Published in final edited form as:

Eat Disord. 2019 ; 27(2): 205–229. doi:10.1080/10640266.2019.1586219.

Family Involvement in Eating Disorder Treatment among Latinas

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Abstract

Latinos are less likely to seek health care for eating disorders and more likely to drop out of treatment than members of other ethnic groups, highlighting existing challenges to engagement in traditional mental health care. This study explored the role of family in the treatment of adult Latinas with eating disorders through content analysis of family sessions adjunctive to cognitive behavioral therapy. This study yielded insight into the experiences of 10 Latinas with eating disorders (*M* age = 39.90 years) and 10 relatives (*M* age = 39.50) from the Promoviendo una Alimentación Saludable trial who were randomly selected to receive six family enhancement sessions. Data from 53 sessions were analyzed using a qualitative content analysis approach. Family intervention might serve as a valuable adjunct to conventional treatment by positively influencing social, family, and emotional support for Latinas with eating disorders.

Keywords

Latino families; eating disorders; bulimia nervosa; binge eating disorder; treatment engagement

Although familism represents the importance of family in Latino culture, the integration of a family member in eating disorder (ED) treatment is a novel approach for many patients—especially because Latinas with EDs tend to live in isolation due to shame, stigma, and fear of not being understood (Reyes-Rodríguez, Ramírez, Davis, Patrice, & Bulik, 2013). Familism is a multidimensional core Latino cultural value that features family support,

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loyalty, obligation to family, interdependence, and pride in family sacrifice and cohesiveness (Lugo Steidel & Contreras, 2003; Nolle, Gulbas, Kuhlberg, & Zayas, 2012). Despite theoretical and clinical models highlighting the advantages of family engagement in ED treatment, the literature regarding how best to incorporate family into treatment for EDs for Latinos is sparse (Perez, Ohrt, & Hoek, 2016).

Although prevalence estimates suggested that bulimia nervosa (BN) and binge-eating disorder (BED) are at least as common and anorexia nervosa (AN) is less common in Latinos than non-Latinos (Kolar, Rodriguez, Chams, & Hoek, 2016; Perez et al., 2016), Latinos in the United States experience barriers to treatment and underuse ED health care compared with European Americans (Cachelin & Striegel-Moore, 2006). The PI research program has aimed to expand the evidence base with respect to understanding the needs of Latinos and their families in ED health care (Guadalupe-Rodríguez, Reyes-Rodríguez, & Bulik, 2011; Reyes-Rodríguez & Bulik, 2010; Reyes-Rodríguez, Ramírez et al., 2013). Qualitative research identified family support and involvement in treatment as putatively helpful factors (Guadalupe-Rodríguez et al., 2011; Reyes-Rodríguez, Ramírez et al., 2013) and together with case studies (Reyes-Rodríguez, Baucom, & Bulik, 2014) suggested that culturally sensitive treatments that incorporate the Latino cultural value of familism have the potential to engage patients in treatment and yield better outcomes. A more nuanced understanding of how therapists can provide culturally sensitive ED treatment to Latinos and their family is needed. The rationale for including the Latino family in treatment is based on: (a) the previous experience adapting cognitive behavioral therapy (CBT) for BN in Puerto Rico, in which 95% of participants were adults and more than six sessions were devoted to addressing family issues (Reyes, Rosselló, & Matos, 2006); (b) the importance of Latino cultural family values such as familism (La Roche, 2002); (c) ED intervention research is increasingly focused on developmentally appropriate approaches to incorporating family members into treatment (Dimitropoulos et al., 2015; Kirby, Runfola, Fischer, Baucom, & Bulik, 2015; Pisetsky, Utzinger, & Peterson, 2016); and (d) experience in treatment of adults with other serious mental disorders, such as schizophrenia and depression, in which family involvement is essential to providing emotional support to the patient (Barrio & Yamada, 2010; Hernandez & Barrio, 2015; Markowitz et al., 2009; Ramírez García, Chang, Young, López, & Jenkins, 2006). Therefore, this study explored the role of family in the treatment of adult Latinas with EDs via analysis of the content of family sessions as an adjunct to CBT.

Methods

Participants

Ten Latina adult patients and 10 relatives from the Promoviendo una Alimentación Saludable [Promoting a Healthy Eating Pattern] project (Reyes-Rodríguez, Bulik, Hamer, & Baucom, 2013) who were randomized to CBT for BN (Fairburn & Wilson, 1993) and a family enhancement intervention comprised the sample in the current study. The mean age at baseline was 39.90 (SD = 6.51) for patients and 39.50 (SD = 7.21) for relatives. Of the relatives included in the treatment, 80% (n = 8) were partners or spouses and 20% were other relatives such as sisters or cousins. Sixty percent of the patients had children.

The ED profile of patients was 70% (n = 7) with purging-type BN, 20% (n = 2) with BED, and 10% (n = 1) with subthreshold BN (i.e., ED not otherwise specified) according to the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychological Association, 2000) and measured using the Eating Disorder Examination Spanish Version, which has been adapted for use with Latinas (Grilo, Lozano, & Elder, 2005).

Materials and Procedure

The Institutional Review Board of a Southeast University of the United States approved the study. The data were collected between March 2013 and September 2015. A full description of Promoviendo una Alimentación Saludable methods is presented elsewhere (Reyes-Rodríguez, Bulik et al., 2013).

Intervention

The current study focused only on the content of the family sessions; patients received 19 individual CBT for BN sessions and six family sessions. The content of the family sessions included psychoeducation about EDs and their treatment, information about how to deal with a family member with EDs, and strategies to reduce caregiver burden (Reyes-Rodríguez, Bulik et al., 2013). The content was adapted depending on the family member involved. For spouses and partners, sessions focused on general couple functioning including communication, sharing thoughts and feelings, and problem solving as well as ED-specific topics such as eating together, body image, and intimacy, as adapted from a model for couples in the treatment of AN (Bulik, Baucom, Kirby, & Pisetsky, 2011). Other topics for extended family included family communication, reduction of conflict and coercive family interactions, establishing healthy boundaries among family members, building trust in relationships and supporting autonomy, recognizing family patterns that can exacerbate EDs (i.e., emphasizing dieting, body image, disturbed eating behaviors), problem-solving skills, and supportive positive conflict resolution methods (Reyes-Rodríguez, Bulik et al., 2013).

In the current study, data from 53 of 60 family sessions were included in the qualitative analysis. Eight dyads of patient and relative completed the six planned family sessions and two dyads completed either two or three of the six planned family sessions. Eighty-nine percent of the sessions were conducted by a clinical psychologist (the study's principal investigator [PI]) and 11% by a licensed clinical social worker from a community mental health clinic who was trained and supervised by the PI. Most sessions (89%) were conducted in Spanish and 11% in *Spanglish*, a hybrid of Spanish and English speech, as preferred by more acculturated participants.

Coding and Analysis

Qualitative content analysis was used to explore the topics discussed in the family therapy sessions (Drisko & Maschi, 2015). Three specific steps were taken during this systematic approach. First, all audiotaped sessions were reviewed by either one of two bilingual research assistants with a psychology background or the PI, and written notes were taken to identify the topics discussed. The audio-recorded sessions were not transcribed verbatim

considering the fact that this does not guarantee that analysis and coding would be better than alternative methods (e.g., listening and debriefing sessions; Halcomb & Davidson, 2006). To reduce bias and increase overall validity, the research assistants received initial training from the PI, who supervised the analysis of audiotapes chosen at random until note-taking and recording of topics discussed reached sophistication. Second, topics were organized into coding categories (i.e., communication problems, psychoeducation regarding EDs, intimacy problems). The content analysis used a mix of a priori codes based on the family guideline (i.e., therapist session-by-session outline) and inductively generated codes that the a priori codes did not adequately cover (Drisko & Maschi, 2015). Third, a consensus among the three independent coders was performed to validate the categories. Reaching ex post facto consensus is a quality control technique to increase reliability. Reliability facilitates consistency of different coders' personal understanding of phenomena and improves replicability (Krippendorff, 2012). Last, the coders recorded the frequency of each category across the dyads.

Results

Demographics

Most participants were first-generation immigrants from Mexico (60% of patients, 50% of relatives), followed by U.S.-born individuals (20% of patients, 20% of relatives) and those from other Latin American countries (e.g., Bolivia, Colombia; 20% of patients, 30% of relatives). Our sample was representative of the Latino population in North Carolina, of which 65% is of Mexican origin, followed by 25% from Central or South America (Brown & Hugo Lopez, 2013). Duration of residence in the United States ranged from 5 to 40 years ($M = 17$, $SD = 12$). Forty percent ($n = 4$) of patients had a job, 30% ($n = 3$) were stay-at-home mothers, and 30% ($n = 3$) were unemployed.

Topics Discussed in Family Sessions

The content analysis showed that 13 topics in the original family guideline and eight newly introduced topics that were not part of the original guideline were discussed across the family sessions. The planned guideline topics were: (a) introduction to family sessions, (b) psychoeducation about EDs, (c) communication problems, (d) problem-solving skills, (e) sharing thoughts and feelings, (f) body image and self-esteem, (g) family support, (h) parenting skills, (i) realistic expectation about weight loss, (j) decision-making process, (k) background history as a couple, (l) lack of understanding of EDs from family members, and (m) intimacy problems. Topics not contained in the family guideline but newly introduced by patient–relative dyads were: (a) establishing priorities in life, (b) partner emotional struggles, (c) marital mistrust issues, (d) extended family or friend involvement, (e) language barriers, (f) economic stress, (g) immigration and acculturation issues, and (h) patients' medical problems. The planned therapeutic content of the family sessions was informed by existing family intervention ideas and models, including couple-based treatment for adults with EDs (Bulik, Baucom, & Kirby, 2012; Bulik et al., 2011), carer skills-based training, and family psychoeducation (Hagenah, 2005), in addition to our previous work with Latinos with EDs (Guadalupe-Rodríguez et al., 2011; Reyes, Rosselló, & Calaf, 2005; Reyes-

Rodríguez, Ramirez et al., 2013; Reyes-Rodríguez, Baucom, & Bulik, 2014). Appendix A includes excerpts from the content analysis of the family sessions.

Planned topics.—Psychoeducation about EDs and introduction to family sessions were the main topics discussed during the first session by the 10 dyads. Another planned topic discussed by all dyads was communication problems. The specific communication issues discussed were lack of communication or making wrong assumptions due to the lack of or ineffective communication. A patient shared with her husband one of their communication issues: "*Yo te hablo y en vez de tu contestarme … tú hablas de otras cosas … es un problema, eso me hace sentir que no me estas escuchando* [I speak to you and instead of answering … you talk about other things … it's a problem, that makes me feel like you're not listening to me]" (Participant 04-05; female, early forties).

Problem-solving skills and sharing thoughts and feelings were topics addressed by nine of the 10 dyads. Body image and self-esteem (i.e., self-care, shame, embarrassment, and weight-related comments) was discussed by eight of the 10 dyads, primarily the couple or partner dyads. A patient (Participant 04-04; female, late forties) mentioned that her partner listed weight loss as a condition for their marriage. In response, her partner said: "*Yo le dije en broma, ¿Quieres casarte? Pues adelgaza. … Pero también lo hice con esa finalidad para que ella hiciera algo por su peso.* [I joked, Do you want to get married? Then get slimmer. … But I also did it for that purpose so that she would do something about her weight]" (Participant 04-04B; male, on his midlife). He also recognized her body shame due to her overweight status: "*Se esconde para cambiarse, se mete al baño y allá se cambia, cuando hemos tenido relaciones es muy, pues de mantener tapado su abdomen.* [She hides when getting dressed, gets into the bathroom and then changes clothes, when we have intimacy, she tends to keep her abdomen covered]."

The need for family support for overcoming EDs was an issue discussed by seven dyads. Specific forms of family support requested by patients included flexibility of mealtime, avoiding ED trigger comments, eating together, avoiding junk food, appointment reminders, doing workout routines together, and providing positive feedback. A patient responded to the therapist's question about what kind of support she needs from her partner: "*Las comidas chatarras que compramos, ya no estarían ahí; las salidas a restaurantes que son muy frecuentes los fines de semana* [the junk foods we buy, they would not be there; going out to restaurants, which are very frequent on weekends]" (Participant 04-13; female, mid-thirties). Other planned topics that were discussed by six or fewer dyads were: parenting skills, realistic expectations about weight loss, decision-making process, lack of understanding of EDs by family member, intimacy problems, and background history as a couple. One of the patients mentioned how intimacy problems with her husband affected her self-esteem and triggered binge-eating behaviors. She mentioned: "*Como he sido rechazada tantos años, era muy doloroso y estar sobrepeso era aliviar un poquito porque yo misma no me sentía cómoda con mi cuerpo* [Because I've been rejected for so many years, it was very painful and being overweight was a little bit of a relief because I did not feel comfortable with my body myself]" (Participant 04-23; female, mid-thirties). Her binge-eating behavior was a way to gain weight and feel disgusted and unattractive, thus lessening the pain of being rejected by her husband.

Newly introduced topics.—Eight new topics that were not part of the original guideline emerged in the family sessions. In six dyads, topics such as establishing priorities, partners' emotional struggles, and mistrust issues in the couple's relationship were addressed. The partner of one of the patients shared how economic stress affected his mood and therefore the family dynamic: "*Estoy en un lapso de mi trabajo que espero que en cualquier momento puedan decir hasta aquí; no puedo dormir, tengo pesadillas* [I am in a period of my work life that I expect that at any moment they can say it's over; I can't sleep, I have nightmares]" (Participant 04-04B; male, midlife). Issues related to extended family or friend over involvement were discussed by five dyads. Generally, Latino family culture emphasizes extended and interdependent family and social networks, whereas American culture promotes a nuclear family structure. These contrasting cultural orientations created tension among family members with different levels of acculturation to American culture (Berry, 2005; Katiria Perez & Cruess, 2014). Language barriers associated with being an interracial couple or having different levels of acculturation among parents or partners and children (see quotes 5.1–5.3 in the Appendix) and economic stress were discussed by four dyads. Other newly introduced topics discussed in family sessions included immigration, acculturation, and patients' medical issues. A patient described how different levels of acculturation have affected her relationship even though the dyad shares the same country of origin. "*Él siempre me ha pedido su privacidad, su espacio, su tiempo… como Latina no estoy acostumbrada a eso de que espacio personal, que le gusta estar solo, ¡está loco!* [He has always asked me for his privacy, his space, his time … as a Latina I am not accustomed to the personal space, to the fact that he likes to be alone, he is crazy!]" (Participant 04-23; female, mid-thirties). Although migratory status was not assessed as part of the study information due to the sensitivity of this issue, some patients shared their migratory background, especially when it contributed to family tension. One partner said: "*Nosotros estamos de forma ilegal en este país. … Lamentablemente la situación migratoria está muy difícil* [We are illegally in this country… unfortunately the immigration situation is very difficult]" (Participant 04–04B; male, midlife).

Discussion

The present study explored the role of family in the treatment of 10 adult Latinas with EDs and an identified key family member using content analysis of family sessions delivered adjunctive to CBT. Our qualitative findings represent rich cultural information related to planned and unplanned topics and themes. Overall, we identified many benefits of family involvement in the treatment of ED. First, patients addressed stigma and shame by breaking their silence and sharing with a relative their struggles with ED, an important first step in the recovery process in a family structure that values closeness and centrality of the family. For several patients, this was the first time they disclosed their ED and openly described the lack of understanding of EDs among family members, thereby highlighting unmet needs for support and understanding. Second, several patients reported that having a family member involved in their treatment helped them with treatment retention. Support came in the form of reminders about their appointments or motivation throughout the treatment process by pointing out positive changes due to treatment. A patient (Participant 04–10; female, late thirties) mentioned that positive feedback from her husband was critical to her retention in

treatment: "*Al principio yo si quería tirar la toalla. Yo decía, ya no voy a ir y mi esposo me decía, tienes cita, no te olvides de tu cita, te vas, te está ayudando* [At first I wanted to throw in the towel. I said, I will not go and my husband was telling me, you have an appointment, do not forget your appointment, you have to go, it is helping you]." Third, receiving support from family facilitated positive changes in terms of recommended eating patterns. Some eating pattern changes required the commitment of the partner or other family members to promote more sustainable changes; during nutritional sessions, the development of a meal plan for the whole family enhanced adherence to healthy eating patterns (Reyes-Rodríguez et al., 2016). Fourth, the family sessions provided an opportunity for patients to share specific triggers of their ED behaviors in the context of family interactions (i.e., weight-related comments, eating together, and interpersonal conflict) and collaboratively brainstorm ways to create an environment conducive to recovery and improved family functioning.

Several insights into the role of family emerged from our findings that can be underscored in future work related to treatment enhancement, development, and research on EDs with Latinos. Latino patients have reported that they are more likely to stay in treatment if experiencing social support from at least one family member or friend (Guadalupe-Rodríguez et al., 2011; Reyes-Rodríguez, Ramirez et al., 2013). Further, individuals who have recovered from EDs generally describe supportive relationships as crucial to their recovery (Linville, Brown, Sturm, & McDougal, 2012). Notably, the need for family support to overcome an ED was noted in most family sessions. Relatives' distress (i.e., not being able to manage ED symptoms, relationship conflict with the patient, burden) evoked high expressed emotion, which has been theorized to trigger a cycle that worsens the patient's ED symptoms (Goddard et al., 2011). In the current study, we identified several opportunities wherein family interventions could help patients and families cope with and reduce interpersonal stressors. For example, increasing relationship skills such as communication, problem solving, decision making, teamwork as partners or relatives, empathy and understanding of each other's perspectives, and finding ways to support each other better were some topics addressed in family sessions.

Several treatment challenges arose in the delivery of the family intervention. We experienced difficulty coordinating some appointments with relatives due to work schedules, and some family issues were deeper than expected (e.g., a relative's emotional distress, marital conflicts) that were not possible to address during six family sessions designed primarily to support the patient with ED. It is also important to carefully identify with the patient which family member could be a good source of support, especially if there is any potential history of an abusive relationship (Reyes-Rodríguez, Ramirez et al., 2013).

Conclusions

Incorporating a culturally relevant and sensitive approach to care is likely to improve treatment engagement and health outcomes for Latino patients with EDs. Family intervention might serve as a valuable reinforcement for core treatment components of social support for the patient with the ED, amelioration of stressors in family relationships, and building of family resilience to stress associated with acculturation and minority status. Our findings indicate that planned inclusion of key family members could have positive

implications for sustained treatment engagement. Further research is needed to build on these findings and increase knowledge of the benefit of integrating a family component in treatment of Latina adults with EDs and thereby identify mechanisms through which family participation may influence treatment outcome.

Acknowledgments

This research was supported by a National Institute of Mental Health grant (K-23-MH087954) to the first author at the University of North Carolina at Chapel Hill. The institute had no further role in study design; in collection; analysis, and interpretation of data; in the writing of the report; and in the decision to submit the paper for publication. We express our gratitude to all participants in this research. Dr. Bulik has served on advisory boards for Shire and acknowledges funding from the Swedish Research Council (VR Dnr: 538-2013-8864).

Appendix A.: Categories and excerpts from family sessions with Latina adults with eating disorders and family members

Category	Description	Frequency across dyads	ID/Source	Representative Quotes
Planned topics				
1.Introduction to family sessions	Discussion of aims, goals and potential topics of interest for family sessions	10	Therapist	N/A
2.Psychoeducation about EDs	Definition and ED symptoms, etiology factors, treatment process, & prevalence across diverse groups	10	Therapist	N/A
3.Communication problems	Lack of or ineffective communication and making wrong assumptions	10	04-05; female, patient, early-40's 04-04; male, partner, midlife	**3.1** Included in Results **3.2** Included in Results
4.Problem solving skills	Discussion about identifying the problem and potential solutions	9	04-04; female, patient, late-40's	**4.1** *"…hay una situación, que hay que resolver y es una cuestión económica,… yo no sabía que él necesitaba una herramienta para poder ir a su trabajo…"* […there is a situation that needs to be resolved and it is an economic issue… I didn't know that he needed a tool to go to work…]
5.Sharing thoughts and feelings	Learning how to express their thoughts and feelings, not attacking each other, recognizing their emotions, identifying the best moment to	9	04-04; female, patient, late-40-s 04–13; male, partner, early-40's	**5.1** *"Me gustaría que valorara más lo que yo hago… cómo me siento yo como mujer, no me da el valor que yo siento que merezco…"* [I would like you to value more what I do… how I feel as a woman? It does not give me the

Category	Description	Frequency across dyads	ID/Source	Representative Quotes
	express their feelings, and being respectful of each other			worthiness that I feel I deserve …] **5.2** *"Lo que le falta a ella (que sea cariñosa), pues quién no quisiera un beso y un abrazo, yo voy a veces y la abrazo y me dice, ya quítate y se siente uno mal…"* [What she lacks (be affectionate), because who does not want a kiss and a hug? I go sometimes and hug her and she says to me, take off out of me and I feel bad …
6.Body image/self-esteem	Self-care issues, shame, embarrassment, weight-related comments	8	04-04; male, partner, early-50's	**6.1** Included in Results
7.Family support	Eating pattern, flexibility of mealtime, avoidance of trigger comments, avoiding junk food, dinning out, eating together, doing work out together, appointment reminders, positive feedback.	7	04-13; female, patient, mid-30's 04-10; female, patient, late-30's	**7.1** Included in Results **7.2** Included in Discussion
8.Parenting skills	Team work as parents, discipline, school issues, boundaries & attachment, responsibilities, quality time.	6	04-04; female, patient, late-40's 04-17; male, partner, late-30's	**8.1** *"…a mí no me gusta hablarle fuerte ni gritarle (a la hija) porque eso la sube y él (padre) si le grita para que se calme y yo veo que por ahí no es…"* […] don't to speak loudly to her or to scream to her (to the daughter) because that raises her up but he (father) yes, he shouts to calm her down and I see that is not the correct way …] **8.2** "…*el niño (hijo 3 años) se queda con nosotros (en la cama) y no nos deja estar juntos (sexualmente) y eso es lo que también ella me dice, que por qué no estamos juntos, pero el niño está ahí*…"[The child (3 y/o son) stays with us (in bed) and doesn't let us be together (sexually) and that is what she also asks me, why we are not together, but the child is there]

Category	Description	Frequency across dyads	ID/Source	Representative Quotes
9.Realistic expectation about weight loss	Frustration of not losing weight fast enough based on their effort, psychoeducation of body function, identifying positive changes not related to their weight, reminder of treatment goal of promoting healthy eating patterns instead of weight loss program.	6	04-13; female, patient, early-30's 04-13; male, partner, early-40's	**9.1** "*Lo que a mí me gusta es conseguir las cosas por las que estoy trabajando (bajar de peso)* …" [What I like is to get the things I'm working for (lose weight) …] **9.2** *"Ella comenzó (tratamiento) en talla 18 y ya se puso una ropa talla 14… y tiene otros más chiquitos que si le sigues echando más ganas, lo vas a poder usar…"* [She started (treatment) in size 18 and already put on a pants size 14… she has other smaller sizes that if she continues putting an effort, she would be able to fit on it…]
10.Decision making process	Associated with life decision about moving out of country, daily routine decisions.	6	04-08; female, patient, early-30's	**10.1** *"Yo le dije a él que si nos casamos podemos tener un hijo, porque si estamos así (conviviendo), igual un papel no puede asegurar nada, pero…"* [told him that if we get married we can have a child, because if we are like that (living together), a piece of paper can't guarantee anything, but …]
11.Background history as a couple	The history context as a couple (e.g., where and how they met)	5		Patients and partners provided information about how they met.
12.Lack of understanding of EDs from family members,	Lack of recognition of patients' effort, lack of understanding of personal struggles of patient with ED.	5	04-05; male, partner, late-30's 04-13; male, partner, early-40's	**12.1** *"Ella es muy débil con la comida… yo creo que ella lo puede hacer, le falta decisión, tiene que programarse mentalmente…"* [She is very weak with food … I think she can do it, it is a lack of decision, she has to program her mind …] **12.2** *"Lo que yo le digo a ella es deja de comer, ya comiste suficiente, para que ella siga comiendo más…"* [What I tell her is, stop eating, you've eaten enough to continue eating more …"]
13.Intimacy problems	Lack of intimacy, shame of body, gender differences on sexuality.	5	4-23; female, patients, mid-30's	**13.1** Included in Results
Newly introduced topics				

Category	Description	Frequency across dyads	ID/Source	Representative Quotes
1.Establishing priorities in life	Differences about their priorities (e.g., cleaning vs having more time with family)	6	04-13; female, patient, early-30's	**1.1** *"Nos falta hablar más, sobre todo a mí porque a veces estoy muy ocupada, hacienda todo en la casa… y cuando él llega y quiere platicarme yo estoy haciendo lo último todavía"* [We need to talk more, especially me because sometimes I'm very busy, doing everything in the house…and when he comes and wants to talk to me I'm still doing the last thing]
2. Partner emotional struggles	Partner presenting with depression, anxiety, alcoholism, and trauma experiences.	6	04-04;male, partner, early-50's 04-23; male, partner early-30's	**2.1** Included in Results **2.2** *"no sé cuál es mi problema…estrés del trabajo, estrés de tener a los papás (en la casa), combinación de todo… también puedo pensar que es una depresión…"* [I don't know what my problem is … work stress, stress of having the parents (in the house), combination of everything … I can also think that it's a depression …]
3. Marital mistrust issues	Mistrust issues due to past experiences with others or current partner, infidelities, lies, or inappropriate comment toward step-daughter.	6	04-17;female, patient, early-30's 04-13; female, patient, early-40's	**3.1** *"…hizo un comentario que me saco de mi centro, (él dijo) pues va a ser afortunado el que se case con (nombre de la hija de la paciente). Para mí no me gustó ese comentario, ¿tú has escuchado lo que has dicho?…"* […] he made a comment that shook me to the core, (he said) would be lucky the person who will marry (name of the daughter of the patient). I didn't like that comment, did you hear what you said?] **3.2** *"…todavía me sigue checando el teléfono, cuando le digo estoy haciendo esto, no me cree y eso como que me frustra y me hace explotar muy rápido…"* […] he still keeps checking the phone, when I tell him I'm doing this, he does not believe me and it frustrates me and makes me explode very fast …]
4. Extended family/friends involvement	Conflicts related with over-	5	04-05; female, patient, early-40's	**4.1** *"Yo le dije a él que si él decide que es allá*

Category	Description	Frequency across dyads	ID/Source	Representative Quotes
	involvement of extended family in the family of insertion, different experiences with family of origin.		04-23; female, patient, mid -30's	*(su país de origen) que él quiere estar, yo lo apoyo pero que si podemos conseguir algo (vivienda) cerca de su familia, no dentro de su familia…"* [I told him that if he decides it's there (his home country) that he wants to be, I support him but only if we can get something (housing) near his family, not living with his family …] **4.2** Included in Results
5.Language barriers	Limitation helping children with homework, disadvantage in the communication due to different language of partner, different level of proficiency of Spanish due to different level of education.	4	04-08; female, patient, early-30's 04-08; male, partner, mid-40's 04-05; female, patient, early-40's	**5.1** *"…yo lo entiendo (inglés) muy bien, pero no lo puedo hablar."* [I can understand (English) pretty well, but I can't speak English] **5.2** *"…she talks too fast (Spanish) for me. When she says something, she wants to turn around and explain it to me but I figure it out by myself…"* **5.3** *"…el tono que yo hablo el inglés no se traduce al español y él lo toma por mal…"* […the tone that I use in English doesn't translate well into Spanish and he misinterprets it …]
6.Economic stress	Stress associated with job instability, problems finding jobs due to migratory status, difficulties with budget priorities or disagreements about supporting economically extended family members.	4	04-04; male, partner, early-50's	**6.1** Included in Results
7. immigration/acculturation issues	Migratory status, deportation issues	3	04-23; female, patient, mid-30's 04-04; male, partner, early-50's	**7.1** Included in Results **7.2** Included in Results
8.Patients's medical problems	Patient struggling with additional medical conditions.	3	04-16;female, patient, early-50's	**8.1** *"Hoy amanecí con un dolor en el corazón…hoy cada vez que me agachaba me dolía más…"* [Today I woke up with a pain in my chest … today every time I crouched it hurts more …]

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