

Accepted Manuscript

British Journal of General Practice

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DOI: <https://doi.org/10.3399/BJGP.2024.0386>

To access the most recent version of this article, please click the DOI URL in the line above.

Received 27 June 2024

Revised 25 October 2024

Accepted 04 November 2024

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Author Accepted Manuscript

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Title:

The social determinants of distress in South Asian men with long-term conditions: a qualitative study

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Abstract**Background:**

People with long-term physical conditions are more likely to experience distress, depression or anxiety. Physical-mental comorbidity is associated with lower quality of life, poorer clinical outcomes, and increased mortality than physical conditions alone. South Asians (SAs) are the largest minority group in the UK, and more likely to have long-term conditions (LTCs) such as diabetes and heart disease.

Aim:

To explore how men of SA origin with LTCs understand and experience emotional distress as well as the experiences of GPs supporting them.

Design and setting:

UK qualitative study interviewing SA men with diabetes or coronary heart disease, and GPs working at practices with higher proportions of SAs.

Method:

Online semi-structured interviews with SA men and GPs. Data were analysed via reflexive thematic analysis. Topic guides were modified iteratively as data collection and analysis progressed. An ethnically appropriate patient advisory group of SA men was involved in all stages of the research.

Results:

Seventeen SA men with LTCs and 18 GPs were interviewed. Participants described contextualising distress including LTC influencing distress, and the intersections of social determinants of distress including ethnicity, poverty and perceptions of prejudice. Participants understood distress as different to depression with the need to negotiate multiple identities as well as integrative paradigms of health.

Conclusion:

This study highlights the influence of social determinants of distress in SA men with LTCs. It provides an insight into how primary care has the potential to address health inequalities by considering the intersection of these factors.

Keywords (up to 6, should be MeSH headings)

General Practice; Mental Health; Distress; Health Inequality; Long-term conditions; Qualitative methods.

How this fits in (max 4 short sentences)

Summarise, in no more than four short sentences, what was previously known or believed on the topic and what your research adds, particularly focusing on the relevance to clinicians.

Little is known about the understanding and experiences of emotional distress among SA men with LTCs. This research explores important social factors that shape experiences of distress within this population, such as, experience ethnicity, poverty and perceptions of prejudice within healthcare. This paper highlights the importance of the social determinants of distress in SA men with LTCs and how they can be considered in the primary care consultation.

Accepted Manuscript—BJGP—BJGP.2024.0326

Main text

Introduction

People with long-term physical conditions (LTCs) are more likely to develop mental health problems such as depression and anxiety. (1-3) People with physical-mental multimorbidity have poorer outcomes for quality of life and mortality outcomes. (4-6) Deprivation is much more common in some ethnic minority communities in the UK; the highest rates of poverty are in people of Bangladeshi and Pakistani ethnicity of 50% and 46% respectively, in comparison with 20% of people of White ethnicity. (7) People from more deprived areas develop multiple LTCs 10-15 years earlier than people from affluent areas, in particular physical-mental comorbidity. (8)

People from ethnic minorities in the UK are under-represented in research, which may make health research less generalisable to this patient group and, inadvertently, maintain and/or widen health inequalities. (9-11) People from ethnic minority groups may not recognise mental health problems yet have a higher prevalence of mental health problems, are less likely to seek help from services, and face discrimination as well as treatment inequalities such as being more likely to be prescribed antidepressants and not referred for 'talking therapies.' (12-14) Stigma related to cultural understandings of health can be a barrier to seeking help and add complexity to consultations. (15,16) Cultural trauma, whereby an oppressive dominant group assaults another group's culture, is a neglected but potential contributor towards health inequalities by reducing access to healthcare services. (17)

South Asians (SAs), who are people of origin of India, Pakistan, Bangladesh, Afghanistan, Sri Lanka, Maldives, Nepal, Bhutan, Indian Ocean Islands, are the largest minority group in the UK. (18) Perspectives within South Asia of health and wellbeing incorporate physical, mental and spiritual dimensions of health, emphasising traditional practices as well as family and community well-being. (19) SAs are more likely to have LTCs such as diabetes (20) and heart disease. (21) Diabetes and heart disease can be considered as exemplars (typical examples) of LTCs which share multiple similarities in terms of risk factors, symptoms, disease progress and lifestyle changes, and have been described to have a '*common soil*.' (22)

Emotional distress includes upset and negative emotions which do not fit diagnostic criteria for mental illness. (23) This term may be more acceptable to SAs with LTCs who use non-medical terminology to describe emotional crises as opposed to mental health diagnoses such as anxiety and depression. (15) Numerous studies have explored mental health of SA women, (24-30) however, a gap in knowledge exists to inform our understanding of experiences of distress among SA men with LTCs and the provision of care in general practice.

The qualitative study presented here asked: *How do men of SA origin LTCs understand and experience emotional distress? What are the experiences of GPs supporting men of SA origin presenting with distress?*

Methods

Qualitative methods using semi-structured interviews to explore perspectives and understandings through the interpretation of experiences of men of SA origin and GPs informed by critical realism. (31)

Setting and participants

The study took place in three regions of England. Men of SA origin aged 18 years or older with self-reported diabetes and/or coronary heart disease and GPs working in a general practice with a higher density of SA patients, either as a partner or salaried doctor.

Sampling and Recruitment

Sampling of SA men with LTCs was purposive to support diversity. Recruitment took place via community channels, such as, community and faith centres and shops frequented by SA communities, social media (Twitter/X^R, Facebook^R), and local radio.

General practices from catchment areas with higher SA population densities of SAs in Staffordshire, Manchester and Lancashire were identified using the Public Health England's SHAPE atlas tool. (32) Practice managers were emailed and asked to distribute study

information to GPs within their practice. This information included a research poster and participant information leaflet explaining the purpose of the study.

Snowball sampling, (33) in which participants were asked to encourage other potentially eligible participants who may be willing to be interviewed, was used as a supplementary means to distribute information to SA men and GPs.

Participant information leaflets and consent packs were sent via email to potential participants, prior to interview. Individuals who agreed to participate were invited to respond by telephone or email to arrange an interview.

Data collection

One author (a male academic GP of SA background trained in qualitative research methods) conducted all interviews between November 2020 and October 2021. Interviews were conducted in English, although participants sometimes used terms from their native languages, which were understood by the interviewer.

Semi-structured interviews took place online and were one-to-one (interviewer: participant). Separate topic guides, one for SA men with LTCs and one for GPs, were developed from the literature and in discussion with the research team and patient advisory group. Topic guides were iteratively revised as informed by concurrent analysis.

Interviews were digitally recorded with consent, transcribed verbatim by a transcription company, and anonymised.

Data collection stopped after inductive data saturation was achieved, when the team was confident that the themes were sufficiently well-established and coherent. (34) Reporting of this study concurs with the Consolidated criteria for reporting qualitative research (COREQ) and the template has been completed. (35)

Data analysis

Reflexive thematic analysis (36) was used to analyse data. A constant comparative approach was also used to inform comparison within and across datasets from SA men and GPs; this technique has been conducted in studies with participants from different groups. (37)

Transcripts of audio recordings were initially coded by one author using NVivo 12 software analysis (<https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software>).

Codes were developed from quotes and evidenced accordingly; codes were then grouped into categories which were used to conceptualise themes. Negative case analysis were sought out and discussed.

Patient and Public Involvement and Engagement

A patient advisory group (PAG) of five SA men met five times during the course of the research and were involved in all stages, following National Standards for Public Involvement. (38) The PAG contributed to the development of the research question, reviewed all public-facing documents to make them more culturally relevant, and supported recruitment, suggesting a poster in shops frequented by SAs and which shops specifically and in which areas. Members also suggested community and faith centres of different backgrounds and reaching out to local media that had a SA following. The PAG informed analysis and development of themes, and dissemination priorities. The PAG co-produced an animation video of key messages from the research (https://www.youtube.com/watch?v=pSuTAF_JU1I).

Research Quality

Reflexive field notes were taken during and after the interviews to support confirmability by ensuring awareness of personal feelings and thoughts and how these could potentially influence the research and how they could be minimised. Triangulation of sources took place via comparison of interviews from GPs and SAs. (39) Triangulation through multiple analysis took place via different members of the research team and the PAG. The research team consisted of two academic GPs, one of who was of SA background, an evidence synthesis specialist and a social scientist. Credibility was maintained with monthly study meetings; Researchers reflected upon their professional and personal backgrounds and how these influenced their perspectives. Interviewing SA men and GPs from three different geographical areas in England makes the research potentially transferable to different geographical settings.

Results

Seventeen SA men with LTCs and 18 GPs were interviewed with most interviews lasting approximately an hour. Table 1 and 2 describe the participant demographics for the SA men with LTCs and GPs, respectively.

Two main themes were developed, contextualising distress and conceptualising distress. Contextualising distress embodies the circumstances within which distress was experienced, which LTCs influencing distress and intersections of the social determinants. Conceptualising distress, i.e. the formalisation of the understanding of distress, was understood in a variety of ways by SAs and GPs, emphasising de-medicalising distress, negotiating multiple identities and integrative paradigms of health. Themes are supported by illustrative quotes whereby names have been replaced with codes.

Contextualising distress

***'Betrayed by my body.'* LTCs influencing distress**

Experiences of being diagnosed with an LTC were a source of distress, being described by SA participants with LTCs as stressful and shocking, as well as feeling let down by their bodies and anxious about future events. This was more pronounced in diagnoses of heart disease than diabetes.

The diabetes at first, it was very depressing, that I felt my body had let me down. Obviously, from being quite active, bouncing about and football and whatever, whenever I could. I think I was 49 or something like that at the time. I felt a bit betrayed by my body. I know it's silly. But then I got used to it and I find that it didn't really affect me that much. I was okay, pretty much, within myself after a couple of months. And then with this heart attack now, it's very depressing. Again, because now, I'm always worried about the next event. (SA02)

GPs described the challenges of supporting SAs managing the burden of their LTC, and SAs tiring from this burden leading to reduced concordance and poorer control of their LTCs. A lack of engagement made it challenging to work with patients to make shared management plans.

They might present to me because the nurse has said she doesn't know what to do with them. Their diabetes is getting worse and worse control. You look and you realise that they haven't been taking their tablets. Their compliance has been really low. When you challenge them on that they deny it completely and go, oh no doctor I take my tablets all the time... It's because they just lost interest in looking after themselves. (GP05)

SA participants with LTCs described frustration managing their LTCs due to the multiple demands of treatment such as dietary and lifestyle changes as well as medication. They described how this could lead to chronic stress which at times tipped into distress and disengagement from managing their health.

Sometimes you almost erupt. We're trying to sort out dietary needs and trying to do everything right concerning diabetes. When a diabetes nurse speaks to you, they tell you, you have to do this, you have to exercise, you must do this and you must do that. Certain things in your life can happen where you just think, forget this, I've had enough. How much longer am I going to put up with all this, or do I have to do this all my life?... And then there have been times where I have thought I've had enough of this or I can't do this anymore. (SA07)

The impact of having a LTC on distress has been described. The next section describes intersections of social determinants causing distress.

Intersections of social determinants contributing to distress

A number of social factors were described as intersecting to contribute to distress to SA participants living with a LTC, namely financial stress, family difficulties and prejudice.

Financial pressures were described as more stressful than physical health problems, due to the constant pressure of poverty affecting all aspects of a person's life as well as directly affecting health.

Financial thing is the main issue. If you don't have the money, without money you can't live. They say that health is more important, I always say money is more important than health, because if you don't have the money, your health will go down anyway. You can't eat the proper thing, you can't pay the bill, your stress will come, you are short of everything. (SA13)

Of note, SA participants with LTCs described health as secondary to financial pressures, and did not describe health as a priority in itself. GPs explained how some SA men with LTCs did not seem able to prioritise their health due to competing problems, such as finances and poor housing, leading to presenting due to socio-economic factors.

Sadly, many present, and the triggers to their presentation tend to be, again, socio-economic reasons. So, they've got financial issues, employment issues, problems within their relationships. And, sadly, lots of addiction problems... And the thread that links all of this across communities, beyond south Asian communities, I think, is deprivation. (GP02)

Family challenges were described as a great source of distress. Some SA participants with LTCs described a tension related to acculturation, struggling between the expectation they had of their children based on the SA culture they were brought up in, in contrast to the more British culture their children grow up in and act upon. This tension was amplified in multigenerational households, more prevalent amongst SAs from low socioeconomic classes (based on occupation), with family members being around each other often yet having different values.

A lot of tension is tension with the family. 99% of problems of tension is with family. It's a family killer, these problems because we're living with our families so much.
(SA02)

Prejudice was described by SA participants with LTCs as a significant contributor to distress, such as the perceived biased nature of media coverage of SAs, and government policies unfairly targeting SAs such as imposing a lockdown the night before an important SA festival whilst easing restrictions for Christmas.

The fact that they announced the lockdown the night before Eid al-Fitr was extremely frustrating. And the fact that now, they're pulling out all the stops, and they couldn't care less about any increase in the infection rate for Christmas, it's infuriating. (SA02)

Suffering across the world was also described as a sources of distress, due to perceptions of prejudice on a global level with loss of life considered insignificant based on where someone was from. When a SA participant described international injustices as a source of distress, the interviewer asked whether world politics makes him distressed, to which he replied:

I'm sorry. It isn't politics. No. It's frustrating, people, if they say, oh forget all the things. They are human. How could it be politics? And then the Palestinian people, they are taking them and killing them. How can it be politics? (SA01)

Contextualising distress has been explored, with SA men with LTCs and GPs highlighting how distress is influenced by having a LTC as well as intersecting social factors such as financial stress, family difficulties and prejudice. The next section describes conceptualising distress.

Conceptualising distress

***'A universal human experience.'* De-medicalising distress**

GPs described how emotional distress is a non-medical and normal human experience but, if left unchecked or untreated and develops beyond the capability a person is able to manage, can lead to more severe problems.

Emotional distress, I think, is a universal human experience, it's a normal human experience. And I think that clearly there are different levels. There's the day-to-day normal and then it becomes gradually more and more difficult to deal with, to survive. And eventually, at some point a person gets to their threshold where they think that it's appropriate to consult their doctor or their healthcare professional.
(GP03)

SA participants with LTCs similarly differentiated distress from medical conditions such as depression. This was based on severity of symptoms, which had a window of treatment before escalating into a mental health disorder.

It depends on how severe it is. I don't know. Emotional distress could change to mental illness quite rapidly, and you could feel, I don't know, trapped. You can't do much, or you don't have much of a challenge in your life. (SA17)

GPs expressed concerns of an overly biomedical approach in which distress is medicalised by clinicians, patients and society in general. This was felt to negatively impact patients' lives by making them feel they had medical disorder and developing an external locus of control as someone ill and helpless, as opposed to feeling empowered to ask for help and be supported.

The more we medicalise matters of emotional wellbeing, the more further away we get from a point of success for patients. (GP02)

SA men with LTCs and GPs described a conceptual need to de-medicalise distress. Negotiating multiple identities, of both with LTCs and GPs will now be explored.

'Men don't cry.' Negotiating multiple identities

SA participants with LTCs described negotiating multiple identities based on ethnicity, living with LTCs, and their culture. From a GP perspective, culture was felt to be intertwined with mental health.

I've always felt that psychiatry, mental health, along with everything else, it is culturally driven, as well as medically driven. (GP01)

SAs and GPs felt that within SA culture, emotional health was viewed as less important than physical health. This ranged across different SA backgrounds, and was more prominent in first-generation SAs.

I think in the Indian subcontinent and our culture, we just see physical as being the most important, not emotional. Emotional, you should be able to manage yourself. (SA09)

Part of SA culture regarding men was a concept of being breadwinners and not being allowed to show signs of weakness. This was more prominent in first-generation SAs who would make all efforts to fulfil this role, and become increasingly distressed if unable to do so.

Men don't cry, and men should be strong, and they should look after their sisters and they should look after their wives and so forth. That's the kind of narrative a lot of the middle to elderly [SA] population has grown up with. (GP16)

As well as complexities in SA men with LTCs negotiating multiple identities, GPs described professional identity as a source of tension. This included when abiding by their own personal culture and beliefs whilst supporting SA patients with often similar beliefs, yet feeling a necessity to keep this out of the consultation.

We have to remain apolitical and areligious within our consultations themselves, and it's a very fine balance. And that's another challenge for us. That, whereas this person might have very strong religious beliefs, and I personally might also have very

strong religious beliefs. We've got to keep that out and keep it as neutral as possible.
(GP05)

The multiple identities that SA men with LTCs, as well as GPs, have to negotiate, have been described. Integrative paradigms of health will now be explored.

'I believe in black magic.' Integrative paradigms of health

Integrative paradigms of health, which synthesise conventional and alternative medicine, were described by some SA participants with LTCs. These included a greater trust in traditional forms of medicine more commonly used within SA countries such as via Hakeems (traditional doctors, from the root word meaning 'wisdom'). SAs described frustration with UK medicine being focused on multiple tests as opposed to traditional doctors who they described would look for causes of illness and offer holistic and natural cures.

In the old days, I remember, all villages, there was good Hakeems (traditional doctors) always helped you. And these days, the doctors say have this test and that test. (SA11)

Other paradigms of health included concepts of black magic and supernatural beings. These were described as potential causes of mental as well as physical illness, with SAs querying if their experiences of distress were related to these.

I believe in black magic, I believe in Jinn [supernatural beings], I believe in Hasad [envy that affects others], I believe in the evil eye. Me, personally, sometimes I do think, am I possessed? Is this what causes my illness? (SA10)

Black magic was ingrained within SA culture, and was perceived as a cause of difficulties across the sphere of a person's life, including causing social and relationship problems, with families encouraging cultural treatments.

So, I think for about a year or two, when I became very unwell, that's what the discussion was in the family and the community, that someone had done black magic, which wasn't the case. It was mental ill health. I was suffering from distress over the fact that my relationship didn't turn out to be as it should have been. So, I think that's what it was. But a lot of the community, the first-generation community of South Asians, they have that opinion, a lot of them, that it's black magic. We need to take you to a religious leader. We need to give you this Taweez, this ribbon for you to wear. So, that's really it. There is still that going on, because mental ill health is largely misunderstood in the South Asian community. (SA06)

Concepts of black magic were almost never discussed by GPs. This may be because SA men with LTCs thought they would be perceived as mentally unwell. If mentioned by GPs, they were attributed to severe mental illness whereby other services would be involved. When directly asked about patients describing black magic a GP replied:

In the 20 years, I've probably had that about two or three times. Tends to be more with those at the severe end of mental illness. The ones who are psychotic and suffering with bipolar disorder and those sorts, at the severe end. Those patients are well known to the metal health services. They've had counselling and support, and continue to do so. I don't really get involved in that, those patients as much. (GP05)

Integrative paradigms of health have been explored, included concepts of black magic and supernatural beings influencing distress, which GPs did not identify. The themes are summarised below in Figure 1.

[Insert Figure 1]

Discussion

Summary

This study explored how men of SA origin with LTCs experience and understand emotional distress from the perspectives of both SAs and GPs. SA participants with LTCs and GPs described contextualising distress in terms of factors that contributed to their distress; this

included living with LTCs and intersections with key social determinants such as family stressors, poverty and perceptions of prejudice. Conceptualising distress - how participants interpreted and made sense of their distress - highlighted conceptual differences between emotional distress as a universal experience and clinical depression, challenges in negotiating multiple identities linked to faith, culture, masculinity and having an LTC, and integrative paradigms of health including traditional doctors and concepts of black magic. Both the contextualisation and conceptualisation of distress are needed to fully understand experiences of distress in SA men.

Strengths and limitations

The study provides new insights into emotional distress in SA men with LTCs. An ethnically appropriate PAG of SA men acting as partners in the research, as well as a SA *'insider researcher'*, was crucial to making the research relevant and facilitated SAs to be more open to talk about issues around culture and mental health such as black magic; a previous study has shown that lack of knowledge of SA culture hindered communication due to having different world-views and understandings. (40) Community sampling took place which facilitated listening to the voice of people from the SA community who may not otherwise be heard. The co-creation of an animation video with the PAG summarising the key messages from the research provided a platform for dissemination for people who may be neglected by other forms of dissemination.

Limitations include interviews being all remote due to restrictions associated with the covid-19 pandemic. Virtual meetings are potentially more accessible, preferred by interviewees and having similar interview lengths, subjective interview ratings and substantive coding in comparison with virtual interviews, although less word-dense (41). Whilst SA participants with LTCs came from the three main SA countries, the majority were of Muslim faith.

Comparison with existing literature

The theme of contextualising distress identifies key social factors contributing to distress in SA men, aligning with literature on the social determinants of mental health. (42) This literature describes a reciprocal relationship where mental health problems and social

determinants influence each other. (43) The social determinants of distress are more relevant for SAs, given their resistance to the medicalisation of distress observed in our study. People from ethnic minority communities are more likely to suffer from socio-economic deprivation, related to a wider social context influenced by racism, including housing, employment and the criminal justice system. (44) GPs and SAs highlighted how social determinants such as ethnicity, LTCs, financial pressures, and prejudice influence distress. A Race Equality Foundation report noted an increased prevalence of mental illness among ethnic minority communities, particularly Pakistani men, alongside reduced access to mental health services, assessment and treatment inequalities, and discrimination during recovery. (14) The allostatic load of the cumulative burden of chronic stress and life events, described by participants both in terms of social determinants as well as coping with their LTC, is known to lead to poorer health outcomes. (45) A systematic review on stigma associated with common mental health disorders found a link to poverty and discrimination from policies and institutions. Our study enhances the understanding of prejudice in healthcare and how broader policies, such as those around COVID-19, directly influence distress in SAs. (46) This exemplifies intersectionality, where multiple social forces, identities, and ideologies intersect to create disadvantage. GPs and SAs in our study described various levels of intersectionality they encounter. Reflecting on the intersectionality faced by SAs can improve patient-clinician interactions by fostering a better understanding of multiple disadvantages and the institutional and structural forces leading to health disparities. It also prompts reflection on GPs' positions of power and privilege and how these, along with their biases, impact consultations. (47,48) This may include impacting GPs who feel they are not able to speak about faith related to distress when the patient is keen for such a discussion. Addressing social determinants of health within primary care involves developing a practice culture that values health equity and employs a team-based approach. (49) As GP Andrew Moscrop asks, *'If social determinants of health are so important, shouldn't we ask patients about them?'* (50)

SAs and GPs in this study conceptualised distress as a distinct entity to depression and other mental health diagnoses. They described a continuum whereby if distress was prolonged and severe it could lead to depression. Research has shown that people who present to primary care can be differentiated to have distress or depression based on symptomatology.

(51). Cultural differences have been found with presentations of mental health problems, for example SA with LTCs have been shown to prefer non-medical terminology such as tension to medical terminology. (15,16) A previous study found that some GPs felt distress and depression were on a continuum, and distinction was not possible, whereas other GPs struggled to separately define the entities and others linked distress with the absence of biological symptoms. (52) UK men prefer to use non-clinical terminology when engaging with mental health services, similar to the views of SA men in this study. (53) Differentiating distress from depression can aid appropriate diagnosis and hence suitable management of both distress and depression, potentially reducing inappropriate diagnosis of depression. (51) There are cultural tensions with the term depression; an Asian population described no benefit of using the term depression above non-medical descriptions of unhappiness. (54) De-medicalising distress provides a platform for SA conceptualisations of distress to be valued not only in the minds of patients but also authenticated and validated by clinicians in the consultation setting.

Implications for practice

Table 3 summarises how the themes can support clinicians in incorporating the social determinants of distress to CARE for SA men with LTCs. By adopting a person-centred approach during consultations with SA men with LTCs, one that negotiates gendered stereotypes and acknowledges socio-cultural backgrounds, GPs could encourage more patients to disclose experiences of distress using their preferred terms and language and, where needed, improve treatment planning which may include discussing traditional forms of medicine. These measures, all of which will act to improve patient-doctor relationships, build trust, and protect and enhance the professional integrity of the clinician, are essential for quality healthcare.

Funding

This research was funded in whole, or in part, by the Wellcome Trust [Grant number 216665/Z/19/Z].

CCG part funded by WM ARC.

Ethical approval

Ethical approval was granted from Keele University's Faculty of Medicine and Health sciences Research Ethics Committee (FMHS FREC project reference MH-200132) as well as Health Research Authority (HRA) and Health and Care Research Wales (HCRW) Approval (Integrated Research Application System (IRAS) project ID 293272).

Competing interests

Nil

Acknowledgements

A great thanks to members of the PAG group whose contribution was invaluable to the research.

HA was funded by an Wellcome Doctoral Fellowship (216665/Z/19/Z).

CCG is partially funded by West Midlands NIHR Applied Research Collaboration.

The views expressed in this publication are those of the authors, and not necessarily those of the Wellcome Trust or NIHR.

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Accepted Manuscript—BJGP—BJGP.2024.0386

Table 1 Characteristics of SA participants with LTCs:

Participant ID	Self-identified ethnicity	Age (years)	Index LTC	Comorbidities	Educational attainment	Occupation	Religion	How many years has been in the UK	Generational status
SA01	Pakistani	60	Diabetes Type 2	None reported	College	Taxi driver	Islam	42	First
SA02	Pakistani	54	Diabetes Type 2 and coronary heart disease	None reported	College	IT consultant	Islam	51	First
SA03	Indian	62	Diabetes Type 2	None reported	University	Operations manager	Islam	55	First
SA04	Indian	67	Diabetes Type 2	None reported	No schooling	Retired factory worker	Islam	22	First

SA05	Pakistani	60	Coronary heart disease	Hypercholesterolaemia and prediabetes	University	IT consultant	Islam	50	First
SA06	Pakistani	39	Diabetes Type 2	None reported	University	Unemployed	Islam	Born in UK	Second
SA07	Bangladeshi	42	Diabetes Type 1	Hypercholesterolaemia, hypertension	College	Security worker	Islam	40	Second
SA08	Pakistani	57	Diabetes Type 2 and coronary heart disease	Hypercholesterolaemia, hypertension	Secondary school	Factory worker	Islam	45	First
SA09	Bangladeshi	33	Diabetes Type 2	Asthma	University	Teacher	Islam	32	Second
SA10	Bangladeshi	37	Diabetes Type 2	Paranoid schizophrenia	University	Unemployed	Islam	26	First
SA11	Pakistani	83	Diabetes Type 2 and coronary	Osteoarthritis	Secondary school	Retired travel agent	Islam	60	First

			heart disease						
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Accepted Manuscript—BJGP—BJGP.2024.

Table 2 Characteristics of GP participants

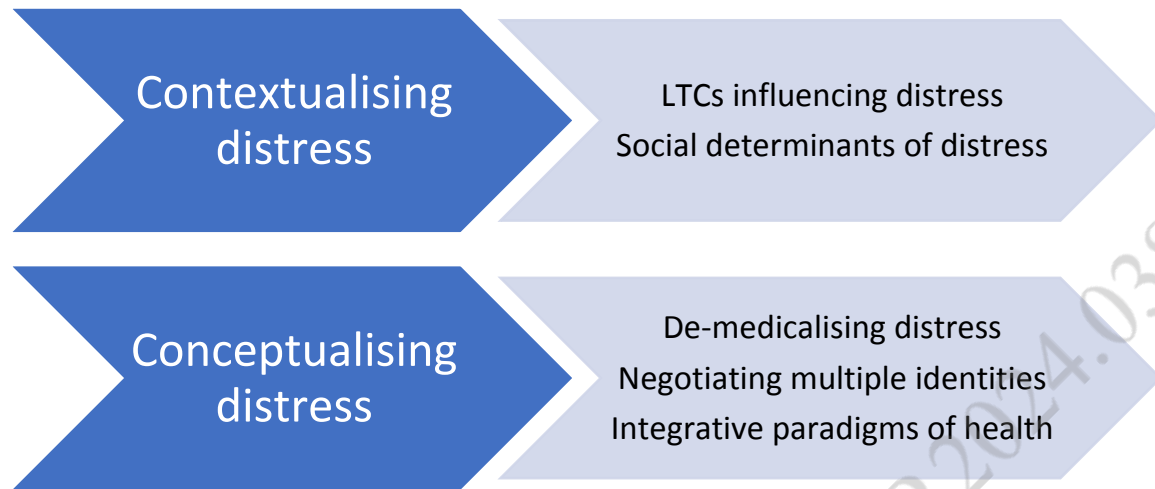
Participant ID	Age (years)	Gender	Self-identified ethnicity	SA languages spoken	Numbers of clinical sessions worked	Years of experience as a GP	Roles
GP01	64	Male	Indian	Gujarati	3	32	Partner; Academia
GP02	40	Male	Pakistani	Punjabi, Urdu	3	11	Partner; Leadership
GP03	55	Male	English	Nil	4	29	Salaried; Medical education
GP04	39	Male	Pakistani	Urdu, Punjabi	6	10	Partner; Medical education
GP05	50	Male	Pakistani	Urdu	9	20	Partner; Leadership
GP06	38	Male	Indian	Gujarati	6.5	11	Partner; Medical education
GP07	43	Male	Pakistani	Urdu, Pashto	6	8	Salaried; Other clinical roles, medical education
GP08	33	Male	Pakistani	Urdu, Punjabi	6	4	Partner; Medical education
GP09	32	Female	English	Nil	4	2.5	Salaried; Academia, medical education
GP10	44	Male	Bangladeshi	Bengali	3.5	16	Partner; Leadership, medical education
GP11	38	Female	Indian	Nil	6.5	6.5	Salaried
GP12	42	Male	Pakistani	Urdu, Punjabi, Hindko	8	5	Salaried (and locum); Medical education

GP13	30	Female	Indian	Tamil	10	1	Partner
GP14	33	Male	Indian	Hindi	2	4.5	Salaried; Other clinical roles
GP15	49	Male	Pakistani	Urdu	7.5	18	Salaried; Other clinical roles
GP16	45	Male	Bangladeshi	Bengali	9	16	Partner; Leadership
GP17	49	Female	Pakistani	Urdu	6	7	Salaried; Other clinical roles
GP18	31	Male	Bangladeshi	Bengali	6	3	Salaried; Leadership

Table 3: Incorporating the social determinants of distress to CARE for SA men with LTCs

Cultural sensitivity	Be sensitive and open to different conceptualisations of distress, including the multiple identities that SA men with LTCs have to navigate, such as a breadwinner role which may perceive distress as a sign of weakness. Consider integrative paradigms of health such as black magic causing distress.
Ask	Ask about the social determinants that may influence distress, such as distress related to the LTC, financial pressures, family challenges, and experiences of prejudice.
Reflect	Reflect on one's own professional identity, including clinician power and privilege and biases, and how this influences the consultation, in a positive or negative way.
Explore/engage	Explore distress using language the patient is comfortable with, which may be non-medical terminology to de-medicalise distress, such as tension, as opposed to diagnostic labelling such as depression and anxiety.

Figure 1 Summary of overall themes:



Accepted Manuscript – BJGP – BJGP-2024-0386