well as its relevance, and whether they were explicitly asked about it (Petronio, 1991; Rossman, Salamanca, & Macapagal, 2017).

Minority stress theory (Meyer, 1995) is also useful in framing this study. According to this theory, sexual minorities experience greater social stressors because of their stigmatized social status. Exposure to stress and stigma in diverse social contexts (e.g. workplace, neighborhood, health care, children's schools) may lead some sexual minorities to anticipate bias (Chapman et al., 2012), and possibly seek to ward off or minimize stigma (e.g. by proactively seeking LGBTQ-affirming environments and/or proactively disclosing details of their family structure; Goldberg, Ross, Manley, & Mohr, 2017). A parallel example in adoptive families is the tendency to expect, or anticipate, adoption stigma (e.g. ignorance about or stereotyping of adoptive families) and in turn to seek out environments, such as health care settings, that are inclusive and responsive to their family structure and child's needs (Goldberg, Kinkler, & Hines, 2011). Supportive and affirming environments have the capacity to minimize or alleviate stress for families, including stress related to adoption, family structure, and parenting in general (Rossman et al., 2017). In the pediatric context, adoptive parents may anticipate adoption stigma (e.g. assumptions that they are biologically related to their children) and, in turn, seek to minimize its impact—such as by seeking out adoption-competent providers or proactively reminding doctors of their adoptive family status.

### ***The current study***

This mixed-methods exploratory study explores LG and heterosexual adoptive parents' experiences with pediatricians. We use generalizing estimating equations (GEE; to account for the nesting of data in couples) to examine whether family context variables (different-versus same-sex parent family; parent gender), child characteristics (race; current health), and aspects of the adoption context and children's early life history (adoption type; history of abuse/neglect; problems at placement) predict whether parents (a) discuss adoption with pediatricians, and (b) feel that pediatricians understand adoption.

We include parents' relational context (same- versus different-sex) given evidence that LG parents may encounter unique challenges related to accessing health care for their children, including stigma and heterosexist assumptions (Chapman et al., 2012). We expect that LG parents (a) will be more likely to talk about adoption with pediatricians (e.g. because of their awareness of their atypical family building route and minority family structure) but (b) will feel less positively about pediatricians' adoption



competence (e.g. because adoption competence in this context may be inextricably linked with competence surrounding non-heteronormative families more broadly, which health care providers often lack; Goldberg et al., 2017).

We include parent gender (female versus male), given that privacy boundaries are enacted differently by men and women based on socialization (e.g. women are socialized to be more disclosing than men; Petronio, 1991, 2010) and, in turn, women are more likely than men to seek health services and consult with doctors generally (Bertakis, 2009) and also contend with greater social expectations of responsibility for and involvement in their children's health care (Doucet, 2009). In turn, we expect that women will be more likely to discuss adoption with pediatricians than men. Yet we also expect that women will rate their pediatricians lower in competence, as research suggests that women have higher expectations for and lower rates of satisfaction with medical care (Elliott et al., 2012; Woods & Heidari, 2003).

The majority of parents in the sample are white, whereas most children are of color. We include child race (white versus of color), with the expectation that parents of children of color will (a) be more likely to talk about adoption (e.g. because in most cases families are multiracial, and thus their adoptive status is simply more obvious and less "private") but also (b) report less positive feelings about pediatricians' adoption competence, given that children of color are treated less favorably than white children by pediatricians (Sabin & Greenwald, 2012).

We include parents' rating of children's current health, expecting that parents who report poorer child health will (a) be more likely to talk to pediatricians about adoption (e.g. because they have more contact with them) but (b) view them as less adoption competent, amidst evidence that parents of children with poorer health are often less satisfied with children's care (Kogan et al., 2008; Liptak et al., 2006; Wood et al., 2009). We also include aspects of children's early experiences, including known exposure to abuse and neglect and number of problems at placement (cognitive, emotional, physical). We expect that parents whose children experienced abuse/neglect, and who have more problems at placement, will (a) be more likely to discuss their child's adoption with pediatricians, in part because they anticipate that the benefits of disclosure will outweigh the disadvantages associated with loss of privacy; and (b) feel less positively about pediatricians' understanding of adoption. These parents' needs are greater, by virtue of their children's complex presentation, and parents may in turn be more affected when they encounter pediatricians with limited knowledge of adoption, including the effects of early adverse circumstances (Garner, Committee On, Adoption, & Dependent Care, 2012).



Finally, we also include adoption type (public domestic, international, private domestic). We expect that parents who adopt via foster care and internationally will (a) be more likely to discuss adoption, but (b) feel less positively about their pediatrician's adoption competence, based on evidence that children adopted via these two routes are more likely to be exposed to trauma, experience emotional/behavioral issues, and have greater medical needs (Diamond et al., 2003).

For all regression analyses, we control for family income, inasmuch as we expect that families with more resources might have more options in terms of choosing pediatricians and thus more positive experiences overall (Decker, 2012).

We also examine, qualitatively, parents' experiences with pediatricians—specifically, their positive and negative experiences, including aspects of provider-parent interactions that they appreciate, and provider behaviors that indicate a lack of adoption competence.

## Method

### *Description of the sample*

Data come from 129 families (224 parents): in 95 families (73.6%), both parents had complete data; in 34 families (26.4%) data were provided by one parent only. A total of 42 lesbian mother (LM) families (both parents in 32 families), 36 gay father (GF) families (both parents in 25 families), and 51 heterosexual parent (HP) families (both parents in 38 families) were included. Parents were surveyed eight years after they adopted their first child. Income differed by family type,  $F(2, 125) = 20.82, p < .001$ . Post-hoc analyses revealed that LM families were less affluent than GF families ( $M = \$112,567, SD = \$48,248$  vs.  $M = \$220,836, SD = \$104,715, p < .001$ ) and HP families ( $M = \$135,137, SD = \$69,614, p = .033$ ). The sample was well-educated: 38 parents (17.0%) had an MD/PhD/JD, 96 (42.9%) had a master's, 57 (25.4%) had a bachelor's, 31 (13.8%) had an associate's/some college, and two (.9%) had a H.S. diploma/GED. Education did not differ by parent gender or family type. The average age of the eldest child was 9.14 years ( $SD = 2.11$ , range 8.00-18.00); age did not differ by family type.

Eighty-five of the focus (target) children (65.9%) were of color, 22 parents (9.8%) were of color, and in all but one couple where a parent was of color, the child was also of color. Sixty-nine families (53.5%) adopted boys, and 60 (46.5%) adopted girls. Since the original adoption, 67 families (51.9%) had adopted additional children. There were no differences across family type in child race or gender, but there were differences in adopting additional children ( $\chi^2(2, 129) = 7.34, p = .025$ ). Follow-up chi squares revealed that GF families were less likely to have adopted more children

compared to HP ( $\chi^2(2, 87) = 5.87, p = .015$ ) and LM families,  $\chi^2(2, 78) = 5.78, p = .016$ ).

Fifty-six families (43.4%) lived in large central metro areas (e.g. Boston, MA); 33 (25.6%) in large fringe metro areas (e.g. Sausalito, CA); 25 (19.4%) in medium metro areas (e.g. Duluth, MN); 10 (7.8%) in small metro areas (e.g. Glens Falls, NY); 3 (2.3%) in micropolitan areas; and 2 (1.6%) in rural, noncore areas (U.S. Census Bureau, 2013, 2016 ).<sup>1</sup> Chi-square analyses showed no differences in region by family type.

Eighty families (62.0%) used private domestic adoption, 26 (20.2%) used international adoption, and 23 (17.8%) used public domestic adoption. Adoption type differed by family type,  $\chi^2(2, 129) = 11.40, p = .002$ . Follow-up chi squares revealed that HP families were less likely than LM families to adopt publicly ( $\chi^2(1, 93) = 5.73, p = .017$ ), and more likely than GF parent families to adopt internationally ( $\chi^2(1, 87) = 6.56, p = .001$ )—but the latter test may be unreliable as there were fewer than 5 GF families ( $n = 3$ ) who adopted internationally. See Table 1 for demographic characteristics by adoption type.

### **Procedure**

Participants were assessed approximately eight years after becoming first-time parents via adoption. Inclusion criteria for the original study were that both partners must be first-time parents, and adopting for the first time. Participants were originally recruited from adoption agencies and lesbian, gay, bisexual, and transgender (LGBT) organizations in the US for a study of the transition to adoptive parenthood. Parents were re-contacted eight years post-adoption and invited to complete an online survey that contained open- and closed-ended questions. This study was approved by the Clark University internal review board. All participants completed a consent form prior to proceeding with the survey.

### **Questions/measures**

Data were gathered from both parents on all variables. Where responses varied within couples, both reports were used in all analyses. There were no differences within families on child race, adoption type, or whether they were adopted under 6 months or not.

### **Outcome variables**

*Discussing adoption with pediatrician.* Participants (i.e., both parents in each couple) were asked, “Have you discussed issues related to adoption with your child’s pediatrician?” and given the options yes (1) or no (0). Of the

**Table 1.** Predictors and demographic variables by adoption type ( $N = 224$  parents).

	Total ( $N = 129$ families; 224 parents)	Private Domestic ( $n = 80$ families; 142 parents)	Public Domestic ( $n = 23$ families; 39 parents)	International ( $n = 26$ families; 43 parents)
	( $M$ , $SD$ , or $n$ , %)	( $M$ , $SD$ or $n$ , %)	( $M$ , $SD$ or $n$ , %)	( $M$ , $SD$ or $n$ , %)
Income	\$151,606 (\$87,408)	\$166,860 (\$92,311)	\$157,054 (\$88,310)	\$129,880 (\$51,085)
Education	4.63 (.95)	4.68 (.96)	4.47 (.94)	4.76 (.93)
Parent Race				
Of color	22 (9.8%)	14 (9.9%)	4 (10.3%)	4 (9.3%)
White	202 (90.2%)	128 (90.1%)	35 (89.7%)	39 (90.7%)
Family Type				
Lesbian <sup>a</sup>	42 (32.6%)	23 (28.7%)	12 (52.2%)	7 (27.0%)
Gay	36 (27.9%)	26 (32.5%)	7 (30.4%)	3 (11.5%)
Heterosexual	51 (39.5%)	31 (38.8%)	4 (17.4%)	16 (61.5%)
Child Age	9.14 (2.11)	8.34 (.79)	10.90 (2.65)	9.27 (.79)
Adopted	67 (51.9%)	39 (48.8%)	16 (61.5%)	12 (46.2%)
Subsequent Children				
Child Gender				
Female	60 (46.5%)	40 (50%)	9 (39.1%)	11 (42.3%)
Male	69 (53.5%)	40 (50%)	14 (60.9%)	15 (57.7%)
Child Race				
Of color	85 (65.90%)	42 (52.5%)	17 (73.9%)	26 (100%)
White	44 (34.1%)	38 (47.5%)	6 (26.1%)	0 (0%)
Infant (< 6 months)				
Yes	90 (69.80%)	77 (96.3%)	7 (30.4%)	5 (19.2%)
No	39 (30.20%)	3 (3.7%)	16 (69.6%)	21 (80.8%)
Child Health				
Excellent	151 (67.4%)	99 (69.7%)	19 (48.7%)	10 (23.3%)
Less than excellent	73 (32.6%)	43 (30.3%)	20 (51.3%)	33 (76.7%)
Problems-Placement				
None	137 (61.2%)	102 (71.8%)	9 (23.0%)	26 (60.5%)
One	59 (26.3%)	33 (23.2%)	12 (30.8%)	14 (32.6%)
Two or more	28 (12.5%)	7 (5%)	18 (46.2%)	3 (6.9%)
Abuse/Neglect				
Yes	29 (12.9%)	4 (2.8%)	23 (59%)	2 (4.7%)
No	195 (87.1%)	138 (97.2%)	16 (41%)	41 (95.3%)

<sup>a</sup>Of the 42 lesbian parent families (74 parents), in 32 families, both participated; in 10, one parent participated. Of the 36 gay father families (61 parents) in 25 families, both parents participated; in 11, one parent participated. Of the 51 heterosexual parent families (89 parents), in 38 families, both parents participated, and in 13 families, one parent reported—11 of whom were heterosexual women.

224 parents reporting within 129 families, 172 participants (76.8%) said they had; 52 (23.2%) said they had not.

*Pediatrician's understanding of adoption.* Both parents were asked: "Did you believe that the pediatrician understood adoption issues and the unique challenges confronting your family?", and responded yes (1) or no (0). Of the 186 parents reporting within 119 families, 157 parents (84.4%) felt their pediatrician understood adoption (154 who said they discussed adoption, three who did not), and 29 (15.6%) felt they did not understand adoption (18 who said that they discussed adoption, 11 who said they did not). We surmise that the 11 participants who said they did not discuss adoption with pediatricians had in fact *told* them that their child was adopted (e.g.

in the context of explaining their limited health history) but had not *discussed* it with them; in turn, they had an opinion about their pediatricians' understanding of (or competence around) adoption, regardless of whether they had actually discussed it with them.

### ***Predictor variables***

*Parent gender.* Participant gender was coded such that 1 = female and 0 = male.

*Same-sex versus heterosexual couple.* Relational context was coded such that 1 = same-sex couple, and 0 = different-sex couple.

*Child race.* Parents indicated whether their child was of color, including biracial or multiracial (1) or white only (0).

*Transracial adoption.* Whether children were adopted transracially (i.e., parents were a different race than their child; 1) or inracially (child and parent were the same race; 0) was included as a predictor in follow-up analyses. This measure was specific to each parent-child pair.

*Child health.* Eight years post-placement, participants indicated their child's health on a 1-5 scale, from poor (1) to excellent (5). Most (151; 67.4%) said excellent; fewer said very good (62, 27.7%), good (10, 4.5%) or fair (1, .4%) health. No parents reported poor health. Because of the highly skewed nature of the data, we dichotomized health (1 = excellent, and 0 = anything less).

*Child total problems at placement.* Three months post-placement, participants were asked, "Does your child have any emotional problems (e.g. attachment difficulties, anxiety?)" "Does your child have any cognitive, developmental, motor, or language delays or difficulties?" and "Does your child have any medical or health problems?" To each question they answered Yes, No, or Don't know. Responses were recoded (1 = Yes, 0 = No or Don't Know). The three items were summed (0-3) to form a score of total problems. A total of 137 parents (61.2%) reported 0 problems, 59 (26.3%) reported 1, 25 (11.2%) reported 2, and three (1.3%) reported 3. Due to the small number with multiple problems, we combined these into one category, such that 0 = no problems, 1 = one problem, and 2 = more than one problem.

*Known child abuse/neglect.* Three months post-placement, participants were asked, “Was your child exposed to abuse or neglect?” and answered Yes, No, or Don’t know. This variable was recoded (1 = Yes; 0 = No or Don’t Know).

*Adoption type.* Three dummy variables were created: public domestic, international, and private domestic, to denote the type of adoption. Public domestic and international were included in each model, such that private domestic was the reference group. Then, private adoption was switched in for international to evaluate differences between public and international.

*Infant at placement.* A series of analyses were conducted to determine whether child age at placement (under 6 months = 1, infant; over 6 months = 0, non-infant) predicted the outcomes.

### **Control variable**

*Family income.* Each parent reported an estimate of the annual family income (i.e., the combination of both partners’ self-reported income), in dollars. This variable was transformed by taking the natural log, due to the large positive skew in the distribution.

### **Open-ended question**

Parents were asked to “please describe any negative or positive experiences that you have had with your child’s pediatrician.”

### **Data analysis: quantitative**

Quantitative analyses comprised a series of regression models predicting whether parents talked with their child’s pediatrician about adoption and whether they felt the pediatrician understood adoption-related issues. As parents’ reports were not independent, but nested in couples, it was necessary to account for their shared variance. To examine differences (e.g. by gender) in continuous variables (e.g. income), multilevel modeling (MLM) was used, and for dichotomous, ordinal, and count variables, generalizing estimating equations (GEE) were used. MLM enables examination of individual and dyad (e.g. couple) level variables, accounts for the extent of the shared variance, and provides accurate standard errors for testing the regression coefficients relating predictors to outcome scores. But MLM produces unreliable estimates when used to examine dyadic data when a link function is required, such as in predicting categorical or count variables

(Raudenbush, 2008). GEE accounts for the shared variance between persons in a couple using a robust variance estimate (Loeys, Cook, DE Smet, Wietzker, & Buysse, 2014), and has performed better than general linear multilevel models when tested on actor-partner interdependence models in samples  $> 50$  couples (Loeys & Molenberghs, 2013).

The results presents GEE models predicting the two binary outcomes, for which a binomial distribution was specified and a logit link function used. Continuous predictors were mean-centered. Dichotomous variables were dummy coded (0, 1). Exploratory interactions between gender x relationship context (same- vs. different-sex couple) in relation to the outcomes were also conducted. These were tested by adding them individually to the full model. Given the lack of research in this area,  $p < .10$  was treated as the cutoff for statistical significance reporting. Findings with  $p \geq .05 < .10$  are reported as trends.

To examine the consequences of multicollinearity between adoption type and age at adoption (i.e., adopted as an infant), abuse history, and family type (captured in the interaction of parent gender with same-sex vs. different-sex couple), a series of follow-up models were run. They included, and then excluded, the variable adopted as an infant and the interaction of parent gender and sexual orientation (separately and in combination) with adoption type. Also, as most parents were white, both child race and transracial adoption could not be simultaneously included. Thus, in follow-up analyses, all models replaced child race with transracial adoption.

### ***Data analysis: qualitative***

Responses to the open-ended query were typically several (e.g. 3–5) sentences of text. We used a content analysis method, which is a standard method for examining responses to open-ended questions, and represents a process of identifying, coding, and categorizing the primary patterns or themes in the data (Patton, 2002). This process of classifying qualitative data represents an organized, systematic, and replicable practice of condensing words of text into a smaller number of content categories (Krippendorff, 1980), with the goal of creating a coding system to organize the data (Bogdan & Biklen, 2007). The first author initiated the coding process with open coding, which involves examining responses and highlighting relevant passages. The second author independently read through the data. Both coders discussed salient points they noted in the responses, a process that led to the refinement of and elaboration upon the initial codes (e.g. negative and positive pediatrician experiences). The second coder's input led to the collapsing and/or refinement of several codes, and the development of several new codes. Next, focused coding was used to sort the data. For example, parents' explanations of

“positive experiences” were distilled into several subcodes. At this point we attended to whether key family characteristics such as family type, adoption type, and child race, nuanced or intersected with the codes. Applying the scheme to the data allowed for the identification of more descriptive coding categories and the generation of themes for which there was the most substantiation.

Although both parents often provided answers to the open-ended questions, parents tended to be unified in their descriptions of and attitudes towards pediatricians—perhaps because, even if both parents did not regularly attend every appointment, one parent likely relayed their interactions and their partner responded accordingly. Thus, the qualitative data are presented by family, not by individual parents.

## Results

### *Descriptive statistics*

Table 1 presents demographic and predictor variables for the full sample and by adoption type; Table 2 presents correlations among the predictors and between the predictors and outcomes.

As Table 2 suggests, infant vs. not, abuse vs. not, and adoption type were all somewhat conflated, such that children were much more likely to be adopted under 6 months if parents used private domestic adoption than if they used public or international adoption; and, abuse was more common in children adopted via public than via private domestic or international adoption. The strongest association was between private domestic and infant ( $r = .74$ ). Thus, in addition to the primary analyses with adoption type, analyses were conducted where (a) infant (1 = < 6 months) at placement was substituted for adoption type, and (b) adoption type and infant were included in the model.

### *GEE regressions: pediatrician experiences*

Two outcomes were examined: whether parents discussed adoption with their pediatrician, and whether parents felt they understood adoption. In all regressions, characteristics specific to the family context (i.e., same- vs. different-sex couple; parent gender), the child (race; current health), the child’s early life experiences (abuse/neglect; total problems at placement), and the adoption context (type of adoption) were entered as predictors. Family income was included as a control.

### *Talking to pediatricians*

In the full model predicting whether parents talked to pediatricians about adoption, women were less likely than men to say that they discussed adoption ( $B = -.85$ ,  $SE = .38$ , Wald = 4.98,  $p = .026$ ,  $e^B = .43$ ; Table 3). Parents who



**Table 2.** Correlations among predictors and outcome variables ( $N = 224$  parents in 129 families).

Predictors														Outcomes	
	Female	Same-Sex	Income	Excell. health	Of color	Abuse	Problems	Public	Intern.	Private	Infant	Discuss Adoption	Believe Ped. Understands Adoption ( <i>n</i> = 186)		
Female	—											-.15*	-.15*		
Same-Sex	-.24	—										-.04	-.07		
Family Income	-.40*	.09	—									.04	.01		
Excell. health	-.15	.00	.35***	—								-.04	.15*		
Of color	.09	.11	-.11	.01	—							-.04	-.05		
Abuse/neglect	.01	.15 <sup>+</sup>	-.17	-.13	.003	—						-.08	-.05		
Total problems	.14	-.16 <sup>+</sup>	-.29**	-.17*	-.11	.47***	—					.06	-.14		
Public	.08	.20	-.13	-.18*	.04	.63***	.47***	—				.09	-.23**		
Intern.	.02	-.25	-.09	.10	.36***	-.12	-.03	n/a	—			.08	.18**		
Private	-.08	.06	.18*	.06	-.32	-.39***	-.34***	n/a	n/a	—		-.13 <sup>+</sup>	.04		
Infant	.01	.13	.14 <sup>+</sup>	.07	-.16	-.52***	-.42***	-.38***	-.59***	.74***	—	-.09	-.02		

Note: <sup>+</sup> $p < .10$ ;

\* $p < .05$ ;

\*\* $p < .01$ ;

\*\*\* $p < .001$ .

Significance levels are based on MLM and GEE model where required, however the standardized measures of association are Pearson correlations, and should be taken as only a general estimate of magnitude where the data is dyadic. Excell. = excellent; Intern. = international; Ped = pediatrician.

reported known abuse/neglect at placement were somewhat less likely to discuss adoption than those who did not, at the level of a trend ( $B = -1.05$ ,  $SE = .56$ ,  $Wald = 3.53$ ,  $p = .060$ ,  $e^B = .35$ ). Parents who used public adoption were more likely to discuss adoption than parents who used private domestic adoption ( $B = 1.24$ ,  $SE = .65$ ,  $Wald = 3.92$ ,  $p = .047$ ,  $e^B = 3.46$ ).

When the reference category for adoption type was changed by substituting private adoption for international (making international the default), neither of the adoption type variables (public or private domestic) was significant. The effects for gender and abuse remained significant.

An exploratory interaction was tested between gender and relational context (same-sex versus heterosexual). When this was added to the main model, it was not significant.

#### *Substituting infant for adoption type: examining the effect of age at placement.*

Due to multicollinearity, adoption type and age at adoption could not both be in the same model; however, a second model was fit in which adoption type was replaced with a variable indicating whether the child was an infant ( $< 6$  months) at placement. With infant in the model, abuse became nonsignificant. Parent gender remained significant ( $p = .032$ ).

*Including age at placement and adoption type.* When infant ( $< 6$  months) at placement and adoption type (public, international) were both included, parent gender ( $p = .026$ ) and abuse ( $p = .023$ ) were significant. Also, public adoption was significant at the level of a trend ( $p = .059$ ).

Thus, the effect of gender was significant across all three sets of analyses. Abuse was significant except when child age at placement but not adoption type was included in the model. Finally, public adoption was significant in both sets of analyses in which it was included.

#### *Pediatricians' understanding of adoption*

In the full model predicting whether parents felt that their pediatrician understood adoption, only one predictor emerged as significant. Namely, parents who adopted internationally were somewhat more likely to feel that their pediatrician understood adoption, at the level of a trend, compared to private domestic adopters ( $B = 1.94$ ,  $SE = 1.14$ ,  $Wald = 2.91$ ,  $p = .088$ ,  $e^B = 6.98$ ; Table 3). When the reference category for adoption type was changed, this revealed that parents who adopted internationally were also more likely to feel that their pediatricians understood adoption compared to parents who adopted publically ( $B = 3.10$ ,  $SE = 1.21$ ,  $Wald = 6.29$ ,  $p = .012$ ,  $e^B = 20.91$ ). Finally, the interaction between gender and relational context was tested; it was not significant.



*Substituting infant for adoption type: examining the effect of age at placement.* When infant (< 6 months) at placement was substituted for adoption type, parent gender was significant at the level of a trend, such that men were more likely to say that they believed their pediatricians understood adoption ( $B = -.91$ ,  $SE = .52$ ,  $Wald = 3.11$ ,  $p = .078$ ,  $e^B = .40$ ). Child health was significant at the level of a trend ( $B = .93$ ,  $SE = .48$ ,  $Wald = 3.67$ ,  $p = .055$ ,  $e^B = 2.52$ ), with parents of children in excellent health being more likely to say they believed their pediatricians understood adoption. And, total problems at placement was significant at the level of a trend, such that parents who reported fewer problems at placement were more likely to say that their pediatricians understood adoption ( $B = -.71$ ,  $SE = .43$ ,  $Wald = 2.73$ ,  $p = .098$ ,  $e^B = .49$ ).

*Including age at placement and adoption type.* When infant (< 6 months) at placement and adoption type (public, international) were both included in the model, none of the predictors that had previously emerged as significant (parent gender and international in the first analysis; parent gender, child health, and child problems in the second) were significant.

Thus, different findings emerged depending on whether child age or adoption type was included. Parents who adopted internationally were more likely to view pediatricians as adoption competent than parents who adopted via public or private adoption when child age was not considered. When age was considered, parent gender, child health, and problems at placement were significant: Male parents, and parents of healthier children and of children with fewer problems, had more positive perceptions. When adoption type and age were included, all previously significant findings disappeared.

### ***Experiences with pediatricians: qualitative findings***

The qualitative analysis aimed to understand parents' general experiences with pediatricians (Table 4), with the goal of providing a more nuanced understanding of the quantitative findings. In 107 families (82%), at least one parent responded to the open-ended query. In some families ( $n = 22$ ), most of whom adopted privately and domestically ( $n = 18$ ), parents made statements such as "he's fine" or "there is nothing notable," indicating that their experiences with pediatricians were neutral or not especially salient. These families are not discussed, as they did not elaborate in meaningful ways on their experiences. The focus is the 84 families (43 private, 21 public, 20 international; 32 heterosexual, 28 lesbian, 24 gay) who emphasized positive or negative experiences.

**Table 4.** Themes, by adoption type and family type (lesbian, gay, and heterosexual).

	Adoption Type			Total
	Private Domestic (43)	Foster Care (21)	International (20)	
<b>Positive experiences<sup>a</sup></b>	37	11	15	63 families
	13L, 9H, 15G	4L, 3H, 4G	1L, 12H, 2G	
Positive experiences, not adoption-specific	10	4	2	16 families
Rely on other professionals for adoption advice	2L, 3H, 5G	2L, 1H, 1G	2H	
Adoption issues not salient	6	0	1	7 families
	5L, 1H		1H	
	2	0	1	3 families
	1L, 1H		1H	
Pediatrician sensitive to missing health history information	5	2	2	9 families
	1L, 1H, 3G	1L, 1G	2H	
Pediatrician sensitive to unique needs of parents who adopted internationally	0	0	4	4 families
			4H	
Pediatrician remembers adoption-relevant details	1	1	0	2 families
	1H	1G		
Adoption specialist	1	4	3	8 families
	1L	1L, 2H, 1G	1L, 2H	
Pediatrician has many adopted patients	0	1	5	6 families
		1G	1L, 4H	
Pediatrician has personal connection to adoption	5	2	2	9 families
	3L, 3H	1L, 1H	1L, 1H	
LGBTQ competence	11	2	1	14 families
	5L, 6G	1L, 1G	1G	
Racial/cultural competence	2	0	1	3 families
	1L, 1H		1G	
<b>Negative experiences</b>	7	10	5	22 families
	5H, 2G	6L, 2H, 1G	4L, 1H	
Behavioral/emotional issues not treated with adoption lens	7	5	1	13 families
	2L, 3H, 2G	5L	1L	
Medical issues not treated with adoption lens	0	1	2	3 families
		1L	1L, 1H	
Insensitivity re: lack of biological relatedness	3	0	0	3 families
	3H			
Culturally/racially insensitive	0	2	1	3 families
		2L	1L	
Switched doctors	2	1	2	5 families
	1H, 1G	1L	1L, 1H	

Note: H = heterosexual, L = lesbian, G = gay.

<sup>a</sup>Only one of these families also reported negative experiences (with a different, previous provider); thus, with one exception, positive versus negative codes are mutually exclusive.

### *Positive experiences with pediatricians*

Parents' descriptions of positive experiences with pediatricians ( $n = 63$  families; 48.8%) outweighed negative experiences. These 63 families included 37 of 80 private domestic adoptions (46.3%), 11 of 23 public domestic adoptions (47.8%), and 15 of 26 international adoptions (57.7%) (Table 4). Some parents pointed to general characteristics of "good providers" but did not invoke adoption or cultural competence; others reflected positively on pediatricians' adoption competence (e.g. sensitivity to a lack of medical information); and still others noted providers' LGBTQ and/or racial competence.

*Positive qualities, not adoption specific.* Some parents lauded the positive qualities of their pediatricians in ways that were not specific to their child's

adoptive status ( $n = 16$  families; 10 private domestic, four public, two international). These parents tended to emphasize pediatricians' positive interpersonal qualities, such as a warm and compassionate bedside manner, and, secondarily, mentioned their professional qualifications and credibility. Miriam, a multiracial heterosexual mother of a multiracial daughter adopted privately and domestically, said: "Our family doctor is wonderful: warm, caring, and always goes out of his way to remember personal details about Sonia and ask her about them." Shawn, an African American gay father who adopted via private domestic adoption, said his African American son's pediatrician "takes an interest in Robbie's growth and activities. He is always honest, warm, and welcoming to us too."

Seven of these 16 parents provided the caveat they did not consult or rely on their pediatrician for adoption related issues (six private domestic, one international). "When we have had adoption-related questions or concerns, we've either consulted with an adoption therapist or our adoption agency," said Denaë, a white lesbian mother who adopted her multiracial daughter via private domestic adoption. "We have told our pediatrician that our daughter is adopted but have not relied on him for guidance," said Tina, a white lesbian mother who adopted her white daughter via private domestic adoption. The possession of adoption-specific and therapeutic resources, then, may have facilitated these families' generally positive impressions of pediatricians: parents did not expect them to be a primary source of guidance around adoption.

In three of these 16 cases (two private domestic, one international), parents noted that they "hadn't felt the need" to talk to pediatricians because issues related to adoption had not come up. This may have minimized their reliance on pediatricians for adoption support, and facilitated positive impressions. "We haven't had any issues about adoption that we needed to discuss with our pediatrician but she's aware that they are adopted and has always been wonderful and sensitive about it," stated Corinna, a white lesbian mother who adopted two African American children privately and domestically.

*Explicit evidence of adoption competence: sensitivity and awareness.* Some parents named specific ways that pediatricians demonstrated adoption competence, including sensitivity to the unique needs, experiences, and backgrounds of adopted individuals and their families. Parents emphasized the importance of doctor's sensitive and appropriate handling of adoption issues as well as the value of doctors remembering and attending to these details without being reminded.

*Sensitivity to lack of information.* One key way in which providers illustrated adoption competence was through sensitivity to participants' lack of

medical background information for their child ( $n = 9$ ; five private domestic, two public, two international). Erica, a white heterosexual mother who adopted her daughter from China, said, “We love our pediatrician; he knows we lack family background for Morgan and is extra sensitive when he asks her to take extra tests.” Dan, a white heterosexual father who adopted an African American daughter via private domestic adoption, said: “Our pediatrician understands that having little knowledge of our child’s birth family and thus medical background is challenging, and is able to help us through it.”

*Sensitivity to the unique needs of internationally adoptive families.* Four heterosexual parent families who adopted from abroad shared that their pediatricians understood the unique needs of internationally adoptive families, exhibiting sensitivity to the unique cultural, language, and medical experiences of their children, some of whom needed special evaluations or referrals. A white heterosexual father, Ben, who had adopted his daughter from China, said that their pediatrician had “been to China many times to care for children in the orphanages,” and was sensitive to his daughter’s physical presentation (e.g. smaller head circumference) and the unique experiences and needs that it implied.

*Attention to details about the adoption.* In one case, a pediatrician demonstrated awareness via remembering and asking about adoption-relevant details about the family. Clara, a white heterosexual mother who adopted her white son via private domestic adoption, said: “She consistently asks if Stephen still sees his birthmother every time we see her. It is nice that she inquires about his relationship with her.” In one case, a white gay father who adopted his white son via foster care, shared how his son’s history of sexual abuse made it difficult for him to undress in front of others. His son’s pediatrician had reportedly made a note of his son’s abuse history and consistently “worked around it” during visits.

*Implicit evidence of adoption competence: professional and personal connections.* In some cases, pediatricians’ adoption competence was implied by way of describing aspects of pediatricians’ professional affiliations, caseload, or personal life.

*Adoption-centered professional affiliations.* Eight families (one private domestic, four public, three international) said that their pediatricians were affiliated with adoption medicine practices, an index of credibility that was presumably advertised publicly, such as on provider websites. Five of these parents (one private domestic, one public, three international) said they



specifically looked for pediatricians affiliated with adoption medicine clinics, recognizing that this indicated some level of professional training or experience with regard to adoption.

*Adoption-centered patient population.* Six families (one public, five international) implied pediatricians' adoption competence by describing aspects of their caseload—namely, highlighting that their pediatricians had a lot of adopted patients. Erin, a white lesbian mother who adopted her daughter from Guatemala, said, “We specifically chose our pediatrician having heard she worked extensively with foreign adopted children; she’s been wonderful.”

*Personal connection to adoption.* Some families shared that their pediatricians had a personal connection to adoption ( $n=9$ ; five private domestic, two public, two international), noting that their providers were adoptive parents or were adopted. Such descriptions suggest that families sought out providers who were familiar with adoption, who may have been found via shared community knowledge (e.g. other adoptive parents).

*LGBTQ competence.* In highlighting their positive experiences with pediatricians, some LG parents focused on providers' LGBTQ competence. Namely, 14 families (11 private domestic, two public, one international) said that their pediatricians were LGBTQ-affirming, with some noting that they purposely chose an LGBTQ pediatrician, or had interviewed several providers to find one who was “completely accepting and understanding of our family construct.” Tim, a white gay father who adopted his white daughter via private domestic adoption, said: “Our pediatrician understands our circumstances with having a daughter in a two dad household. She encourages us to read [up] on certain female issues we will inevitably be faced with in our experience of raising a female daughter. I often feel grateful we found such a great pediatrician!”

*Racial/cultural competence.* In three families (two private domestic, one international), parents commented positively on pediatrician's racial/cultural competence, with two families indicating that their pediatrician was the same race as their child, which they felt facilitated racial competence. David, a Latino gay father who adopted his Latino son internationally, explained, “Our pediatrician is of Latin origin and has four boys of her own, so she ‘gets’ our son.”

#### *Negative experiences with pediatricians*

Negative impressions of pediatricians were less commonly articulated than positive ones ( $n=22$ ), and most often noted by families who adopted via

foster care (10 of 23; 43.4%), followed by those who adopted internationally (5 of 26; 19.2%) and via private domestic adoption (7 of 80; 8.8%) (Table 4). The nature of parents' critiques most often centered on lack of sensitivity to the possible relevance of the adoption context (e.g. children's early life circumstances, including prenatal drug exposure and loss surrounding birth family) in their medical, neurological, or psychiatric issues.

*Adoption insensitivity, mental health.* Thirteen families (seven private domestic, five public, one international) voiced disappointment with pediatricians' lack of knowledge about adoption's potential relevance to their child's mental health difficulties, which were not treated with an adoption competent lens. Betsy, a white lesbian mother whose African American daughter was adopted via foster care, said: "When Mimi was having night terrors and demonstrating anxiety, perhaps related to adoption anxiety... the MD didn't seem to connect the possibility of adoption to any of her behavioral issues or anxiety. She said Mimi would probably grow out of it." Kristine, a white heterosexual mother who adopted her Latino son privately and domestically, also felt dismissed: "We discussed some of Devon's anxiety issues with his former pediatrician and received a general 'sometimes adopted children have these types of issues.' I was not impressed with her knowledge or insight into adopted children." Sarah, a white heterosexual mother, who adopted privately and domestically, felt that her multiracial daughter's elimination challenges were intertwined with mental health issues, but these were minimized by the pediatrician, who "says she understands but doesn't do much... this past year, Laila has had a great deal of anxiety around her body, starting with poop issues and now going into hypochondriac behavior. We've had to basically scream to get help."

Two of these 13 families (both public) highlighted their frustration with pediatricians' lack of familiarity with the effects of adverse childhood experiences (ACEs). Lauren, a white lesbian mother of two Latino siblings adopted via foster care, shared: "We don't depend on her for trauma-related care. I don't think the doc nor the practice understand ACEs' impact on kids' health." In two of these 13 families (one public, one international), parents shared how a lack of competence manifested in outdated, inappropriate diagnoses. Nina, a white lesbian mother who adopted her son from Guatemala, was upset about the pediatrician "bringing up RAD [reactive attachment disorder] and FASD [fetal alcohol spectrum disorders] as diagnostic considerations when there was substantial evidence that counter-indicated these diagnoses—just because he was adopted."

*Adoption insensitivity, physical health.* Three families (one public, two international) described medical issues that they felt were not treated with an

adoption-competent lens. These included prenatal substance exposure, chronic sleep issues, and chronic gastrointestinal issues. Hannah, a white lesbian mother of a multiracial daughter adopted via foster care, described their pediatrician as “frustratingly” ignorant about adoption, and stated: “No medical professional, except the one who diagnosed her with FASD, has ever been that engaged or understanding about adoption or about Kory’s particular challenges. It is so frustrating and disappointing.”

*Adoption insensitivity, assumptions of biological relatedness.* In three private domestic adoption cases, parents noted insensitivity related to the lack of a biological connection between parents and child, with one white mother noting that her child’s pediatrician frequently forgot that she had not given birth to her Latina daughter, and two mothers stating that their pediatrician regularly forgot their child was adopted. All of these were heterosexual parent families, suggesting that pediatricians were seemingly more likely to fall victim to heteronormative family building assumptions with them than with same-sex parent families.

*Cultural/racial insensitivity.* In three cases (two public, one international), pediatricians were described as not simply adoption incompetent, but culturally or racially insensitive. A white lesbian mother noted that their pediatrician used American growth charts for her son, who was adopted from a country where norms are quite different (“he’s small, but that’s not unusual for being Vietnamese”).

*Switching doctors.* Five of these 22 families (two private domestic, one public, two international) mentioned switching doctors due to dissatisfaction with their pediatrician’s adoption competence. Miranda, a Latina lesbian mother who adopted her Latino son via foster care, shared that she and her wife switched pediatricians because, alongside their sense that the pediatrician had “limited knowledge of issues related to mental health and adoption,” they felt “dismissed and disrespected in responding to our child’s needs,” such as their request to have their son assessed for ADHD. Susan, a white lesbian mother who adopted her daughter from Nepal, said: “We switched pediatricians shortly after our daughter came home, because our original pediatrician didn’t fully address her chronic giardia. Her new pediatrician was familiar with international adoption issues and successfully treated the giardia and had her bone growth charted over time as well.”

## Discussion

The current mixed-methods study of lesbian, gay, and heterosexual adoptive parent families provides insight into the types of characteristics that

are related to parents (not) discussing adoption with pediatricians, and to parents' perceptions of pediatricians' adoption competence. It sheds light on how adoptive parents choose and evaluate pediatricians, and points to areas for improvement in adoption, LGBTQ, and racial competence among medical professionals.

First, our analysis explored predictors of whether parents reported discussing adoption with pediatricians. More than three-quarters of families reported talking to their pediatricians about adoption, indicating that parents commonly determined that some level of disclosure was valuable in the pediatric context. Contrary to expectation, women were less likely than men to say that they discussed adoption. The interaction between relational context and gender was not significant, indicating that the tendency for men to be more likely to discuss adoption is not driven by gay father families, who theoretically might seem to be more comfortable discussing their route to parenthood, in that it is "obvious" and they are also less beholden to and influenced by heteronormative ideals surrounding family-building (Goldberg, 2012). This finding may reflect gendered differences in what parents interpret as "discussing" adoption, such that men endorsed it if they had ever talked about their child's history, whereas women had a more stringent threshold for what "discussed" entailed, possibly related to socialized norms around communication. It may also reflect gendered differences in the nature of provider-parent interactions, whereby men and women enact, experience, and reflect differently on provider interactions (Elliott et al., 2012). Finally, men and women may make different evaluations about the value of sharing private information about adoption or maintaining privacy (Petronio & Caughlin, 2006), such that men perceive more value in sharing, or less risk in forgoing privacy, than women.

Parents whose children had a known history of abuse/neglect were somewhat less likely to talk to pediatricians about adoption. Children with such histories are at greater risk for various challenges as they age (Child Welfare Information Gateway, 2013); in turn, parents may discuss this very sensitive aspect of their child's history more with specialists than with pediatricians. As seen in the qualitative data, some parents asserted that they had specialized services and thus engaged in minimal adoption-related discussion with pediatricians; indeed, such discussions may have been viewed as unnecessary or even counterproductive, if they had doubts about their pediatricians' adoption competence, or simply viewed adoption information as irrelevant in this context. Perhaps they limited disclosures to where they perceived these would result in the most direct benefit (Petronio & Caughlin, 2006). It may also be that parents viewed their child's history of abuse or neglect as an additional form of minority status that could be vulnerable to stigma, and thus

were motivated to minimize their adoption-related disclosures to avoid the risk of incurring additional stress for themselves or their children (Meyer, 1995). Ideally, pediatricians can play a role in supporting parents in managing the challenges of parenting maltreated children—for example, by proactively exploring maltreatment possibilities early on with parents, albeit with great sensitivity given that some parents will find this topic difficult (Garner et al., 2012).

At the same time that parents who reported known abuse/neglect at placement were somewhat less likely to discuss adoption than those who did not, parents who adopted children via foster care (who frequently have a history of abuse and/or neglect; U.S. Department of Health & Human Services, 2015) were, as a group, more likely to discuss adoption than parents who became parents via private domestic adoption. This could suggest that parents who adopted non-abused children from foster care were most likely to discuss adoption. Since parents who adopt via foster care typically do not parent their children from birth, they may have been more likely to share their child's adoptive history in the context of providing their child's family medical history, immunization history, and other pre-adoptive documentation. And, inasmuch as children are often placed in foster care due to a range of adverse circumstances, including parental substance abuse and poverty, which can affect children's medical and psychological well-being and are also associated with an increased likelihood of a child's exposure to teratogens in utero (Burd, Cohen, Shaw, & Norris, 2011), parents of children adopted via foster care may be specifically seeking out information related to the consequences of prenatal drug exposure—an area that would presumably be well within pediatricians' wheelhouse. They may therefore have viewed the benefits of disclosure as outweighing the possible drawbacks (Petronio, 2010).

No differences were found between parents who adopted internationally and those who adopted via private or public domestic adoption in their communication with pediatricians. International adoptions do share characteristics with foster care adoptions (i.e., non-infant adoptions that involve limited health information); in turn, perhaps differences in children's known early adversities or parents' beliefs about adoption between these two types of adoption may help to account for differences in communication.

Second, our analysis explored predictors of whether parents felt that their pediatricians understood adoption. This yielded more complex findings that varied depending on the presence of adoption type and child age in the model—variables that are highly collinear and thus resulted in unstable findings across models. Our initial models found that parents who adopted internationally were somewhat more likely than those who adopted via public and private domestic adoption to believe that their pediatricians understood

adoption. This may in part reflect the tendency for parents who adopt internationally to receive a great deal of guidance from their adoption agencies, as well as online, regarding finding pediatricians with expertise in adoption medicine—which may reflect the fact that adoption medicine specialties have historically tended to focus on intercountry adoptions (Brodzinsky, 2013, 2014). These pediatricians can help inform their selection of a child to adopt (e.g. by evaluating a potential adoptive child's health through medical reports) and provide specialized ongoing medical care (e.g. due to the unique nutritional and health related issues that adoptees from other countries may possess; Bledsoe & Johnston, 2004; Diamond et al., 2003).

Parent gender was also significant when adoption type or child age were included (but not both, likely due to the high conflation of child age and adoption type, and differences in adoption route by family type). Again, men were somewhat more likely to feel that their pediatricians understood adoption, which may reflect broader differences in patient satisfaction: Some work shows that men tend to be more satisfied with patient care than women, perhaps reflecting women's higher expectations for treatment (Elliott et al., 2012; Woods & Heidari, 2003).

When child age, but not adoption type, was included in the model predicting perceptions of adoption competence, parents who rated their children's current health more negatively were somewhat less likely to feel that their pediatricians understood adoption. Parents whose children had more health issues likely had higher demands of pediatricians (e.g. requesting testing, referrals, and resources) and in turn had more opportunities for evaluating, and being disappointed by, providers' adoption competence. This interpretation is consistent with literature suggesting that children with poorer health, including special needs, often have more unmet health needs, and their parents are less satisfied with care (Kogan et al., 2008; Wood et al., 2009). The effect of child health was not present when international and public adoption type were included, as these accounted for the same variance in the outcome as child health, possibly because child health problems are less likely for parents who adopted privately and domestically (70% of whom described their child as in excellent health, compared to 49% of parents who adopted via public adoption and 23% of parents who adopted internationally).

In line with these findings, parents of children who had more problems at placement were somewhat less likely to perceive pediatricians as adoption competent. Even though this finding was not present when adoption type was included (due to overlap between these variables, with larger number of problems experienced by publicly adopted children), it shows a similar pattern whereby parents with higher levels of need and difficulty also appear to feel less positively about providers' ability to understand and

meet their family's needs (Kogan et al., 2008). These findings, and those on child health, are echoed in our qualitative data: parents who described their children's psychological or medical challenges typically did so in the context of voicing dissatisfaction with pediatricians, rather than sharing how they had been helpful in providing support or referrals.

Neither child race nor parents' different/same-sex relational status were related to parents' discussions with or perceptions of competence by pediatricians. As most parents were white, this may have mitigated the effects of racial bias that have been observed in other research on patient-provider interactions (Sabin & Greenwald, 2012), or may suggest the possibility that providers respond more to parent/guardian race than to the child's race. And, the fact that same-sex parents did not perceive pediatricians less positively than heterosexual parents may reflect their efforts to locate LGBTQ-affirming providers (e.g. in an effort to minimize anticipated stigma), a possibility that was hinted at in the qualitative data.

Parents in almost half of families elaborated on positive experiences with pediatricians. Often, they described positive qualities of pediatricians that they appreciated but that were not adoption-specific; these were often interpersonal (e.g. attentiveness, warmth), echoing prior work on valued health provider characteristics (Galil et al., 2006). Parents with generally positive remarks often said that they relied on sources other than pediatricians (e.g. therapists) for adoption information, suggesting that perhaps their lower expectations facilitated more generous appraisals. These results echo Rykkje's (2007) finding that parents who had adopted internationally were fairly satisfied with providers but had little confidence in their adoption competence. Indeed, parents who expect little benefit from disclosure will likely choose to maintain their privacy (Petronio & Caughlin, 2006), which may reduce their exposure to adoption stigma, rendering them generally more satisfied with providers (Meyer, 1995).

Some parents provided illustrative examples of adoption competence, such as sensitivity to a lack of background information, and attunement to adoption-specific dynamics such as contact with birth family or a history of sexual abuse. Others drew on more implicit indices of competence, noting that their pediatricians had a personal connection to adoption or many adopted patients, suggesting that parents may have sought providers with such characteristics—likely a proactive and adaptive means of minimizing stress and optimizing positive outcomes. This finding can be understood in the context of prior findings that parents are more satisfied with pediatricians who share more personal information and common experiences (Holmes et al., 2010), practices that may take on added meaning and salience in an adoption context. Yet connection to adoption does not ensure adoption competence; the latter encompasses adoption-specific skills and preparation (Atkinson et al., 2013).



Similar to parents who appreciated their providers' personal connection to adoption, several parents sought out and/or appreciated that their pediatrician was LGBTQ affirming or racially/culturally sensitive. Again, this is likely a proactive way for families to mitigate their exposure to stigma in the health care context (Goldberg et al., 2017; Meyer, 1995). Such findings echo work highlighting the personal significance of status matching in choosing health providers: sexual and racial minorities have both been found to value therapists and medical professionals who share their sexual minority or racial statuses, respectively (Street, O'Malley, Cooper, & Haidet, 2008). They also echo adoption professionals' recommendation for transracially adoptive parents to seek out adults in positions of authority (e.g. teachers, pediatricians) who share their child's race (Goldberg, 2010).

Negative accounts of pediatricians' adoption competence, which were disproportionately named by families who adopted via foster care, tended to center on insensitivity or inattentiveness to the possible relevance of the adoption context in understanding children's current psychological, neurological, or physical well-being, and their inability to provide appropriate referrals for testing, treatment, or support. Some noted their pediatrician's unfamiliarity with the effects of ACEs on well-being as a source of ongoing frustration, whereas others described providers' assignment of inappropriate diagnoses, possibly reflecting a lack of up-to-date training on adoption (Brodzinsky, 2013). Several parents said they switched pediatricians due to providers' lack of adoption competence. Of course, some parents, such as those in rural areas or with few resources, do not have the option of switching providers, rendering them vulnerable to working with adoption-insensitive providers—and multiple forms of stress—which speaks to the need for generalist training on adoption, such as coursework aimed at pediatric residents (Henry et al., 2006).

## Limitations

Although this exploratory, mixed-methods study makes inroads into our understanding of adoptive families' experiences with pediatricians, it has many limitations. Regarding the measures, this study employed a crude index of children's problems at placement; future work should assess problems in a more fine-tuned way. Parents were asked about physical and psychological problems in very general ways because at three months post placement, parents were just getting to know their children and were responding based on what they were told at placement or what they had observed in the short time they had known their children. More explicit and specific probing about the nature and severity of problems (e.g. disabilities) would be useful, as this inevitably impacts what parents and children need and want from pediatricians. Additionally, this study used one-item measures for current child

health, as well as the two outcomes. Single-item measures are less reliable and valid than multi-item measures, in addition to being more vulnerable to random measurement errors, as well as unknown biases in meaning and interpretation. The question of whether parents “discussed” adoption with pediatricians was likely interpreted differently by parents, with some understanding it as referring to disclosure and others interpreting it as referring to in-depth, meaningful conversations—and these differences may have been gendered, with men having a lower threshold for what “discussion” meant.

This study did not assess prenatal substance exposure as a predictor of whether parents talked to pediatricians about adoption, or their perceptions of adoption competence. No parents mentioned positive experiences with regard to providers’ understanding of drug exposure, but several mentioned negative experiences, suggesting that parents were generally frustrated with providers’ ability to deal with it when it did come up. Future work should inquire about this topic directly and explore how known prenatal substance exposure relates to adoptive parents’ experiences with and perceptions of pediatricians.

The open-ended question regarding pediatrician experiences was very general—a strength in that it allowed us to obtain parents’ descriptions of whatever was salient to them, but a limitation in that it did not contain probes that may have elicited more in-depth data on a more narrow range of topics. Similarly, this study did not systematically explore how families learned about the pediatrician they selected. Future work should assess this, and investigate whether certain pathways or referral sources (e.g. adoption agencies) appear to be associated with greater parent satisfaction with pediatricians than others. Likewise, this study did not ask about whether parents had switched pediatricians—yet this emerged as important in the qualitative data, and should be asked of adoptive parents in future work, alongside queries about why they switched.

Significantly, there was little variability in adopted children’s parent-reported health: Most were viewed as having excellent or good health. This may have impacted parents’ experiences with health care providers, resulting, for example, in more limited contact with pediatricians. Families with children with more intensive health care needs or concerns may interface with health care systems more frequently and report unique or more nuanced experiences with pediatricians.

## **Conclusions and implications for families, pediatricians, and adoption practitioners**

Our study has implications for adoptive families, pediatricians, and adoption practitioners, as well as pointing to several future areas of study. Adoptive families should be aware that although every family should ideally feel

empowered to discuss their child's health with their pediatrician and should expect them to take their child's adoption context into account, pediatricians typically receive little exposure to adoption-specific curricula as part of their training (Koh et al., 2017), despite its value (Henry et al., 2006). In turn, families should be prepared to offer some initial guidance to pediatricians on their child's specific needs or history (e.g. substance abuse exposure), and hold their pediatrician accountable for remembering and/or following up on these issues. Even if a child was adopted privately with no immediate health concerns, it is reasonable for families to expect pediatricians to (a) remember that the child was adopted and whether birth parents are present in the child's life, and (b) consider how the adoption may shape the child's health needs over time.

Pediatricians should be aware that families do not expect them to be adoption experts, but do expect them to take their child's adoption context into account while caring for them. Towards this end, pediatricians should familiarize themselves with the published standards for care of adopted children (Jones et al., 2012; Jones & Schulte, 2019) and also seek ongoing training regarding treatment of adoptive families. Pediatricians should be aware of the effects of childhood trauma in the context of adoptive families, know how to anticipate and identify trauma in children, and be able to provide suggestions on or referrals toward counteracting its effects (Mason et al., 2014). More generally, pediatricians should seek to create a practice environment that encourages and supports adoptive parents in sharing their child's adoption story, including known and unknown medical history, pre-placement experiences such as quality of care received by the child, the child's connection (or lack thereof) with birth family, and current challenges (and positive experiences) in the child's and family's life (Jones et al., 2012). Moreover, pediatricians should strive to make every adoptive family feel encouraged to (a) share about their child's needs, and (b) expect sensitive treatment of those needs.

Adoption practitioners should be aware that they often play a role in guiding families in finding appropriate referrals, including adoption-competent pediatricians—although their knowledge of such providers may be limited by a number of factors, including the availability of adoption-competent providers in their region and the absence of medical certifications for adoption competency. In turn, practitioners can at the very least guide families regarding the questions that they can ask of pediatricians to assess their adoption competence (e.g. "How do you work with adoptive families? In your experience, what characteristics may set adoptive families apart from biological families? How do you address these?"). Practitioners can also empower families to direct their pediatricians to resources that may enhance their practice with adoptive families.

Finally, future research should include more specific queries about and definitions of problems for which adoptive parents need assistance from their

pediatricians (e.g. a child's disability). Second, research should focus on how pre-natal substance abuse exposure relates to family experiences with pediatricians, given its prevalence among adopted children. Third, studies should investigate why families who adopt internationally may tend to have better experiences with pediatricians compared to other types of adoptive families. Fourth, future work should seek to understand how adoptive families find their pediatricians, and how and when they are prompted to switch pediatricians. Fifth, scholars should pursue in-depth qualitative exploration of lesbian, gay, and heterosexual adoptive families' experiences within the health care setting, and with pediatricians specifically, as this study is only a first step in understanding this domain. These research efforts will expand knowledge of adoptive families' experiences within the health care system, and ultimately lead to more affirming and sensitive pediatric care.

## Note

1. Large central metro counties are counties in metropolitan statistical areas (MSA) of 1 million + that 1) contain the population of the largest principal city of the MSA, 2) are contained in the largest principal city of the MSA, or 3) contain at least 250,000 residents of any principal city of the MSA. Large fringe metro counties are counties in MSAs of 1 million + that do not qualify as large central. Medium metro counties are counties in MSAs of 250,000 to 999,999 population. Small metro counties are counties in MSAs of less than 250,000. Micropolitan counties are counties in micropolitan statistical areas. Non-core counties are nonmetro counties that are not in a micropolitan statistical area.

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