GPs to humanely contain or guide our encrypted distress? We have much to retrieve.
An historical view.

JHH's articled dialogue *Men and distress: the final frontier?* (Vol 14, Issue 3, Autumn 2017) portrays richly the complexity – the covert, often encoded – nature of men's emotional and relationship problems. It is percipient, too, in viewing such problems as being substantially developmental and cultural; only later precipitating and presenting as physical and mental illness – so becoming medicalised.

Yet to talk optimistically of 'the GP is often a crucial first port of call' is wishful thinking: an unrealistic optimism that poses more problems than likely help. The discrepancy – between wish and reality – speaks of issues quite as large as the topic generating the discussion. It is these collateral issues I wish to consider here.

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Your two discussants, in defining 'male' patterns of distress, also identify the broad and ancient roots that germinate and sustain them. So it is then very plausible to go on to attribute these largely to the cultural and societal. So far, so good.

But here we run into many practical difficulties, particularly if we wish to enlist GPs as prime movers.

For such deeply and complexly rooted problems are the ones most difficult to counter: they can rarely be sorted or 'fixed' rapidly, in the way that current GPs are corralled to work. Instead, any complexly rooted distress is likely to need our most

subtle and long-term guidance and containment. That is usually our best chance for therapeutic influence.

Yet this is now less and less likely to come from our current GPs. This is because, in the last two decades, GPs have become increasingly subject to certain kinds of management: those that are generic, procedural and make strangers of patients and colleagues. Consequently the working milieu has become indifferent – even hostile – to *personal continuity of care* – often the most basic element in any influence to healing and growth. Generally, what we have seen is that as these schematised reforms have increased the demands for procedural and administrative compliance, so they have displaced personal understanding and relationships. First we lose therapeutic opportunities, then we lose our skills.

Examples of how this happens in General Practice are wide-ranging:

- the abolition of personal lists (registering patients with a *place* = locationed practice, rather than a *person* = a named practitioner)
- the systematic closure of small practices
- the tendency to short-term, part-time locum staffing, rather than long-term, vocationally invested partnerships
- management by measurable procedural compliance, rather than trust in less measurable (non-procedural!) relationships…

There are many more. All of these have made barren the fertile soil of consultations: the more natural possibilities for personal familiarity, trust, understanding and receptive time. These constitute not just our foundations for healing, comfort and growth, but also our therapeutic fraternalism … these are here worth emphasising

because they provide the kind of soul-food allegedly so often lacking in male relationships and culture.

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We can learn from our history. We must understand what we have lost, why, and what the consequences are.

Older practitioners working, say, in the 1980s and before will describe working milieux where working relationships had much more trust than management – the opposite to now. Interested and gifted practitioners were encouraged to develop the far-sighted, long-spanned relationships with patients whom they knew could not be 'fixed', yet whose lives and pains could be undramatically and slowly comforted, contained and beneficently guided. This is often more important than usually currently realised, for even apt and successful referral often requires deft personal skills: the crucial first steps to candour, vulnerability, trust and agency are often the hardest and most precarious. The quality of relationship with the referring practitioner here is often a decisive bridge: any holistic practice involves far more than mere intervention and despatch.

Practitioners in this earlier and more personal era were freer to help by flexible and subtle interactions: by providing a safe-space rather than a treatment programme, by subtle allusion rather than didactic instruction, by contemplating the subtext rather than adhering to text. Yes, many men – their armoured and hidden fears, their angry counterdependence, their too-much-activity-for-vulnerability-or-intimacy – could thus be slowly engaged, then guided and helped, by such informal therapeutic contact. This often happened by various kind of personal osmosis and apposition.

The psychiatry and general practice of those earlier and less schematised times may have had more patchy variation, yet this was frequently mitigated by greater opportunities for natural therapeutic influence. This is exampled by that era's burgeoning of supportive psychotherapy, therapeutic communities and the Balint movement – these were all common expressions of such values and possibilities. With egregious oblivion they have all been driven out to the point of extinction by our contemporary, often threateningly-hued shibboleths: schematised management, measurement and standardisation – each procedurally conveyed in life-leeched technical language … Behind such regulation lies the follied myth that compliant procedures will fix all. What possible place can there be in this strictly packed new order to address any hidden meaning, for considering subtext? For the tender and furtive vulnerabilities we are considering?

Yet, as your dialogue illustrates so clearly, the serious damage men can inflict on themselves and one another can often *only* be read and understood by deciphering such subtext. So we have here a serious conundrum, for such nuanced work requires the very kinds of personal space, contact and freedom that are perishing; our healthcarers are working in a culture whose sickening qualities are disturbingly similar to those adduced to be responsible for men's myriad miseries. This tangle can be tragic in its consequences.

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I currently visit my GP only for infrequent health-checks and prescription endorsements. I sense he is a kind, thoughtful and intelligent man, but I see in his unrested and dulled eyes computer-weariness, regulation-wariness and anxiety

about the nature of his own professional survival. With discretion, he tells me a little about these: we tacitly acknowledge a vaster subtext.

I would not want to trouble him with my own emotional troubles, gender-related or otherwise.

I may have to wait until I am mentally ill.

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