V-VICTA®

VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - ANXIETY

Training Manual

VirTra

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TRAINING COURSE CERTIFICATION

This "Mental Illness: A Practical Approach" training course has been certified by the IADLEST™ National Certification Program on 9/23/2022.
Certification number: 22505-2209

TOPIC

Mental Illness: A Practical Approach - Anxiety

ESTIMATED TIME

1 hour

PERFORMANCE OBJECTIVES

(Slide 3) At the end of 1 hour of instruction in a video simulation the student will successfully be able to:

A. Understand the role of contact professionals
B. Recognize signs, symptoms and behaviors associated with anxiety
C. Demonstrate skills for dealing with individuals who have anxiety

CLASS SIZE

Designed for pairs of officers with maximum class size of 8 (4 pairs). If class size is smaller than 8 (4 pairs) scenarios can be cycled through.

The following training plan and lesson plan is designed to be used with the VirTra simulator. Where as many of the techniques have been used over many years in LE, this training plan maximizes training time and leverages the strengths of the VirTra Training System.

The instructor shall first ensure that students are familiar with the presented material. The outline is provided to supplement and provide context to the use of the simulation scenarios.

The simulation scenarios are used as a tool to facilitate the understanding of the concepts. The first scenarios will be provided in a slower tempo with the use of the PLAY/PAUSE feature to elaborate on the training points. Once the first simulation is provided in this format the remaining scenarios will be provided to each pair of officers. The Socratic methodology should be used for event debriefing.

"What did you know?"
"What did you see or hear?"
"What did you do and the reason behind it?"
"What would you do differently in the future?"

All officers will be allowed to watch the other pairs participate in the exercise. This is done to maximize the benefit of modeling for adult learners. Students shall be given the opportunity to ask questions at the end of each section.

SAMPLE STUDENT GROUP SET UP

Non-test scenarios should be used with the concept of social learning theory and observation. The non-participating students should be watching their peers and be ready to answer what other options may have been available after the initial Socratic debrief.

A. Officer Yackley and Officer Emerson
B. Officer Danninger and Officer Ashley
C. Officer Bacon and Officer Adams
D. Officer Stephens and Officer Marks

First Scenario - Executed in “PLAY/PAUSE” methodology for all students - key concepts are applied and discussed
Second Scenario - Group A participates while Groups B, C, and D watch
Third Scenario - Group B participates while Groups A, C, and D watch
Fourth Scenario - Group C participates while Groups A, B, and D watch
Fifth Scenario - Group D participates while Groups A, B, and C watch
Sixth Scenario - (Practical skills test) Class is sequestered with students brought one at a time (not pairs) to evaluate performance.

SCENARIO BANK TO BE USED

A. Office Anxiety
B. On the Case
C. Party Pooper
D. Government Spy Games

I. INSTRUCTOR INTRODUCTION

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

A. WHAT IS MENTAL HEALTH?

B. MENTAL ILLNESS

C. WHO CAN DIAGNOSE?

D. THE ROLE OF CONTACT PROFESSIONAL

III. ANXIETY DISORDERS

A. ANXIETY DISORDERS

1. Generalized Anxiety Disorder

2. Social Anxiety Disorder

3. Panic Disorder (with or without agoraphobia)

4. Panic Attacks

5. Agoraphobia

6. Specific Phobias

7. Obsessive Compulsive Disorder

B. RISK FACTORS/CAUSES OF ANXIETY DISORDERS

C. SIGNS, SYMPTOMS, BEHAVIORS

D. HOW TO HELP SOMEONE WITH ANXIETY

E. CRISIS BEHAVIORS ASSOCIATED WITH ANXIETY

1. Suicidal Ideation and Behavior

2. Non-Suicidal Self Injury

3. Requirement of Medical Attention

F. VERBAL DE-ESCALATION LOOP BEHAVIORS

IV. CONCLUSION

TABLE OF CONTENTS

I. INSTRUCTOR INTRODUCTION

Instructor will introduce themselves to the class. This introduction should be no more than 2-3 minutes long and establish why they are qualified to teach the course and how long they have been with the organization. This not a moment to brag, but to build confidence and trust from the attending students.

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

A. WHAT IS MENTAL HEALTH?

(Slide 6) Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

B. MENTAL ILLNESS

(Slide 7) Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities. Many factors contribute to mental illness: biological factors, stress and trauma, life experiences, and long-lasting health conditions. Mental illness becomes problematic when daily activities, relationships, and work is affected. Mental illness can be very impactful in a person's life.

C. WHO CAN DIAGNOSE?

(Slide 8, 9) Psychiatrists, psychologists, counselors, clinicians, therapists, clinical social workers, psychiatric nurse practitioners, physicians, and nurse practitioners. This can vary by state, licensing requirements, and master's level program requirements. Only psychiatrists, physicians, physician's assistants, psychiatric nurse practitioners, and nurse practitioners (state dependent) can prescribe medication.

A mental health professional will conduct a full mental health assessment before diagnosing a person with a mental illness. The assessment may consist of:

1. Physical Exam
2. Lab Tests
3. Mental Health History
4. Personal History
5. Mental Evaluation
6. Cognitive Evaluation

D. THE ROLE OF THE CONTACT PROFESSIONAL

1. Contact professionals are not trained to diagnose nor should they. Familiarization and recognition of behaviors are critical in decising an intervention response. The intervention response should be as safe and effective as possible for all parties involved.
2. Behavioral health response and/or crisis intervention should be a coordinated effort that is as safe and effective as possible for everyone involved.
3. The focus should fall in recognizing indicators and signs associated with behaviors.
4. Safety is paramount and should not be compromised situationally for a behavioral health response or crisis intervention. Crisis intervention, behavioral health intervention, and de-escalation tactics are integrated responses based on the totality of circumstances.
5. Refer to department policies and legal department mandates for behavioral health or crisis response.

III. ANXIETY DISORDERS

Play the “Depression and Anxiety 2” 10 minute video from the simulator. Click on the V-VICTA icon > Content > Manuals > V-VICTA > Mental Illness > Videos

(Slide 11) Everyone experiences anxiety at some point in their life. Sometimes, anxiety can be a motivator to do better or be more cautious. Normal anxiety is temporary. However, anxiety disorders surface when feelings of excessive worrying, intense fear, and distress become overwhelming and interfere with the daily activities, such as work, school, and relationships.[1,2] Anxiety can vary in severity and symptoms and increase over time.

Overall, anxiety disorders are the most prevalent mental illness with an estimated 19.1% of people had an anxiety disorder on the past year and 31.1% of U.S. adults experience an anxiety disorder in their life.[2] Anxiety disorders usually share the common symptoms of excessive worry in non-threatening situations.[1] Many times, anxiety disorders share symptoms of physical health conditions and ban be difficult for a practitioner to diagnose without a full physical examination and lab tests.

People who have high levels of anxiety or a long period of time may also experience depression. Many people who have anxiety disorder may have a substance use disorder as well in an attempt to self-medicate. The substances themselves may also increase anxiety over time.

A. ANXIETY DISORDERS[1, 2, 3]

1. Generalized Anxiety Disorder

(Slide 12) Generalized Anxiety Disorder (GAD) has symptoms of excessive anxiety and worry that occur more days than not for not less than six months. The individual finds it difficult to control the worry and three out of the six symptoms are present for more days than not in the past six months:

A. Restlessness
B. Being easily fatigued
C. Difficulty concentrating or mind going blank
D. Irritability
E. Muscle tension
F. Sleep disturbance

The excessive anxiety and worry occur even when there is nothing to worry about. The symptoms interfere with the ability to function in various areas such as work, school, and home.

2. Social Anxiety Disorder

(Slide 13) People with social anxiety disorder have a general intense fear or anxiety toward social or performance situations. This can be driven by the irrational fear and worries about being embarrassed or humiliated. Many times, individuals with social anxiety disorder become isolated.

3. Panic Disorder (with or without agoraphobia)

People with panic disorder have recurrent unexpected panic attacks. Panic attacks are sudden periods of intense fear that come on quickly and reach their peak within minutes. Attacks can occur unexpectedly or can be brought on by a trigger, such as a feared object or situation. People with panic disorder often worry about when the next attack will happen and actively try to prevent future attacks by avoiding places, situations, or behaviors they associate with panic attacks and may become agoraphobic. Panic disorder is associated with several psychiatric conditions, such as depression and other anxiety disorders and is one of the most common anxiety disorders overall.[4] There is an increased suicide risk in people with panic disorder that experience depression.[5]

4. Panic Attacks [2, 3]

(Slide 14) Panic attacks are sudden periods of intense fear that come on quickly and reach their peak within minutes. Attacks can occur unexpectedly or can be brought on by a trigger, such as a feared object or situation. Having a panic attack does not mean a person will develop panic disorder. Panic attacks can be singular, isolated incidents. Symptoms of a panic attack are as follows:

A. Heart palpitations, a pounding heartbeat, or an accelerated heartrate
B. Sweating
C. Trembling or shaking
D. Sensations of shortness of breath, smothering, or choking
E. Feelings of impending doom
F. Feelings of being out of control

Panic attack symptoms mimic heart attack symptoms in many ways. It is not up to the contact professional at the scene to determine whether or not a person is experiencing a panic attack versus a heart attack. It is important to call for medical assistance immediately.

5. Agoraphobia

(Slide 15) When most people think about agoraphobia, they think about someone never leaving the house. Agoraphobia is more than just that. People who have agoraphobia have an intense fear of two or more of the following:

A. Using public transportation
B. Being in open spaces
C. Being in enclosed spaces
D. Standing in line or being in a crowd
E. Being outside of the home alone

In the most severe form of agoraphobia, individuals may become housebound.

6. Specific Phobias

(Slide 16) People who have a specific phobia have an intense fear of specific types of objects or situations. Some examples of specific phobias include the fear of:

A. Flying
B. Heights
C. Specific animals, such as spiders, dogs, or snakes
D. Receiving injections
E. Blood

7. Obsessive Compulsive Disorder [3, 6]

(Slide 17) Most people have obsessive thoughts or compulsive behaviors on occasion. An individual with obsessive-compulsive disorder has symptoms that generally last for more than an hour each day and interfere with daily life. Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). Although people with OCD may know that their thoughts and behavior don't make sense, they are often unable to stop them.

A. (Slide 18) Obsessions are intrusive, irrational thoughts or impulses that repeatedly occur. Examples of obsessions are:

   1. Thoughts about harming or having harmed someone
   2. Doubts about having done something right, like turning off the stove or locking a door
   3. Unpleasant sexual images
   4. Fears of saying or shouting inappropriate things in public

B. (Slide 19) Compulsions are repetitive acts that temporarily relieve the stress brought on by an obsession. Examples of compulsions are:

   1. Hand washing due to a fear of germs
   2. Counting and recounting money because a person can't be sure they added correctly
   3. Checking to see if a door is locked or the stove is off
   4. "Mental checking" that goes with intrusive thoughts is also a form of compulsion

B. RISK FACTORS/CAUSES OF ANXIETY DISORDERS [1]

(Slide 21, 22) Studies have shown that there are both environmental and genetic risk factors for anxiety disorders. Some general risk factors are:

1. Shyness or behavioral inhibition in childhood
2. Exposure to stressful events in early childhood and adulthood (divorce, separation, poverty)
3. Exposure to traumatic events in childhood and adulthood (physical, emotional, sexual abuse)
4. Alcohol abuse
5. Prolonged illness
6. History of anxiety or other mental illness in biological relatives
7. Certain physical health conditions

Symptoms can also occur as a result of side effects of prescriptions drugs as well as intoxication and withdrawal from alcohol, prescription drugs, or illicit drugs.

C. SIGNS, SYMPTOMS, BEHAVIORS [1, 3, 6]

(Slide 24) Anxiety can manifest in many ways. An individual may show many signs, very few, or sometimes none at all. Some symptoms of anxiety are:

1. Feeling restless, wound-up, or on-edge
2. Being easily fatigued
3. Having difficulty concentrating; mind going blank
4. Being irritable or restless
5. Having muscle tension
6. Difficulty controlling feelings of worry
7. Having sleep problems, such as difficulty falling or staying asleep, restlessness, or unsatisfying sleep
8. Feelings of apprehension or dread
9. Feeling tense or jumpy
10. Anticipating the worst and being watchful for signs of danger

D. HOW TO HELP SOMEONE WITH ANXIETY

1. Be direct. Talk openly and ask questions.
2. Be willing to listen. Let the person talk. Do not interrupt or interject your own experiences.
3. Allow expression of feelings. Emotions and feelings are energy and have to go somewhere.
4. Accept the feelings.
5. Be non-judgmental.
6. Be cautious about saying you “understand” what someone is going through or experiencing. That can be inadvertently inflammatory. More appropriate would be “help me understand what you’re feeling or going through.”
7. Encourage the person to get help.
8. Call for medical assistance if a person appears to be experiencing a panic attack
9. If a person expresses thoughts of suicide or self-harm, there will be the need for behavioral health intervention.

E. CRISIS BEHAVIORS ASSOCIATED WITH ANXIETY

(Slide 26) Addressing crisis behaviors is imperative to stabilizing the situation and the person. Crisis behaviors associated with anxiety disorders are similar to that of depression.

1. Suicidal Ideation and Behavior

(Slide 27) Crisis intervention is critical for a suicidal person as well as asking the questions that determine the level of suicidality to provide the person the appropriate level of services. Be direct and ask the following questions:

A. Are you thinking about killing yourself?
B. Are you having thoughts of suicide?
C. Do you have a plan to kill yourself?
D. If so, what is your plan?

Saying the word(s) suicide or killing yourself will not put that idea into a person’s thoughts. A person talking about suicide can be reaching out for help and serious about completing the act. The only way to determine if the person wants to kill himself is to ask directly.[8]

2. Non-Suicidal Self Injury

A. (Slide 28) Non-suicidal self injury (NSSI) is defined as intentionally causing destruction to one's skin or body without the intent to die.[9] NSSI can be both a mental health crisis and physical health crisis dependent on severity of injury.
B. NSSI is also known as self-mutilation, self-harm, or self-injury.
C. Common behaviors associated with NSSI: [9, 10]

1. Cutting
2. Burning
3. Interfering with wound healing (picking or reopening wounds)
4. Punching or hitting oneself or other objects
5. Inserting objects into the skin
6. Purposely bruising or breaking one's bones
7. Certain forms of hair pulling

3. Requirement of Medical Attention

(Slide 29) A person in crisis may exhibit many signs of distress and may require medical attention at some point during contact. Staging medical during a crisis situation is appropriate so there is not a delay in treatment for that person. Be aware of both the behavioral health and physical health crisis that may surface.

A. Shallow, rapid breathing
B. Grunting
C. Bluish tinge from a lack of oxygen
D. Nasal flaring
E. Confusion/disorientation
F. Seizures
G. Vomiting
H. Hyperventilating
I. Unconscious
J. Headache

F. VERBAL DE-ESCALATION LOOP INTERVENTIONS [11, 12]

(Slide 30)
1. Speak in a low, calm voice
2. Listen with empathy
3. Respond to some aspects of communication with understanding
4. Be clear but non-confrontational
5. Use active listening skills

IV. CONCLUSION

As it is of utmost importance, below is a reiteration of the role of the contact professional.

A. Contact professionals are not trained to diagnose nor should they. Familiarization and recognition of behaviors are critical in deciding a response. The intervention response should be as safe and effective as possible for all parties involved.
B. Behavioral health response and/or crisis intervention should be a coordinated effort that is as safe and effective as possible for everyone involved.
C. The focus should fall in recognizing indicators and signs associated with behaviors.
D. Safety is paramount at all times and should not be compromised situationally for a behavioral health response or crisis intervention. Crisis intervention, behavioral health and de-escalation tactics are integrated responses based on the totality of circumstances.
E. Refer to department policies and legal department mandates for behavioral health or crisis response.

V. QUESTIONS?

VI. REFERENCES

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