



January 2016

## The 'worried well' and the 'walking wounded': How will we know them?

One of Dr. Henry A. Nasrallah's resolutions (16 New Year's resolutions for psychiatrists in 2016, From the Editor, January 2016, p. 23,24) stated that a significant percentage of one's practice should be dedicated to the sickest patients, followed by the statement, "There are enough non-physician mental health professionals to handle the walking wounded and worried well."

Who are the "walking wounded" and the "worried well"? These are commonly used terms, but who falls into these categories? I think it is important to get a sense of who is in these groups, because my takeaway from this editorial is that it is acceptable to let the walking wounded and worried well be treated by lesser-trained clinicians. Do these terms refer to a diagnostic group? Level of functioning? Severity of symptoms? Or severity plus chronicity? Level of suffering? Ability to "fake" looking less severe?

I wonder, am I a walking wounded or worried well? Are some of my friends, or my family members? When I see a patient, I ask myself if he (she) might be in that category.

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## Dr. Nasrallah responds

*I use those terms to refer to persons who have psychiatric symptoms but are not disabled socially or vocationally. They deserve a full psychiatric evaluation when they initially seek help, but generally do well with various types of psychotherapy, including cognitive-behavioral therapy, interpersonal therapy, psychodynamic therapy, or dialectic behavior therapy. There are many well-trained psychologists and licensed therapists who can administer those therapies as well as, or better than, some psychiatrists.*

*I recommended that psychiatrists dedicate a significant percentage (more than 50%) of their practice to more severely ill patients (those with psychosis, bipolar disorder, major depressive disorder, panic disorders, obsessive-compulsive disorder, post-traumatic stress disorder, etc.) because we are the only mental health professionals who can competently integrate biopsychosocial treatments for these patients and administer pharmacotherapeutic agents in addition to non-drug approaches. The supply of psychiatrists is short, and the number of seriously ill patients who need the medical expertise we can provide is large.*

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## 'Struggling with inner demons'

I would hope that Dr. Nasrallah would understand that the use of the metaphor, "struggling with inner demons," does not suggest "stupid" (Stop blaming 'demons' for bizarre

delusions or behavior!, From the Editor, February 2016, p. 19,20,22). A celebrity, or any other person, might be struggling with intense, conflicting emotions that create chaos and distress. I would shudder if I read in *The New York Times*, "Well known actor's divorce and drug use clearly leading to hypertrophied amygdala." The term *inner demons* does not necessarily imply medieval superstition, but rather a well-established use of creative language.

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## Dr. Nasrallah responds

*Dr. Samarian missed the reason for my umbrage with the "inner demons" metaphor. As a psychiatrist, educator, and researcher, I am exquisitely sensitive to the poor understanding of mental illness and the rampant stigma associated with psychiatric disorders despite the incredible neurobiologic advances. Thus, I regard the metaphor that employs words like "demons" when describing intense struggles with emotional upheavals and stress as having an unfortunate connotation to the obsolete beliefs that abnormal behavior, thoughts, or mood are due to the devil and his nefarious demons.*

*I would welcome a metaphor that describes a depressed person as having a shrunken hippocampus, which would regrow with antidepressant or electroconvulsive therapy, because that's the biologic truth and has no misleading connotations; the same with Dr. Samarian's example of a hypertrophied amygdala in a person with chronic stress.*