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Heterosexual and sexual minority adoptive parents' help-seeking and service satisfaction of pediatricians and mental health providers

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Abstract

The aim of our study was to examine the associations between heterosexual and sexual minority adoptive parents' adoption-related help-seeking and their service satisfaction with pediatricians and mental health providers. We examined associations with (a) satisfaction with pediatricians and (b) understanding of adoption by a mental health provider among adoptive parents who sought advice for adoption-related issues using data drawn from the Modern Adoptive Families study ($N = 1{,}419$). Logistic regressions were used to examine associations with service-seeking and satisfaction with professionals' adoption advice. About half of the sample adopted a child with either special needs at placement (55%) and/or preplacement adversity (74%), which were significantly associated with seeking adoption-related advice. Consulting pediatricians about adoption was common (78%), and 83% of those parents reported being satisfied with adoption-related advice provided by their pediatrician. About half (51%) of the parents sought mental health services, but only 41% of those parents reported having access to an adoption-competent mental health provider and 50% of those parents felt their mental health provider understood adoption. Parent sexual orientation, higher income, older child age, and having a child with special needs were positively associated with satisfaction with adoption-related advice provided by the pediatrician and having a mental health provider who understood adoption. Adopting a child with special needs

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at placement and an older child were positive associations of seeking adoption-related help, while parent demographics, including higher household income, were positively associated with satisfaction. Results suggest an inclusive family-centered approach to care is important.

Keywords
Adoption, health care, mental health, sexual minority parents

Introduction

Adopted children can face significant medical problems and are at increased risk for a variety of psychological, behavioral, and academic problems, primarily due to preplacement adversity, especially when adopted from the child welfare system and via international adoption (Askeland et al., 2017; Eckerle et al., 2014; Hussey, Falletta, & Eng, 2012; Nadeem et al., 2017; Palacios et al., 2019). Experiencing prenatal and postnatal adversity prior to the adoption placement contributes to the majority of medical and mental health problems. Adopted children face substantially increased risk of developing medical problems such as hearing/vision loss (Eckerle et al., 2014), speech/language delays (Mason, 2014), growth delays due to malnutrition (Miller, 2004), and additional adverse consequences due to prenatal substance exposure (Mason, 2014). Children raised in institutions (e.g., orphanages) prior to adoption are at increased risk for cognitive deficits, delays in growth development, and social/emotional problems, including depression, attention-deficit/hyperactivity disorder (ADHD), attachment insecurity, and conduct problems (Smyke et al., 2007; Vandivere, Malm, & Radel, 2009). Adopting an older child (>4 years) at the time of placement is associated with greater externalizing behaviors, likely due to increased exposure to preplacement adversity (Nadeem et al., 2017). For providers, then, screening all adopted children for additional medical and mental health services is a crucial and not uncommon occurrence.

Following the adoption placement, pediatricians in the U.S. are often the first professionals that adoptive parents consult about their children's problems, not solely for medical issues and developmental delays, but also emotional and behavioral issues and general adoption advice (Brodzinsky, 2014). Adopted children are more likely to receive mental health services (DeJong, Hodges, & Malik, 2016) and are overrepresented in both outpatient and inpatient mental health settings (Brodzinsky, 2013). Moreover, pediatricians often make referrals to mental health providers to address psychological/behavioral issues and adoption-related issues (Gleason, Goldson, & Yogman, 2016). Internationally, medical and mental health providers contribute to the provision of support services and their role to provide guidance and treatment is critical across the lifespan of an adoptee (Palacios et al., 2019).

There is a growing concern among adoptive families that many health-care professionals they work with do not fully understand their unique histories or the challenges they face, and sometimes offer unhelpful advice related to their family's adoptive status or their adopted children. According to prior research, a common challenge for adoptive parents is finding mental health providers who understand the adoption-related issues in their families (Brodzinsky, 2013). Parents often encounter therapists who ask them to educate and legitimatize the distinctive challenges faced by adopted children and as well as by adoptive parents (Riley, 2009).

In part, the negative experiences of adoptive parents may stem from inadequate training in adoption-related issues among health-care professionals. The small body of literature that exists regarding

training of medical and mental health students about adoption and foster care reports minimal, if any, related curriculum (White et al., 2006). This limited training raises questions about their understanding of the complexities and challenges faced by adopted children and their families, as well as their sensitivity in addressing adoption issues in supporting and treating these patients (Brodzinsky, 2013).

Research shows that sexual minority (SM) people regularly face discrimination and stigma by medical and mental health-care providers, including poor, limited, or even refusal of health insurance or medical care (Chapman et al., 2012; Gianino, 2008; Sabin, Riskind, & Nosek, 2015). These experiences raise the question as to whether SM parent families seeking services for their children, especially in relation to adoption, might encounter similar challenges. Indeed, prior work shows that they are vulnerable to interpersonal and systemic stigma in various contexts including adopting (Gianino, 2008), finding a school (Goldberg, Allen, Black, Frost, & Manley, 2018), and in health care (Chapman et al., 2012). SM parents who adopted their children, and who therefore differ from normative ideas about 'family' in multiple ways, may face additional and/or unique challenges with providers. Furthermore, transracial adoptive families adopted by SM parents may be particularly vulnerable. Earlier work examining health-care trainee attitudes toward transracial heterosexual and SM parent adoptive families found that gay fathers may be at the highest risk of experiencing implicit negative attitudes from the provider, which are linked with biases in behavior (Tan, Jordan-Arthur, Garofano, & Curran, 2017).

Stigma theory suggests that when individuals' social characteristics differ from what is considered the norm, they are vulnerable to bias (Goffman, 2009). Adoptive families, especially those that are transracial and/or headed by SM parents, defy what it is typically considered a traditional family and thereby may be subject to varying forms of stigma because of their multiple marginalized identities, based on racial, adoptive, and/or SM status (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Golombok, 2015). Accordingly, because experiences of stigma are associated with negative health consequences, family composition must be studied in order to understand diverse and often marginalized individuals' health experiences.

To date, relatively little data have been collected on health-care service use and service satisfaction among adoptive families, and especially whether parents believe the professionals they work with have provided useful advice and are (in the eyes of parents) adoption competent—that is, sensitive, aware, and knowledgeable about adoption and its impact on family members (Atkinson, Gonet, Freundlich, & Riley, 2013). This study aimed to address this gap by exploring the intersections of multiple identities of adoptive parents and their experiences with pediatric care and mental health care for their children. Thus, the purpose of this study was to assess adoptive parents': (1) service-seeking of pediatricians and mental health providers with issues related to adoption, (2) perceptions of satisfaction with pediatricians' adoption-related advice, and (3) perceptions of mental health providers' understanding of adoption. Based on stigma theory and previous research, we hypothesized adoptive parents with multiple marginalized identities (i.e., transracial families, SM-headed families) would be less satisfied with pediatricians' adoption-related advice and less satisfied with perceptions of mental health providers' understanding of adoption.

Materials and method

Participants and data collection

Data were drawn from the Modern Adoptive Families project, a nationwide survey of adoptive parents' beliefs and experiences related to adoption, which was conducted from 2012 to 2013

through the Donaldson Adoption Institute (see Brodzinsky, 2015 for details). An online survey was developed via Survey Monkey for adoptive parents and sent to adoption agencies and adoption attorneys, especially those agencies known to work with SM parent families. Due to oversampling of SM parent families, this sample is unique compared to previous national data sets of adoptive families. For this study, participants were excluded whose oldest adopted child was 18 or older or if the family lived outside of the U.S. Study procedures were reviewed and approved by the Institutional Review Board (IRB) of (Brodzinsky, 2015). Only one parent per family completed the survey. Refer to (Brodzinsky, 2015) for additional details about participant recruitment, the scope of the survey questions, and inclusion/exclusion criteria for participants.

Table 1 displays the demographic characteristics of the participants ($N = 1{,}419$) and their oldest adopted child. Overall, parents identified as heterosexual ($n = 1{,}109$; 82%), SM mothers ($n = 148$; 10%), and SM fathers ($n = 103$; 8%). The majority of parental respondents identified as White (87%). Most parents had at least a bachelor's degree (83%) and 57% had an annual estimated family income of US$100,000 or more. Families represented different adoption placement types, such as public (i.e., foster care; 30%), private domestic (33%), and international (37%). SM mothers and SM fathers were significantly more likely to adopt via public adoption (41% and 52%, respectively), compared to 27% of heterosexual parents, $X^2(4) = 66.09$, $p < .01$. Children adopted via public adoption were significantly more likely to have received mental health services (81%), compared to children adopted via private domestic (29%) and international adoption (47%), $X^2(2) = 232.94$, $p < .01$.

Variables

Outcome variables.

Talked with pediatrician about adoption: Participants were asked if they "talked with pediatrician about adoption" (yes/no).

Satisfied with pediatrician advice about adoption: Participants were asked if they were "satisfied with info/advice about adoption from physician" (yes/no).

Sought mental health services: Participants were asked if they had consulted with a mental health professional (yes/no).

Mental health provider understood adoption: Participants were asked if their "mental health professional understood adoption and the unique challenges faced by child/family" on a scale of 1 "Not at all" to 5 "Very well." This item was recoded into a dichotomous variable[1] with responses 1 "Not at all", 2 and 3 "Somewhat" recoded into 1 "Did not understand." Responses 4 "Well" and 5 "Very well" were recoded into "Did understand."

Predictors

Sexual orientation. Respondents' sexual orientation was identified from their answers to two questions: (a) whether they self-identified as heterosexual, lesbian, gay, bisexual, or other (e.g., queer, pansexual) and (b) whether they self-identified as an SM parent. Sixteen women who identified as bisexual, queer, or pansexual and as an SM parent were categorized as SM mothers; five women who self-identified as bisexual but not as an SM parent (i.e., they were married to a man) were classified as heterosexual for the purpose of this analysis. Although participants were grouped in this way for practical concerns and to maximize participant responses, we recognize

Table 1. Factors associated with satisfaction of pediatricians among heterosexual and SM adoptive parents ($N = 1,419$).

	Total sample ($N = 1,419$)	Talked to pediatrician about adoption ($n = 1,060$)			Satisfied with pediatrician adoption advice ($n = 1,060$)		
	N (%)	*N* (%)	OR (95% CI)	AOR (95% CI)	*N* (%)	OR (95% CI)	AOR (95% CI)
Sexual Orientation							
Heterosexual	1,109 (82%)	863 (78%)	1.00	1.00	697 (81%)	1.00	1.00
SM mothers	148 (10%)	116 (78%)	1.03 (0.68–1.56)	1.09 (0.71–1.68)	99 (86%)	1.45 (0.84–2.54)	1.55 (0.87–2.75)
SM fathers	103 (8%)	81 (79%)	1.05 (0.64–1.71)	1.15 (0.69–1.93)	74 (93%)	2.90 (1.24–6.78)**	1.37 (0.41–4.53)
Placement age group							
0–5.9	1,293 (92%)	980 (78%)	1.00	1.00	803 (82%)	1.00	1.00
6–10.9	91 (6%)	63 (73%)	0.76 (0.46–1.24)	0.53 (0.31–0.92)*	52 (83%)	1.02 (0.52–1.99)	1.81 (0.87–3.78)
11–13.9	18 (1%)	14 (78%)	0.97 (0.32–2.96)	0.64 (0.20–2.03)	12 (86%)	1.29 (0.29–5.83)	2.54 (0.52–12.46)
14–17.9	4 (<1%)	3 (75%)	0.83 (0.09–8.01)	0.52 (0.05–5.13)	3 (100%)		
Preplacement adversity							
Yes	1,038 (74%)	813 (81%)	1.84 (1.40–2.43)***	1.44 (1.02–2.03)*	648 (80%)	0.45 (0.29–0.71)***	0.64 (0.37–1.08)
No	367 (26%)	247 (70%)	1.00	1.00	222 (90%)	1.00	1.00
Preplacement special needs							
Yes	767 (55%)	613 (82%)	1.76 (1.36–2.28)***	1.53 (1.08–2.18)*	477 (78%)	0.48 (0.32–0.68)***	0.58 (0.38–0.90)**
No	639 (45%)	447 (73%)	1.00	1.00	393 (88%)	1.00	1.00
Parent covariates							
Parent gender							
Male	179 (13%)	145 (81%)	1.00		130 (90%)	1.00	1.00
Female	1,181 (87%)	915 (78%)	0.81 (0.54–1.21)		740 (81%)	0.46 (0.26–0.82)**	0.62 (0.27–1.43)
Married/partnered							
Yes	1,124 (83%)	872 (78%)	0.88 (0.62–1.25)		726 (83%)	1.49 (1.01–2.20)*	1.04 (0.66–1.62)
No	232 (17%)	185 (80%)	1.00		142 (77%)	1.00	1.00
Parent age group							
21–34 years	156 (12%)	111 (71%)	1.00	1.00	86 (77%)	1.00	1.00
35–49 years	873 (65%)	692 (79%)	1.55 (1.06–2.27)*	1.62 (1.09–2.41)*	585 (85%)	1.62 (0.99–2.65)*	1.52 (0.89–2.61)
50+ years	320 (24%)	248 (78%)	1.40 (0.90–2.16)	1.24 (0.79–1.96)	192 (78%)	1.01 (0.59–1.74)	1.35 (0.70–2.60)
Parent race							
White	1,225 (90%)	962 (79%)	1.00	1.00	785 (82%)	1.00	
Black/AA	48 (3%)	31 (65%)	0.50 (0.27–0.91)*	0.43 (0.22–0.81)**	25 (81%)	0.92 (0.37–2.29)	
Race-other	82 (6%)	64 (78%)	0.97 (0.57–1.67)	0.86 (0.50–1.51)	58 (91%)	2.14 (0.91–5.05)	

(continued)

Table 1. (continued)

	Total sample ($N = 1,419$)	Talked to pediatrician about adoption ($n = 1,060$)			Satisfied with pediatrician adoption advice ($n = 1,060$)		
	N (%)	*N* (%)	OR (95% CI)	AOR (95% CI)	*N* (%)	OR (95% CI)	AOR (95% CI)
Education							
<Bachelor's	234 (17%)	181 (77%)	1.00		140 (78%)	1.00	
Bachelor's	447 (33%)	346 (77%)	1.00 (0.69–1.46)		292 (84%)	1.52 (0.96–2.39)	
Graduate degree	675 (50%)	530 (79%)	1.07 (0.75–1.53)		436 (83%)	1.37 (0.90–2.08)	
Household income							
<50,000	132 (9%)	79 (75%)	1.00		49 (63%)	1.00	1.00
50,000–100,000	532 (35%)	355 (78%)	1.16 (0.70–1.90)		287 (81%	2.46 (1.45–4.18)***	2.32 (1.32–4.10)**
100,000–150,000	439 (29%)	308 (78%)	1.14 (0.69–1.88)		256 (84%)	3.03 (1.75–5.25)***	2.73 (1.49–5.00)**
>150,000	423 (28%)	295 (80%)	1.31 (0.79–2.19)		258 (88%)	4.24 (2.38–7.55)***	3.40 (1.76–6.56)***
Child covariates							
Child age group							
0–5.9	519 (37%)	384 (77%)	1.00		330 (86%)	1.00	1.00
6–10.9	483 (34%)	369 (79%)	1.10 (0.81–1.48)		307 (84%)	0.82 (0.55–1.23)	0.86 (0.55–1.35)
11–13.9	196 (14%)	150 (79%)	1.14 (0.76–1.72)		115 (77%)	0.54 (0.34–0.88)**	0.56 (0.32–0.98)*
14–17.9	208 (15%)	157 (77%)	1.01 (0.69–1.50)		118 (75%)	0.49 (0.31–0.77)**	0.56 (0.32–1.00)*
Child gender							
Male	709 (50%)	531 (78%)	1.00		431 (82%)	1.00	
Female	697 (50%)	529 (78%)	1.00 (0.78–1.30)		439 (83%)	1.11 (0.81–1.52)	
Child race/ethnicity							
White	448 (32%)	340 (78%)	1.00		271 (80%)	1.00	
Black/AA	261 (19%)	207 (82%)	1.30 (0.88–1.93)		169 (82%)	1.08 (0.70–1.69)	
Asian	275 (20%)	214 (80%)	1.14 (0.78–1.66)		175 (82%)	1.09 (0.70–1.70)	
Hispanic	179 (13%)	129 (75%)	0.87 (0.57–1.31)		109 (84%)	1.26 (0.74–2.17)	
Multiracial	206 (15%)	144 (73%)	0.77 (0.52–1.13)		23 (87%)	1.57 (0.91–2.74)	
Other	37 (3%)	26 (72%)	0.73 (0.34–1.58)		23 (88%)	1.87 (0.54–6.41)	

(continued)

Table 1. (continued)

	Total sample ($N = 1{,}419$)	Talked to pediatrician about adoption ($n = 1{,}060$)			Satisfied with pediatrician adoption advice ($n = 1{,}060$)		
	N (%)	*N* (%)	OR (95% CI)	AOR (95% CI)	*N* (%)	OR (95% CI)	AOR (95% CI)
Transracial placement							
No	463 (34%)	355 (77%)	1.00		288 (82%)	1.00	
Yes	910 (66%)	705 (79%)	1.11 (0.85–1.45)		582 (83%)	1.06 (0.76–1.48)	
Adoption type							
Foster care	427 (30%)	329 (80%)	1.00	1.00	264 (80%)	1.00	1.00
Private, domestic	459 (33%)	310 (70%)	0.59 (0.43–0.82)***	0.79 (0.51–1.22)	266 (86%)	1.54 (1.00–2.35)*	0.72 (0.41–1.26)
International	520 (37%)	421 (83%)	1.21 (0.86–1.68)	1.22 (0.83–1.80)	340 (81%)	1.03 (0.71–1.49)	0.86 (0.56–1.31)

Note. SM = sexual minority; OR = odds ratio; CI = confidence interval; AOR = adjusted odds ratio.
*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

that this categorization of different identities masks the heterogeneity within SM parents to a certain extent.

Preplacement adversity. Participants were asked if their child experienced one or more of eight preplacement traumas (e.g., prenatal exposure to substance, malnutrition, neglect, physical abuse, sexual abuse, multiple foster homes, orphanage life, or other trauma). This was categorized as the total trauma score at placement on a scale of 0–8. Preplacement adversity was defined as experiencing any of the trauma at the time of placement and recoded to be a dichotomized variable (yes/no).

Special needs. Participants were asked if their child had one or more special needs at the time of placement: medical or emotional or learning, or behavioral problems, developmental delays, or other special needs. This was categorized as the total special needs score at placement on a scale of 0–6. This was recoded to be a dichotomized variable if they had special needs at the time of placement (yes/no).

Placement age. This was categorized as the age the child was at the time of the adoption placement. This was recoded into child age groups (0–1.9, 2.0–5.9, 6.0–10.9, 11.0–13.9, 14.0–17.9).

Controls

Demographic characteristics. Additional demographic characteristics for parents included gender, age, race, married/partnered, educational attainment, and total household income. For children, demographics included current age,[2] race/ethnicity, and gender. Adoption type (private domestic, international, public child welfare) and transracial adoption (the child being of a different race from respondent and partner, in cases of two-parent families) were also included. Each of these demographic characteristics was included in the data analyses as covariates based on earlier research conducted among SM adoptive parent families (e.g., Farr & Patterson, 2009; Goldberg, Black, Sweeney, & Moyer, 2017). In a comprehensive review of studies that identify barriers to accessing child mental health services, demographic factors, including minority race/ethnicity, and lower Socioeconomic status (SES) was associated with decreased likelihood of initiating or continuing treatment (Young & Rabiner, 2015).

Statistical analysis

A series of logistic regression models were used to predict the odds of satisfaction with adoption-competency of pediatricians. First, bivariate logistic regression models were conducted to examine the associations between utilization of pediatrician consultation for adoption advice with each of the demographic characteristics. Demographic characteristics included transracial adoption, parent gender, marital/partner status, parent age, parent race, parent education, household income, child age, child gender, child race/ethnicity, child age at placement, child history of preplacement adversity, child special needs at time of placement, and adoption type.[3] A final model was run with all predictors and controls that were significant ($p \leq .05$) in bivariate analyses to help inform interpretation of satisfaction.

Second, bivariate logistic regression models were conducted to examine the associations between satisfaction with adoption-competency of pediatricians, parent sexual orientation, and each of the demographic characteristics. A multivariable logistic regression model was then

conducted to obtain adjusted odds ratios (AORs) in examining the associations between satisfaction with adoption-competency of pediatricians after adjustment for demographic characteristics that were significantly associated with satisfaction at $p \leq .05$ in bivariate analyses. The AORs for parent sexual orientation in the multivariable models therefore represent their effect on being satisfied, independent of demographics. These analyses, including calculating AORs, were repeated for parents' perceptions of mental health providers understanding of adoption-related issues. All analyses were conducted using Stata 14 SE (Acock, 2008).

Results

Pediatrician services

In this sample of participants, the majority of parents (78%; $n = 1{,}060$) talked with their pediatrician about adoption. Of those who talked with their pediatrician about adoption-related issues, 83% ($n = 882$) felt their pediatrician understood adoption and 82% ($n = 870$) reported they were satisfied with their pediatrician' feedback and guidance regarding adoption.

Talked with pediatrician about adoption. Adopting a child who had experienced preplacement adversity at the time of placement, adopting a child who had special needs at the time of placement, being a parent age 35–49, being a Black or African American parent, and doing a private domestic adoption were positively associated with talking with a pediatrician about adoption (Table 1).

In the adjusted multivariable model, preplacement exposure to adversity (AORs = 1.44; CI = 1.02–2.03), special needs at placement (AOR = 1.53; CI = 1.08–2.18), being a parent 35–49 (OR = 1.62; CI = 1.09–2.41), and being a Black or African American parent (OR = 0.43, CI = 0.22–0.81) remained positively associated with pediatric consultation. Adopting a child who was between 6 years and 10.9 years at the time of placement (AOR = 0.53; CI = 0.31–0.92) was positively associated with consulting a pediatrician about adoption in the fully adjusted model, but having gone through a private domestic adoption was no longer significant.

Satisfaction with pediatrician's adoption advice. Being a gay father, adopting a child who had experienced preplacement adversity, adopting a child who had special needs at the time of placement, being a female parent, being married/partnered, being between 35 years and 49 years old, having an income US$50,000 and higher, having a child age 11 and older, and having a private domestic adoption were positively associated with being satisfied with pediatrician advice regarding adoption-related issues among those participants who consulted their pediatrician (Table 1).

In the adjusted multivariable model, all covariates were retained that were significantly associated ($p \leq .05$) with being satisfied with their pediatrician's adoption-related advice in bivariate analyses. Special needs at the time of placement (AOR = 0.58; CI = 0.38–4.06), household income US$50,000–100,000 (AOR = 2.32; CI = 1.32–4.10), 100,000–150,000 (AOR = 2.73; CI = 1.49–5.00), and >US$150,000 (AOR = 3.40; CI = 1.76–6.56), and having a child ages 11–13.9 (AOR = 0.56; CI = 0.32–0.98) and 14–17.9 (AOR = 0.56; CI = 0.32–1.00) remained positively associated with satisfaction. Sexual orientation, preplacement adversity, special needs at placement, parent gender, married/partner status, parent age, and adoption type were no longer significant in the fully adjusted model.

Mental health services

Within our sample, 51% ($n = 697$) of parents sought mental health services. Yet, only 41% ($n = 225$) of those parents reported having access to an adoption-competent provider, and only half ($n = 347$; 50%) of parents who sought services felt their mental health professional understood adoption.

Sought mental health services. Bivariate logistic regression revealed that being a lesbian mother, adopting a child aged 6 or older, adopting a child who had experienced preplacement adversity, adopting a child who had special needs at the time of placement, being a parent over 50 years, being a Black or African American parent, having a college degree or graduate degree, having a household income of US$50,000 or higher, having a child aged 6 or older, having a daughter, having a private domestic adoption or international adoption, and having an Asian child or Hispanic/Latino child were positively associated with seeking mental health services (Table 2).

In the adjusted multivariable model, all covariates were retained that were significantly associated ($p \leq .05$) with seeking mental health services in bivariate analyses. Special needs at the time of placement (AOR = 1.65; CI = 1.18–2.30), being a parent over 50 years (OR = 1.79; CI = 1.01–3.17), having a child aged 6–10.9 (AOR = 5.67; CI = 3.99–8.06), 11–13.9 (AOR = 9.39; CI = 5.68–15.53), or 14–17.9 (AOR = 9.70; CI = 5.76–16.33), a daughter (AOR = 0.67; CI = 0.51–0.89), an Asian child (AOR = 0.47; CI = 0.30–0.75), and a private domestic adoption (AOR = 0.23; CI = 0.15–0.37) or international (AOR = 0.21; CI = 0.16–0.29) remained positively associated with seeking mental health services. Parent sexual orientation, placement age group, preplacement adversity, parent race, education, household income, and having a Hispanic/Latino child were no longer significant in the fully adjusted model.

Mental health provider understood adoption. These analyses were conducted on the sample of parent ($n = 697$, 51%) who had sought help from a mental health provider. Bivariate logistic regression showed being a gay father, adopting a child with special needs at placement, a parent aged 35–49, a Black or African American parent, having a college degree or graduate degree, and having a child age 14–17.9 were positively associated with endorsing that their mental health provider understood adoption (Table 2).

In the adjusted multivariable model, all covariates were retained that were significantly associated ($p \leq .05$) with being satisfied with their mental health provider's understanding of adoption in bivariate analyses. Being an SM father (AOR = 2.01; CI = 1.09–3.70), adopting a child with special needs at placement (AOR = 0.63; CI = 0.41–0.95), being a parent aged 35–49 (OR = 0.56; CI = 0.31–1.00), being a Black or African American parent (AOR = 0.34; CI = 0.15–0.75), having a college degree (AOR = 1.73; CI = 1.10–2.71) or graduate degree (AOR = 2.03; CI = 1.32–3.12), and having a child aged 14–17.9 (AOR = 0.56; CI = 0.33–0.97) remained positively associated with endorsing that their mental health provider understood adoption.

Discussion

This study examined the association between family composition and satisfaction with health-care providers among a national sample of adoptive parents. Previous research (Sabin et al., 2015; Swank & Raiz, 2010; Webster & Telingator, 2016) has addressed the health-care experiences of SM individuals and adoptive parents, but not both. This study explored the intersections of multiple identity statuses and their associations with health-care satisfaction. Being an SM father

Table 2. Factors associated with perceived adoption-competency with mental health providers among heterosexual and SM adoptive parents.

	Sought mental health services ($n = 712$)			Mental health providers' understanding of adoption ($n = 712$)		
	N (%)	OR (95% CI)	AOR (95% CI)	*N* (%)	OR (95% CI)	AOR (95% CI)
Sexual orientation						
Heterosexual	548 (49%)	1.00	1.00	264 (48%)	1.00	1.00
SM mothers	94 (64%)	1.74 (1.22–2.48)*	1.55 (0.99–2.43)	46 (49%)	1.05 (0.67–1.62)	0.95 (0.60–1.50)
SM fathers	58 (56%)	1.33 (0.88–1.99)	1.07 (0.60–1.95)	37 (65)%	1.97 (1.12–3.49)*	2.01 (1.09–3.70)*
Placement age group						
0–5.9	600 (48%)	1.00	1.00	294 (49%)	1.00	1.00
6–10.9	76 (88%)	8.25 (4.23–16.09)***	1.70 (0.79–3.64)	42 (55%)	1.28 (0.79–2.07)	1.64 (0.96–2.81)
11–13.9	17 (94%)	18.44 (2.45–139.02)**		9 (53%)	1.17 (0.44–3.07)	1.64 (0.58–4.65)
14–17.9	4 (100%)			2 (50%)	1.04 (0.14–7.41)	2.48 (0.33–18.81)
Preplacement adversity						
Yes	581 (58%)	2.82 (2.18–3.64)***	1.13 (0.78–1.64)	287 (49%)	0.91 (0.61–1.36)	1.23 (0.75–2.01)
No	116 (32%)	1.00	1.00	60 (52%)	1.00	1.00
Preplacement special needs						
Yes	492 (66%)	3.90 (3.11–4.90)***	1.65 (1.18–2.30)**	233 (47%)	0.70 (0.50–0.97)*	0.63 (0.41–0.95)*
No	205 (33%)	1.00	1.00	114 (56%)	1.00	1.00
Parent covariates						
Parent gender						
Male	102 (57%)	1.00		56 (55%)	1.00	
Female	598 (50%)	0.77 (0.56–1.05)		291 (49%)	0.77 (0.50–1.18)	
Married/partnered						
Yes	567 (50%)	0.78 (0.59–1.04)		281 (50%)	1.01 (0.69–1.47)	
No	132 (56%)	1.00		65 (50%)	1.00	
Parent age group						
21–34 years	63 (40%)	1.00	1.00	38 (61%)	1.00	1.00
35–49 years	415 (47%)	1.37 (0.97–1.93)	1.09 (0.68–1.75)	197 (48%)	0.58 (0.33–0.99)*	0.56 (0.31–1.00)*
50+ years	219 (68%)	3.24 (2.18–4.82)***	1.79 (1.01–3.17)*	111 (51%)	0.6 (0.37–1.17)	0.73 (0.38–1.40)
Parent race						
White	612 (50%)	1.00	1.00	310 (51%)	1.00	1.00
Black/AA	38 (79%)	3.84 (1.90–7.78)***	2.08 (0.82–5.22)	9 (24%)	0.30 (0.14–0.64)**	0.34 (0.15–0.75)**
Race-other	48 (59%)	1.43 (0.91–2.25)	1.23 (0.66–2.29)	27 (56%)	1.24 (0.68–2.23)	1.42 (0.76–2.66)
Education						
<Bachelor's	144 (62%)	1.00	1.00	53 (37%)	1.00	1.00
Bachelor's	221 (49%)	0.60 (0.44–0.83)*	0.88 (0.57–1.35)	109 (50%)	1.70 (1.11–2.62)**	1.73 (1.10–2.71)**
Graduate degree	334 (49%)	0.61 (0.45–0.82)***	1.05 (0.69–1.60)	184 (55%)	2.13 (1.43–3.19)***	2.03 (1.32–3.12)***

(continued)

Table 2. (continued)

	Sought mental health services ($n = 712$)			Mental health providers' understanding of adoption ($n = 712$)		
	N (%)	OR (95% CI)	AOR (95% CI)	*N* (%)	OR (95% CI)	AOR (95% CI)
Household income						
<50,000	70 (67%)	1.00	1.00	33 (47%)	1.00	
50,000–100,000	249 (54%)	0.60 (0.38–0.093)*	1.10 (0.62–1.94)	118 (48%)	1.03 (0.60–1.75)	
100,000–150,000	201 (51%)	0.51 (0.33–0.80)**	1.03 (0.57–1.84)	99 (50%)	1.10 (0.64–1.90)	
>150,000	168 (45%)	0.41 (0.26–0.64)***	0.85 (0.46–1.54)	167 (54%)	1.31 (0.75–2.30)	
Child covariates						
Child age group						
0–5.9	115 (23%)	1.00	1.00	65 (57%)	1.00	1.00
6–10.9	290 (62%)	5.47 (4.13–7.24)***	5.67 (3.99–8.06)***	140 (49%)	0.72 (0.46–1.11)	0.75 (0.47–1.19)
11–13.9	138 (73%)	9.22 (6.28–13.53)***	9.39 (5.68–15.53)***	79 (57%)	1.01 (0.61–1.67)	1.09 (0.63–1.87)
14–17.9	157 (77%)	11.63 (7.87–17.17)***	9.70 (5.76–16.33)***	63 (40%)	0.51 (0.31–0.82)**	0.56 (0.33–0.97)*
Child gender						
Male	373 (55%)	1.00	1.00	185 (50%)	1.00	
Female	327 (48%)	0.76 (0.62–0.95)**	0.67 (0.51–0.89)**	162 (50%)	1.01 (0.75–1.36)	
Child race						
White	229 (52%)	1.00	1.00	112 (49%)	1.00	
Black/AA	148 (59%)	1.30 (0.95–1.78)	1.26 (0.81–1.95)	70 (47%)	0.93 (0.61–1.41)	
Asian	102 (38%)	0.56 (0.41–0.77)***	0.47 (0.30–0.75)**	59 (58%)	1.45 (0.91–2.34)	
Hispanic	109 (63%)	1.56 (1.09–2.25)*	1.36 (0.85–2.19)	55 (51%)	1.07 (0.68–1.70)	
Multiracial	94 (47%)	0.82 (0.58–1.14)	0.94 (0.59–1.49)	45 (48%)	0.97 (0.60–1.57)	
Other	18 (50%)	0.91 (0.46–1.80)	0.60 (0.25–1.43)	6 (33%)	0.52 (0.19–1.43)	
Transracial placement						
No	237 (51%)	1.00		114 (48%)	1.00	
Yes	460 (51%)	1.00 (0.80–1.25)		233 (51%)	1.11 (0.81–1.52)	
Adoption type						
Foster care	331 (81%)	1.00	1.00	157 (47%)	1.00	
Private, domestic	128 (29%)	1.00 (0.07–0.13)***	0.23 (0.15–0.37)***	64 (51%)	1.14 (0.76–1.72)	
International	241 (47%)	0.21 (0.16–0.29)***	0.24 (0.15–0.38)***	126 (53%)	1.23 (0.89–1.72)	

Note. SM = sexual minority; OR = odds ratio; CI = confidence interval; AOR = adjusted odds ratio.
*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

was positively associated with understanding of adoption by mental health providers. While this was initially surprising because of gay fathers' reports of discrimination (Vinjamuri, 2015), it is important to consider that being an SM father is associated with household income and parent education, which helps to contextualize this finding. The multivariate results suggest that gay fatherhood was an independent predictor above and beyond income, suggesting additional factors may be contributing to their experiences. SM fathers might be the most likely to anticipate possible stigma, thus prompting them to conduct the most research before settling on a provider. These results suggest parental SES may be one driving factor in satisfaction, perhaps providing more choice in finding an inclusive provider or agency and outweighing parental sexual orientation. Similarly, in a qualitative study of adoptive parents' perceptions of inclusivity in their child's school setting, lesbian mothers reported less positive impressions of schools as compared to gay fathers, who had greater income, suggesting that resources may have been driving parental choice (and thus satisfaction) in this context as well (Goldberg et al., 2018). The lesbian mothers in this study also reported having to make more "trade-offs" in school choice than gay fathers, such as sacrificing academic rigor for racial diversity (Goldberg et al., 2018). Alternatively, SM fathers and/or parents with greater education levels may be conducting more research to find an adoption-competent provider. SM fathers may also be the most direct with providers about their family structure, or the most easily recognized as an adoptive family, prompting more instantaneous adjustment on the part of providers to treat them as such.

Parent gender was associated with pediatrician satisfaction, such that women were more satisfied with adoption-related advice. This is interesting as gender is not typically associated with health-care satisfaction (Crow et al., 2002). However, some research suggests provider satisfaction does vary by gender, with women more likely to change providers due to dissatisfaction with services (Henderson & Weisman, 2012). This finding led to additional analyses to further explore the intersections of sexual orientation, parent gender, and household income. Being an SM father and a higher household income were both positively associated with satisfaction in this sample; however, it is not clear if the association between gender, sexual orientation, and satisfaction is solely due to the financial differences. As our sample of heterosexual fathers was small ($n = 76$), a larger sample of both SM and heterosexual fathers may provide more insight. Further explorations into the narrative experiences of SM fathers are needed, especially as our findings differ from qualitative research outlining the often discriminatory experiences gay fathers experience in health care (Chapman et al., 2012; Vinjamuri, 2015) and other settings (Goldberg et al., 2017; Kinkler & Goldberg, 2011). Furthermore, this study suggests that due to the intersections of gender and income, households run by a lesbian couple or single mother, regardless of sexual orientation, may be at risk for less satisfactory services, possibly due to fewer choices in service providers or related to geographical location. Further exploration of how household income can provide access of provider choice and more information is needed to support this line of inquiry.

Age of child was associated with seeking mental health services, as well as satisfaction with mental health providers and pediatricians, highlighting how developmental stage may be salient for parents' experiences in general, which translates to their experiences with providers. Adoptive parenting issues may be more complex during adolescence, and satisfaction with providers may wane (Bañez, 2017). Indeed, some research suggests an intensification of attachment and/or behavior problems among some adopted children as they approach adolescence (Askeland et al., 2017; Bimmel, Juffer, Van IJzendoorn, & Bakermans-Kranenburg, 2003)—although adoptive parents may attribute such challenges to adolescence rather than their children's adoptive

status (Bañez, 2017). The provision of support is critical during this stage, as parents may be more likely to consult with providers during this period and be sensitive to perceived adoption insensitivity as they navigate their children's adolescence and important milestones (Paniagua, Palacios, & Jiménez-Morago, 2019). Qualitative research that addresses how parents experience health care across their child's developmental stage may offer further insight into the expectations of health-care providers. In addition, preplacement adversity and special needs prior to placement increased the likelihood of parents seeking adoption-related advice from their pediatricians and mental health providers, reiterating the need for providers to be well-versed in adoption issues (Brodzinsky, 2014). These findings reflect previous work which found parenting a child with special needs increased the likelihood for service use, including mental health services (Vandivere et al., 2007). These findings also hold implications for the field's understanding of which parents are most likely to seek services based on factors that are present at the time of placement.

Our sample of Black and African American parents was very small, and thus, these results need to be interpreted with caution. We found no differences in satisfaction or perceived provider understanding based on transracial family composition. In contrast, being a Black or African American parent, the majority of whom adopted within race was positively associated with parent perception of adoption-competency by mental health providers. While unexpected, given the historical mistreatment of Black and African American individuals, this may be due to health-care providers' awareness of racial disparities and stigma that exist within health care and their attempts to overcompensate by "over-treating [racial] minorities" (Chandra & Staiger, 2010). For example, providers may take extra care in their delivery of services when working with racial minority families. It might also be that racial minority and multiracial families are increasingly common and accepted (Parker, Morin, Horowitz, Lopez, & Rohal, 2015). There might also be regional differences that could explain this finding, which we did not explore. Our sample of Black and African American parents was very small, and thus, these results need to be interpreted with caution. Future research should explore this relationship with larger sample sizes.

Limitations

The data set contains a relatively large sample of adoptive families from across the U.S., although not necessarily representative of all adoptive or SM-headed families; the sample also includes a relatively large sample of SM families. The few participants who identified as bisexual, pansexual, or queer were reclassified as either an SM mother or father, following criteria noted previously. Although done for practical reasons, this decision could obscure differences in health-care service use and satisfaction for these individuals, as well as for transgender individuals who were not represented at all in our sample. Perspectives from adopted children and service providers would provide additional insight into the experiences of adoptive families and their relationships with providers, especially as the survey data captured only limited elements of care and some research suggests adolescents report less satisfaction with health-care services than their parents (Madan, Sharp, Newlin, Vanwoerden, & Fowler, 2016). Ideally, satisfaction variables for medical and mental health would be measured the same for ease of comparison. Additionally, parents may have consulted multiple providers, yet these measures reflect their opinions on just one identified provider. Parent reports were retrospective and experiences were not necessarily aligned with their current demographics (e.g., household income was at the time of data collection while services may have occurred several years prior). As this was a cross-sectional study, the results cannot imply causation. Further exploration of family characteristics, such as the concerning behaviors

that served as the precipitant for parents to seek out therapy, would be beneficial as parent expectations or the kind of problem that youth are displaying may play a role in parent satisfaction with treatment. Despite these limitations, this study extends our knowledge on the experiences of potential support systems and evolving family structures within adoptive families today.

Conclusions

These findings can potentially support past research that pathways to quality health care continue to differ for families, with parents' report of satisfaction with health-care services and providers varying based on family type and demographics. Moreover, because associations between sexual orientation of parents and satisfaction of services differed significantly, this may suggest to practitioners, policy-makers, and researchers that as family structures become increasingly diverse, intervention efforts should continue to focus on developing inclusive practices to reduce preventable health-care disparities, especially for parents with lower income and younger children. Leading adoption researchers recommend using clinicians who are affirming, skilled, and knowledgeable about practices related to managing homophobia, utilizing personal resilience, and developing strong family relationships as the most beneficial type of care for SM-headed families (Brodzinsky & Goldberg, 2016). Training of health-care providers on this topic should continue to help tailor interventions and services for SM-headed adoptive families. If households with lower incomes are more likely to report less satisfaction, interventions should target trainings toward health professionals more likely to serve lower income populations. Future research is needed to examine the protective strategies parents may be employing to help manage or reduce bias during their experiences with health-care services, which may be buffering the potential negative effects of discrimination experienced by SM individuals and their families.

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Notes

1. Several items were dichotomized to accommodate the varying sample sizes of parents when categorized by sexual orientation.
2. Unfortunately, the sample with adolescents 14–17.9 years was quite small ($n = 4$).
3. Transracial adoption was originally included as a predictor variable but was dropped due to insignificance.

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