Psychological Interventions

6

Reena Shah

Introduction

There is a bi-directional process between skin conditions and psychological distress, with an overlapping biological mechanism associated with inflammation. Psychological distress can be manifested in a number of ways, including through the skin and cutaneous disease with organic or physical causes which can cause psychological distress (i.e. low-self-esteem, social anxiety, depression, stress). A review of the literature shows the relationship between various skin disorders and mood disorders indicating that there are various biological pathways that explain the biological relationships (such as hypothalamic–pituitary–adrenal axis hyperactivity, glucocorticoid receptor desensitisation and sympathetic nervous system activation). There is also a plethora of evidence to show that psychological distress can cause skin disorders and inflammation.

Prevalence

Approximately 30% of those living with a skin condition experience clinical levels of psychological distress. Eighty-five percent of those report that the psychological impact is the main component of their skin condition. High rates of suicidal ideation have also been reported, with 8.6% of outpatients with skin conditions and in particular, 7.2% of those with psoriasis and 5.6% of those with acne, which is higher than in general medical patients.

R. Shah (✉)
Central and North West London NHS Foundation Trust, University of Hertfordshire, Hatfield, UK

A. Bewley et al. (eds.), *Psychodermatology in Clinical Practice*,
https://doi.org/10.1007/978-3-030-54307-5_6

Efficacy of Psychological Interventions

Over the years, studies have looked at the effectiveness of psychological interventions in dermatology but there is lack of randomised-controlled trials. Lavda et al. (2012) conducted a meta-analysis that included 22 studies. They showed that psychological interventions were beneficial for people with skin conditions; effect sizes suggested that interventions had a medium effect on the severity of the condition and psychosocial outcomes and a medium-to-large effect was seen on itch/scratch reactions. Recent therapeutic guidelines recommended the use of psychological interventions in routine practice. It is useful for clinicians to have an awareness of different evidence-based psychological approaches to draw on in the assessment process so they can refer on for appropriate psychological intervention. Dermatologists and nurses can utilise basic psychological techniques such as relaxation or habit reversal therapy within their practice. This would be in line with the stepped care model for providing psychosocial interventions for patients (with mild to moderate psychological distress) and then referring on for more complex issues as per patient need. Developing a therapeutic relationship and conducting a brief psychological assessment can be an intervention in itself, which would dramatically increase the quality of clinical care for patients with skin disease.

Principles of Skin Care Regimes

Finding the most beneficial skin care regimen is key for the patient to manage their skin condition effectively. It can be helpful to motivate and reassure the patient to not give up if one cream does not work and highlighting that it may take months of 'trial and error' to find the most effective treatment strategy. Adapting the skin care regime to suit the patient's daily schedule can also increase success. Promoting simple techniques to reduce stress can benefit the patient such as: good sleep hygiene, deep breathing, having a healthy work-life balance and rest, 'me time' and promoting a healthy and positive lifestyle. Supportive, social networks with others who experience the same difficulties can contribute to better treatment outcomes. Therefore, introducing support groups, such as The National Eczema Society, Eczema Outreach (EOS) and/or increasing psychoeducation via relevant websites (e.g. www.skinsupport.org.uk) or giving leaflets from specific charities, such as The Vitiligo Society and The Psoriasis Association, can also be helpful.

Mode of Therapy

Principles and Set Up

Psychological therapy can be conducted either on a one-to-one, couple, family or group basis with people of all ages. Usually in group therapy, the content is organised around one type of problem (such as anxiety or social skills) or type of condition (such as eczema or dermatillomania) and in general have around 6–8 patients per group. Depending on the patients' difficulty and goals, the clinician's skills and the

service remit, this can govern which mode of treatment is offered. However, the psychology service set up can also vary from service to service and some have a pathway to follow, for example, patients attend first a group, then telephone sessions and then individual/couple or family face-to-face sessions. Whereas other services offer mode of therapy based soley on the individual's needs and the clincian's experience.

Benefits and Disadvantages

There are disadvantages as well as benefits of the different modes of therapy, for example in group therapy, patients are given the opportunity to share and explore their experiences with one another, which can help to reduce stigma, to normalise the problem/condition and to feel supported. Patients often encourage one another, model positive strategies, decrease feelings of isolation and increase self-confidence which would not feature in individual therapy. However, in individual therapy patients have the opportunity to explore deep-rooted issues where more complex problems can be explored and therapy can be tailored to meet the individual's needs.

Treatment Pathway/Stepped Care Model

Principles

Studies have shown that a high percentage of patients perceive the severity of their skin disorder and its impact on their life as more distressing than the objective severity of their disorder. Therefore, it is key to explore the patients' perceptions of their disorder. Within a psychological assessment, completing baseline objective measures can be useful (such as the Dermatology Life Quality Index (DLQI, Finlay and Khan 1994), Patient Health Questionnaire (PHQ-9, Kroenke et al. 2001), a brief measure for General Anxiety Disorder (GAD-7, Spitzer et al. 2006), as well as specific assessments such as the Cardiff Acne Disability Index (CADI, Motley & Finlay 1992), or a vitiligo-specific quality-of-life instrument (VitiQoL, Lilly et al. 2013). This can help to ascertain the severity of the psychological distress and the impact on their daily life. A 2018 study suggested that it would be useful for dermatologists to detect patients at risk of psychological problems by using a simple psychological outcome measure and subsequently refer them for psychological consultation (Panebiano et al. 2018). Skin disorders have historically been treated with medicine. However, it is known that reducing stressors and psychological factors can reduce flare-ups of skin conditions. The gold standard treatment in psychodermatology is to embed a psychologist in dermatology services, however, this is not always possible due to lack of resources and finances.

Stepped Care

The stepped care model is a system of delivering and monitoring treatments, so that the most effective and least resource-intensive treatment is delivered to patients first, then stepping up to intensive and specialist services as clinically relevant, see Fig. 6.1.

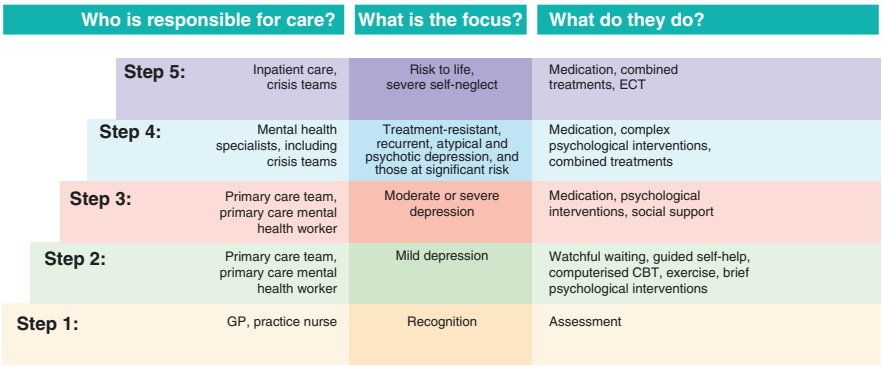

Fig. 6.1 An example of a stepped care model. Taken from https://wellbeinginfo.org/self-help/mental-health/stepped-care/

Within a psychological service, this entails increasing time with the patient and the therapy process, and increasing intensity based on severity. Firstly, offering behavioural treatments such as self-help or guided self-help, which includes behavioural activation and exposure and response therapy (stage 2). The next stage is offering CBT (group or 1:1), and/or other therapies such as Mindfulness, ACT or Systemic Family Therapy (stage 3–4).

What Can Dermatologists Do?

Dermatologists can offer self-help tips depending on the patients concerns and depending on the dermatologist's remit. They can either offer strategies that they feel comfortable with (such relaxation, stress management strategies, thought challenging, motivational interviewing approaches to increase motivation to change), or they can refer to local primary care mental health services, a psychologist, or to a specific psychodermatology service. Within all types of consultations and therapy sessions, managing patient and clinician expectations is helpful to improve and enhance success. Being mindful of what these are can positively influence the experience and dynamic between the clinician and patient. Exploring expectations can be useful, as it helps to set boundaries and create a safe non-judgemental space for the patient to explore their emotions fully.

Self-Help Approaches

Self-Help

Self-help is most beneficial to those with mild to moderate difficulties. It aims to increase patient knowledge and helps them to gain skills in how to better self-manage and overcome their psychological distress and/or skin condition. The self-help leaflet

can be based on either a specific skin condition, or a certain type of psychological approach to help a mood disorder associated with a skin condition (e.g. Hudson et al. 2020; Shah et al. 2014). Providing self-help has shown to reduce the time needed in individual therapy at a later stage and often patients have reported that further support is not necessary. Computer or literature-based self-help can be cost and resource effective. Patients who are engaged in this way are more likely to have better compliance and adherence to regimens. In addition, self-help material alongside a plan of when to use it has shown to reduce psychological distress in relation to skin disease and increases adherence (Shah et al. 2014). Specialists nurses can offer guided self-help which has shown to be more effective than self-help alone, which can be attributed to repeated reassurance and encouragement and maintaining hope.

- *Stage 1-signposting—websites, support groups and books, leaflets.*
- *Stage 2-psychoeducation, leaflets, books.*
- *Stage 3-guided self-help.*

Psychological Approaches/Therapies

Behavioural Therapies

Behavioural therapies aim to change behaviour/s that are unhelpful (sometimes habitual), external factors that increase stress. It is based on the premise that all behaviours are learnt. There are different types of therapies such as behavioural activation and exposure response prevention.

Behavioural Activation

Behavioural Activation is when the patient approaches activities that they were previously avoiding, using activity schedules. The aim is to slowly increase the time spent doing one activity with the hope to increase the number of positively rewarding activities. The rationale is that the difficulty (such as anxiety or depression) is a consequence of avoiding particular activities or situations. Specific goals are set for the week and the patient works towards meeting those goals.

Exposure Response Prevention

Exposure response prevention is when the patient faces their fear/s (such as fear of socialising or swimming) and they let the negative thoughts occur without challenging them. Within this the patient learns relaxation training and uses systematic desensitisation. This is a technique in which a hierarchy (listing anxiety-producing triggers from least to most distressing) is created with the patient. The exposure component helps the patient learn to tolerate increasing levels of distress with respect to situations that they fear. They expose themselves to the thoughts, objects, images, situations that make them feel anxious. The response prevention part involves the patient making a choice not to do the 'neutralising' behaviour/s (to make them feel better; e.g. to avoid going on holiday or swimming or to leave a party early) once the anxiety has been triggered.

Habit Reversal Therapy

Habit reversal therapy is a behavioural approach for patients with eczema or those who pick their skin. It aims to help patients to stop scratching or picking. See chapter 28 for more details.

Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) looks at the link between thoughts, emotions, physiology and behaviour. There is a plethora of research to show the effectiveness of CBT for a variety of skin conditions. When people feel distressed, they may fall into unhelpful patterns which worsen how they feel. CBT helps to recognise the problematic thinking styles (e.g. 'I am ugly) or behaviours (e.g. avoidance of socialising) and works on present symptoms (e.g. racing heart, sweating, shaking). It aims to challenge and alter difficult thoughts and unhelpful behaviours to more adaptive ways of thinking and behaving, which in turn impacts on the patient's physical feelings and emotions.

How patients cope with their skin condition also impacts the way they deal with their negative feelings. Explaining the link between the mind and the skin when exploring these factors in therapy can influence the dermatological and psychological treatment goals. Within sessions, there are numerous techniques that the therapist utilises such as eliciting thoughts, exploring thinking styles and emotions, cost and benefit analysis, problem-solving, event scheduling, promoting self-reward and positive affirmations, relaxation training, behavioural activation and thought diaries.

Figure 6.2 shows an example CBT model for someone with a skin condition. It shows how our underling core beliefs influence the way we think about ourselves,

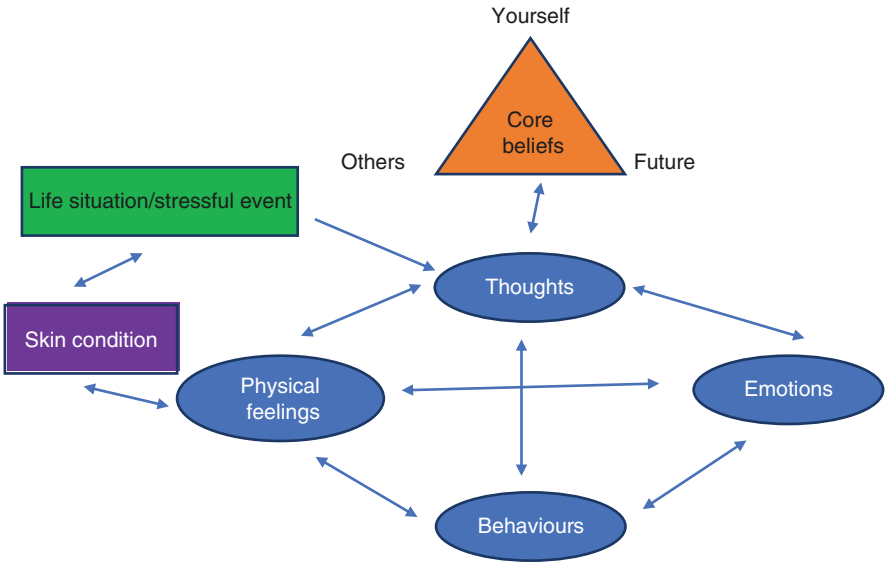

Fig. 6.2 Example CBT model

others and the world, which then impacts on the way we cope with life events/stressful situations. This influences how we cognitively process the situation and our thoughts, physical feelings, emotions and behaviours. Living with a skin condition adds an extra component that can exacerbate and/or precipitate stressful situations, given the biological link between stress and the skin.

There are particular models of CBT that are helpful to address underlying difficulties that may cause stress and consequently skin flare-ups (e.g. CBT for social anxiety or Body Dysmorphic Disorder). The approaches have specific evidence-based strategies. They help the psychological difficulties, mediated primarily by fear and avoidance, which are perpetuated by dysfunctional thoughts.

Relaxation

The link between the mind and the skin and the vicious cycle of stress and exacerbation of skin disease is well known. In particular, the relationship between stress and flare-ups of skin conditions (such as psoriasis, eczema and acne): activation of the stress HPA axis is known to affect the skin. Therefore, teaching patients simple strategies, that can be incorporated into daily life to reduce physiological arousal associated with stress and anxiety can be useful.

One strategy is slow deep breathing (which is the first skill to learning relaxation effectively). The purpose of slow deep breathing is to regulate physiology, therefore learning and teaching relaxation can help to reduce stress and worry. It also distracts from unhelpful thoughts and gives the experience of having some control. Once the basic skill of slow deep breathing has been established, the next step is to add in other components such as colour breathing, counting or external visualisation. If practiced regularly, the new skill can be effective in stressful situations. This provides the patient with a discreet coping strategy that can be used anywhere to help reduce the potential consequence of a stressful event as well as a flare-up. Facilitating relaxation with an imagery component is an effective method to lower state anxiety levels and itchy sensations. Studies have shown that relaxation can have a positive effect on many skin disorders, and with practice, the strategy can become automatic rather than consciously applied. Free patient handouts can be accessed online (e.g. www.getselfhelp.co.uk/docs/relaxation).

Trauma-Based Therapy

Trauma-based therapy looks at background factors from childhood or significant life events that cause distress in the present day. People who experience adverse childhood life events that are abusive or stress-filled are more likely to develop a range of physical health problems and social problems in adulthood. Patients often relate the exacerbation of the skin condition and psychological distress to memories or flashbacks from a trauma. Facilitating trauma therapy can work on reducing flashbacks of abuse (including the impact of them on daily life) and

stressful triggers, helping to reduce the psychological burden that is perpetuating the skin disorder (such as dermatillomania, acne excoriee or psoriasis). For some patients, their psychological difficulties predate the onset of the skin condition. Therefore, at times the predisposing skin condition could be viewed as an expression of their psychological problems, such as trauma, abuse, retirement or bereavement. When working with these patients, concentrating on the underlying problem rather than their skin condition can help reduce the severity of the skin condition by resolving psychological distress.

Schema Therapy

Schema therapy is an attachment-based therapy. It is an approach that combines CBT, Gestalt experiential therapy and psychoanalytical thinking. Schemas are a way of referencing the way in which we understand the world, a lens in which we use to view experiences (e.g. 'I am loveable'). We all have schemas, positive and negative, schema therapy has identified 18 core schemas. However, maladaptive schemas about ourselves and others (e.g. 'I am not loveable', 'I am not safe') are developed when childhood needs are not met.

Schema therapy aims to help people change longstanding patterns of thinking and acting, i.e. the maladaptive schemas. The approach looks to change the self-defeating core themes that are consistently repeated in the patient's life. The role of early maladaptive schemas of patients and the link to psychological distress in people with skin disorders is relatively new. An initial study (Mizara et al. 2012) linked some of the 18 schemas to skin disorders (specifically in eczema and psoriasis). The authors postulated that six early maladaptive schemas are reported by patients with skin disease: (1) emotional deprivation, (2) social isolation, (3) defectiveness/shame, (4) failure, (5) vulnerability to harm and (6) subjugation. Here, vulnerability to harm and defectiveness/shame predicted anxiety and vulnerability to harm and social isolation predicted depression. Overall the therapy helps to achieve change and improve adjustment in living with a skin disorder. Patients learn more adaptive ways of coping and relating to others and, consequently become less susceptible to psychological distress.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) is a behavioural therapy about taking values-guided action, by accepting the thought rather than challenging them and then to defuse it using techniques such as mindfulness. These are based on acceptance and commitment to values-based living. The patient uses their core values to guide, motivate and inspire behavioural change whilst engaging in the six core processes of ACT, see Fig. 6.3. They learn to accept what is out of their control and commit to taking action. The aim is to help create a meaningful life, while

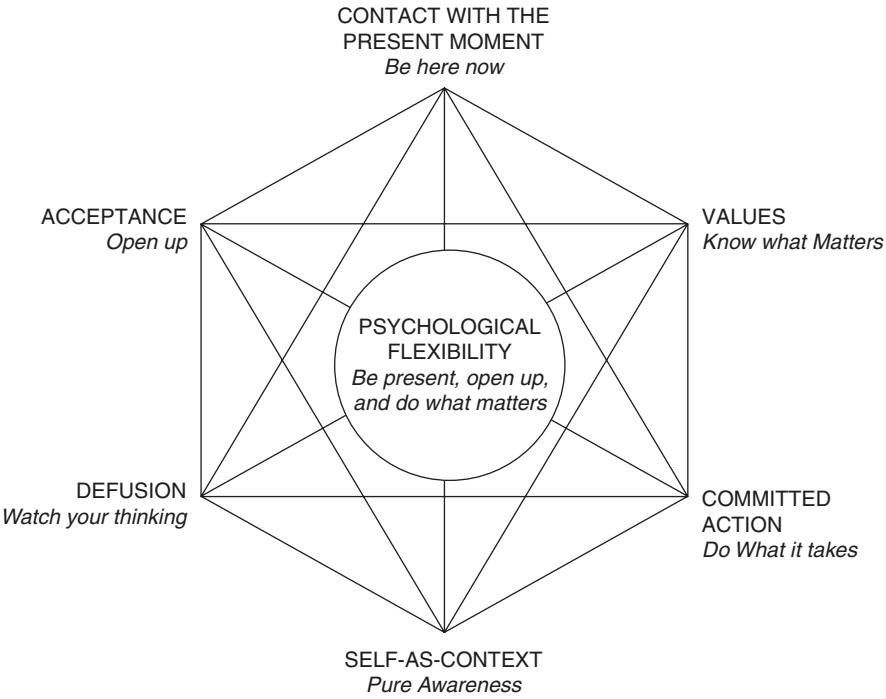

Fig. 6.3 ACT hexaflex—the six core therapeutic processes of ACT

accepting the pain that life inevitably brings. ACT has been shown to be effective for increasing psychological resilience for patients and significant reductions in measures of depression, anxiety and avoidance for skin pickers.

Mindfulness

Mindfulness is learning to disengage with thoughts and concentrate on the present moment. To be able to sit with distress and become aware of patterns in the mind. For example, to notice an urge to pick and to avoid self-critical thoughts without judgement. Whilst mindfulness is an ancient form of Buddhist meditation, it has become increasingly popular in current day therapies; within psychological therapy for skin conditions and especially via Apps, such as Headspace or Calm. Mindfulness is 'cultivating our ability to pay attention in the present moment'. It helps the individual to alleviate distress by disengaging from their automatic negative thoughts. Mindfulness facilitates acceptance of the situation in the present moment, whilst taking mindful action toward desired change. As with many new strategies, practice is the key to developing the skill. Over time the patient learns to cope with automatic thoughts and become more tolerant of stress. This is turn reduces the effect of

stress on the skin condition. Research has shown that delivering a brief audio mindfulness intervention during ultraviolet light therapy can increase the resolution rate of psoriatic lesions in patients with psoriasis. It has also been shown to be effective for those with dermatillomania. Studies show that mindfulness can change brain structures. The outcome of consistent regular practice can eventually lead to new automatic authentic changes, which lead to permanent behaviour modification.

Systemic Family Therapy

Systemic family therapy is a therapy that does not directly work on the mental illness within the patient. It aims to help the person mobilise the strengths of their relationships, to make the psychological difficulties less problematic. There is an understanding that psychological difficulties are due to past and present relationship problems and develop in the context of family and social relationships. Also that reciprocal dynamics in the family influence the problem/s.

One person can hold the stress, anxiety or anger for example, but focussing on the family dynamics and relationships in therapy can reduce stress in the individual, see Fig. 6.4 below.

One idea in SFT is that problems have a dual construction; they do not exist only within an individual, but rather are a product of the interactions between people and wider systems, such as communities and cultures. Within psychodermatology this approach links the patient's skin story with how patients are often influenced by other people's opinions (i.e. the problem of stigma within communities).

Figure 6.5 shows a formulation created for a patient who had psoriasis. The patient's psychological distress was rooted in adverse past experiences, perpetuated by negative thoughts and were precipitated and perpetuated by past and present relationship dynamics and interactions. She had a traumatic history of sexual abuse, being bullied and not being accepted by her parents or first husband. When she disclosed to her first husband that she had been abused, he left her, which perpetuated

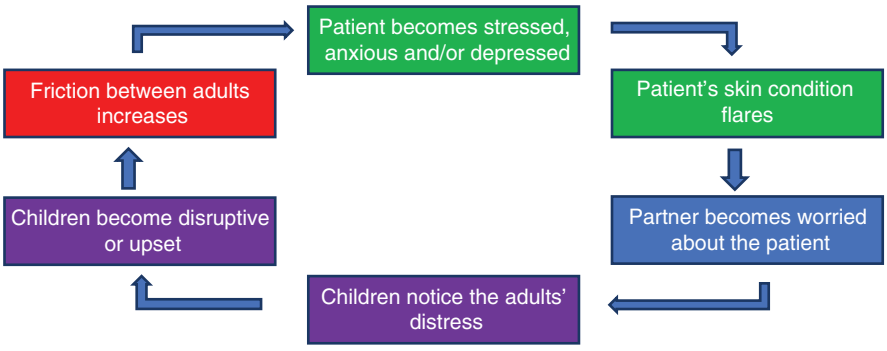

Fig. 6.4 Systemic family therapy diagram adapted for skin (taken from—http://www.svhf.ie/systemic-family-therapy.html)

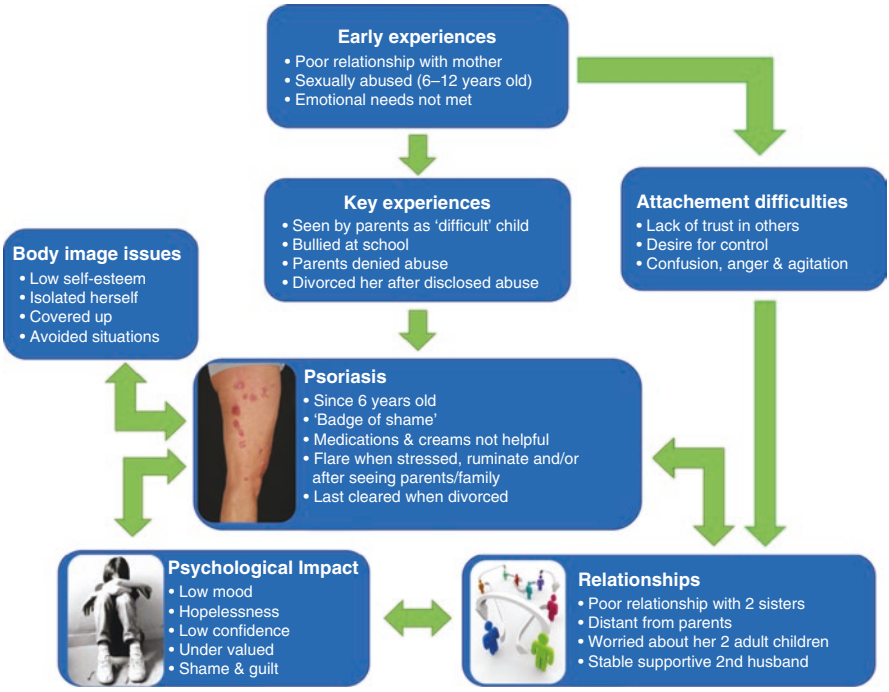

Fig. 6.5 Psychological formulation of the patient's experience and how the factors were related to each other (taken from Shah and Bewley 2014)

her shame about the abuse and exacerbated the psoriasis. She had difficult relationships throughout life as a consequence, due to a lack of trusting others and an underlying anger towards those she loved. She lived with periods of depression and shame which correlated with the inflammation of psoriasis. Using SFT, the difficulties that she had in her relationships were addressed. Helping her work on her difficult emotions and her interactions within her family and wider system, had an indirect positive effect on her skin (given the link between stress and the skin).

Overview of Talk Therapies

In this chapter, we have looked at various psychological approaches. When thinking about which therapy to offer, a thorough assessment is required and then a psychologist would also create a formulation for the patient (see Fig. 6.6). It is important to consider the impact on the quality of life and daily functioning and the level of distress and risk. The need for more complex psychological therapies is dependent on the severity of psychological distress. Table 6.1 gives an overview of the types of therapies that could be considered for different types of skin conditions.

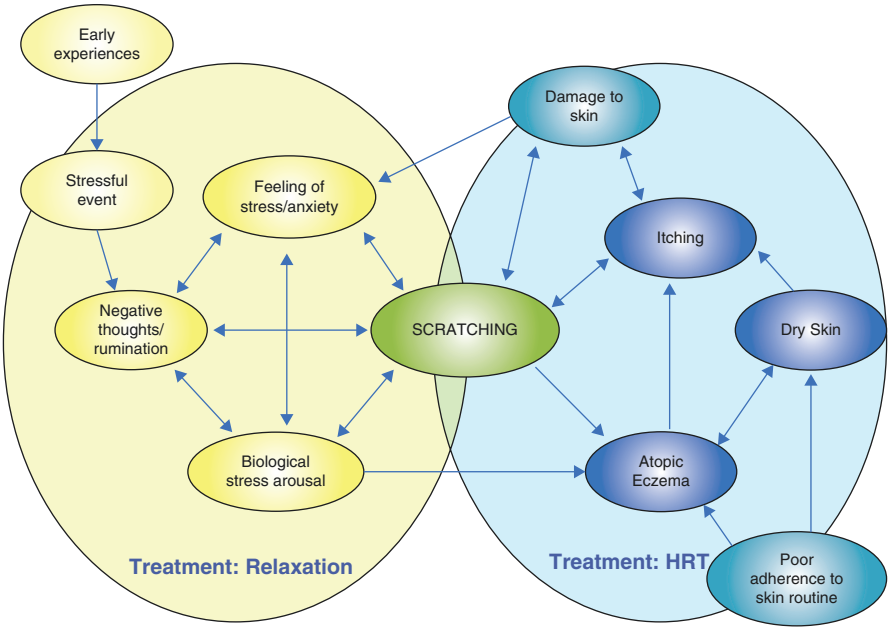

Fig. 6.6 Psychological formulation showing the links between scratching and stress and the mode of therapy used to help the difficulties. Shah and Bewley (2014)

Table 6.1 Overview of different talk therapies and which may be considered for each skin problem grounded on evidence-based and practice-based evidence

	Behavioural therapies	Cognitive behavioural therapy	Systemic family therapy	Schema therapy	Trauma-based therapies
Efficacy (evidence and practice based)	Eczema, psoriasis, vitiligo, acne, nodular prurigo, dermatillomania	Eczema, psoriasis, vitiligo, acne, dermatillomania, trichotillomania, vulvodynia, body dysmorphic disorder, delusional infestation	Psoriasis, eczema, vulvodynia, vitiligo, dermatitis artefacta	Psoriasis, eczema, acne, rosacea, urticaria pigmentosa	Acne excoriee, Dermatillomania, psoriasis, BDD, dermatitis artefacta
Time frame	Here and now symptoms	Here and now symptoms	Relationships, interpersonal issues, here and now symptoms	Here and now symptoms, adjustment issues	Past issues, current relationships
Duration	Short-term	Short-term	Mid-range	Short-term	Long-term

Formulation

Principles

Formulation is a method that Psychologists use to conceptualise the person's problem/s and situation presented to them to help gain an understanding of the individual's needs. Clinical Psychologists are trained in multiple models, which they can draw upon to develop an individual understanding of the patient's predisposing, precipitating, perpetuating, presenting and protective factors. Therefore, therapy is tailored to meet the patient's goals (based on evidence-based and practice-based evidence). This method sometimes requires the therapist to integrate different psychological approaches within the therapy. An example of this is shown below where after the assessment, a formulation was completed and two approaches were used within therapy: habit reversal therapy (HRT in diagram) and relaxation/mindfulness to enhance outcome (Fig. 6.6).

Consequences for Clinical Set Ups

Having a psychologist dedicated to working in dermatology can be helpful and recommended as gold standard as they are able to work with complex histories and problems. The cost and clinical benefits are also undeniable. One UK study (Shah 2018) showed that 86% of patients were discharged from the dermatology service after completing psychological therapy. This was a significant increase in the discharge rate in the service. The results on clinical utility indicated that there was a statistically significant improvement in patients' psychological distress; anxiety, depression, appearance-related concern, and QoL scores. Savings were calculated because patients who were successfully discharged no longer sought dermatological services at the same rate as before they were seeing a psychologist. The cost-benefit analysis showed that for the successful patients, for each year of a 5-year period, the projected savings from not providing additional dermatological services would accumulate at £19,370/year savings to the service. Studies have demonstrated significant cost-savings across a range of psychocutaneous diagnoses, (e.g. Golding et al. 2017).

Practice Points

- When assessing patients for levels of psychological distress, using standardised measures such as the PHQ-9, GAD-7 or DLQI can be helpful, (see Shah 2014 for a list of measures).
- Allow time for psychoeducation: explaining the link between the mind and skin and the importance of considering psychology. This can help to reduce the stigma of mental health, fear of the unknown and the potential high

level of shame about their difficulties. For example, providing a leaflet about how skin disorders can affect emotional wellbeing can be helpful.
- Understanding the benefit of psychological interventions will help with the assessment process to increase the use of psychological strategies in routine practice or to refer on as appropriate.
- Dependent on the severity of psychological distress, look at the stepped care model and where to refer. Psychologists offer consultation to bring a different perspective to complex cases.
- Offer relaxation as a baseline strategy to help reduce stress.

References

Finlay AY, Khan GK. Dermatology life quality index (DLQI): a simple practical measure for routine clinical use. Clin Exp Dermatol. 1994;19:210–6.

Golding GMR, Harper N, Kennedy L, Martin KR. Cost-effectiveness in psychodermatology: a case series. Acta Derm Venereol. 2017;97:663–4.

Hudson MP, Thompson AR, Emmerson L-M. Compassion-focused self-help for psychological distress associated with skin conditions: a randomized feasibility trial. J Psychol Health. 2020;35(9):1095–114.

Kroenke K, Spintzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606–13.

Lavda AC, Webb TL, Thompson AR. A meta-analysis of the effectiveness of psychological interventions for adults with skin conditions. Br J Dermatol. 2012;167:970–9.

Lilly E, Lu PD, Borovicka JH, Victorson D, Kwasny MJ, West DP, Jundu RV. Development and validation of a vitiligo-specific quality-of-life instrument (VitiQoL). J Am Acad Dermatol. 2013 Jul;69(1):e11–8.

Mizara A, Papadopoulos L, McBride SR. Core beliefs and psychological distress in patients with psoriasis and atopic eczema attending secondary care: the role of schemas in chronic skin disease. Br J Dermatol. 2012;166(5):986–93.

Motley RJ, Finlay AY. Practical use of a disability index in the routine management of acne. Clin Exp Dermatol. 1992;17:1–3.

Panebiano A, Sampogna F, Lemboli ML, Sobrino L, et al. A screening programme for dermatologists as a guide to request psychological consultation in routine clinical practice. Eur J Dermatol. 2018;28(3):326–31.

Shah R. Psychological assessment and interventions for people with skin disease. In: Bewley A, Taylor RE, Reichenberg JS, Magid M, editors. Practical psychodermatology. 1st ed. Chichester: Wiley; 2014.

Shah R. Impact of collaboration between psychologists and dermatologists: UK hospital system example. Int J Women's Dermatol. 2018;4(1):8–11.

Shah R, Bewley A. Psoriasis: 'the badge of shame'. A case report of a psychological intervention to reduce and potentially clear chronic skin disease. Clin Exp Dermatol. 2014;39:600–3.

Shah R, Hunt J, Webb TL, Thompson AR. Starting to develop self-help for social anxiety associated with vitiligo: using clinical significance to measure the potential effectiveness of enhanced psychological self-help. Br J Dermatol. 2014;171(2):332–7.

Spitzer RL, Kroenke K, Williams JB, et al. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092–7.