

Facilitator Notes: **Schizophrenia**

We are preparing these lessons for individuals with a wide range of experience in providing training to their staff and co-workers. As a result, we have provided considerable structure and advice for those who would like it. Please feel free to change and improve on these lessons and make them your own. Our philosophy is that the best lesson is the one that reflects what you think is worth learning.

What to do before the session

- Read the lesson; decide if you want to make changes.
- Adjust the amount of materials covered by eliminating exercises or by deciding what to cover in greater detail.
- Make copies of handouts and exercises for each participant.
- Set up the presentation area to accommodate participants in groups of 2-5. It will be helpful but not critical if they have a surface to write upon.

Notes to the Facilitator

Notes to the facilitator of the lesson are written in blue and enclosed in []. They include background information, questions to ask the learners, points to emphasize, and answers to exercise questions. The “participant” versions of the handouts and exercises do not have them. Use them to orient yourself to the lesson, or simply ignore them if it is too much information.

Introducing the topic -- here are some points you might want to make

- Schizophrenia is among the most disabling of the major mental illnesses, and the most common mental illness experienced by supported employment participants
- Perceptual/sensory difficulties, cognitive limitations, apathy, poor social skills, and stigma can make these individuals difficult to serve.
- Having a basic understanding of schizophrenia and how it impacts people can help us get to know the individuals we serve and to identify effective support strategies.

30 Minute Lesson: Schizophrenia

Facilitator Version

Lesson Summary

Schizophrenia (also known as thought disorder) is a brain disease that causes impairment in thinking, delusions, hallucinations, changes in emotions, and changes in behavior. This lesson focuses on building an understanding of this disorder.

Learning Objectives

- < Build an understanding of Schizophrenia: causes, prevalence, symptoms, treatment strategies
- < Understand the difference between positive and negative symptoms
- < Learn about the origin of the stigma associated with Schizophrenia

The Ideal Participant

- < Works with individuals with mental health (psychiatric) disabilities in an employment context

Prep activities and time required

10-20 minutes, including reading the lesson, making copies of handout exercises, and organizing.

Lesson length, other requirements

30-45 minutes. Can be adjusted by eliminating or modifying exercises

Does not require an overhead or LCD projector. A flip chart or whiteboard is handy but not necessary. All handouts are ready to use, or can be modified by user to meet specific needs.

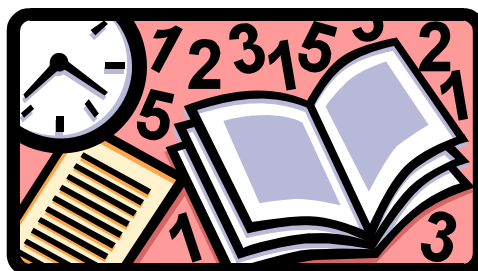
Other related lessons

Mood (Affective) Disorders

Personality Disorders

Test Your Knowledge!

[About 5 minutes to take the quiz; 5 additional minutes at the end to review the correct answers. The point of this activity is to get your learners thinking about their knowledge, and to test some of their assumptions. Have them complete the questions individually or with a partner, then hang on to their papers. At the end of your session, review the correct answers (supplied in green).]



1. When (what time of life) do the symptoms of schizophrenia generally appear?

Late teens or early adulthood. This is significant for employment services, since this is the time of life that people typically complete their education and explore career options. People who spend those years dealing with schizophrenia often miss some important developmental activities.

2. What is the difference between positive and negative symptoms?

Positive symptoms are added to the person's behavior (e.g. hallucinations); negative symptoms are missing from the person's behavior (e.g. apathy or flat affect).

3. True or false: people with paranoid delusions often believe that they are being watched, followed, controlled, or cheated.

True.

4. True or false: people who have schizophrenia are immune from developing major depression.

False; many people with schizophrenia area also depressed.

5. Does the Greek meaning of the words "schizo" and "phrenia" accurately reflect the disease we know as schizophrenia? Why or why not?

No; "schizo" and "phrenia" translate as "split brain" and more accurately reflect the illness we now know as multiple personality disorder rather than the splitting from reality found in schizophrenia.

6. True or false: Negative symptoms generally respond better to medication than positive ones.

False; positive symptoms are more often alleviated by medication while negative symptoms like flat affect persist.

Schizophrenia (Thought Disorder) Overview

[10 minutes. These two pages review information about schizophrenia. You can go through the material in lecture format, have participants read the sections to themselves, or take turns reading them out loud. You might have the group address the questions in blue type as you go along.]

Schizophrenia (also known as thought disorder) is a brain disease that causes impairment in thinking, delusions, hallucinations, changes in emotions, and changes in behavior. It is not the same as split personality. Its symptoms are predictable and usually treatable.

It is most common for schizophrenia to be diagnosed between 15 and 30 years of age, but it may develop as late as age 40. It occurs in all races, in all cultures, in all social classes, and in both sexes.

[Why is the timing of diagnosis significant for employment providers? (Interferes with typical education and vocational development)]

The long-term impact of schizophrenia differs widely across those who experience the disorder. Some individuals find that their symptoms are well controlled by medication, and they are able to maintain a lifestyle that includes full-time employment, a family, and other aspects of “normal” life. Others will have less success with medication and will continue to experience many intrusive symptoms that make it more difficult for them to achieve any sort of stability, let alone employment. Between these extremes lie the majority of people with schizophrenia, whose symptoms are lessened but not eliminated by medication; and who need skill training and support to deal with those symptoms while going to school, working, living independently, and establishing stable personal relationships.

[Which kind of folks do we see in employment services – those who are doing well or those who are disabled by the illness?]

What causes schizophrenia?

The causes of schizophrenia are still unclear. Schizophrenia tends to “run in families;” that is, a person inherits a tendency to develop the disease. Schizophrenia generally appears when the body undergoes hormonal and physical changes, like those that occur during puberty in the teen and young adult years. The symptoms of schizophrenia may also be triggered by environmental events, such as viral infections or highly stressful situations or a combination of both.

People with schizophrenia have a chemical imbalance of brain chemicals (serotonin and dopamine) which are neurotransmitters. These neurotransmitters allow nerve cells in the brain to send messages to each other. The imbalance of these chemicals affects the way a person's brain reacts to stimuli--which explains why a person with schizophrenia may be overwhelmed by sensory information (loud music or bright lights) which other people can easily handle. This problem in processing different sounds, sights, smells and tastes can also lead to hallucinations or delusions.

Early treatment is important to reduce the chance of suicide (1 out of 10) and minimize the physical and psychological damage that can result from prolonged symptomatic periods.

Schizophrenia is not thought to be curable at this time. In some cases people get better on their own, but most people find that medication and supportive services help control symptoms.

Many if not most people with schizophrenia will continue to recover and improve over a very lengthy period. After the age of 40, life often becomes less difficult: positive symptoms tend to diminish and medication can often be taken at a low dose or less frequently. One study done for more than 30 years on persons from the Vermont State Hospital who were moved into the community showed that one-half to two-thirds eventually functioned at a level that showed minimal affects of the disability. New medical treatments and an emphasis on treating people in the community rather than isolating them in hospitals for extended periods will undoubtedly improve the prognosis for people with schizophrenia.

[Before going on to the discussion of the symptoms of schizophrenia, you might want to have the group brainstorm what they have noticed about people with this diagnosis, then as you move through the next few pages, see how many of the common symptoms are included in the list that's developed.]

“Positive” Symptoms of Schizophrenia

[5-7 minutes to cover the next two pages. You can go through the material in lecture format, have participants read the sections to themselves, or take turns reading them out loud.]

Positive" as used here does not mean "good." Rather, it refers to having easy-to-spot behaviors that are not seen in other people. Positive symptoms can come and go. Sometimes they are severe and at other times hardly noticeable.

Hallucinations. A hallucination is something a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. Many people with schizophrenia hear voices that comment on their behavior, order them to do things, warn them of impending danger, or talk to each other (usually about the person). They may hear these voices for a long time before family and friends notice that something is wrong. Individuals who experience this describe it "like a tape playing in my head". The experience is so real that many people with schizophrenia are convinced someone has implanted a broadcasting device in their bodies. It is so real to the person that it cannot be dismissed as imagination.

During periods of stability, people often learn to control their voices, ignore them, or treat them as a benign part of everyday living. During periods of increased symptoms, it may seem like the voices take control and the person feels victimized, powerless, and at the mercy of another presence.

Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects, and feeling things like invisible fingers touching their bodies when no one is near.

Hallucinations are thought to be a result of over-sharpening of the senses and of the brain's inability to interpret and respond appropriately to incoming messages. They often respond to a lessening of stress and an increase of antipsychotic medication. Keeping busy is important as it provides a helpful distraction. Competing stimuli (like listening to music through headphones) can sometimes "drown out" the voices. Encouragement to persevere and reassurance that other people understand, are important. Constant talking about hallucinations can be exasperating but it is understandable that the person is preoccupied with such extraordinary events.

There is a great booklet, "Coping with Voices: Self-help strategies for people who hear voices that are distressing" by Patricia Deegan that offers 18 different strategies. It is available from the National Empowerment Center; go to <http://www.power2u.org/mm5/merchant.mvc>? and click on books.

Some example suggestions from Pat Deegan's book on coping with voices:

- Use your own voice (speaking, singing, counting)
- Try activities or tasks that require your full attention such as housework or sports.
- Put an earplug in one ear.
- Get physical exercise.
- Use meditation or relaxation techniques.

Delusions. Delusions are ideas that the person believes to be true, but which cannot be true or are not validated by members of his/her culture; and to which he adheres in despite obvious evidence to the contrary. A belief that might be considered delusional in one cultural may be the norm in another culture. Think about a person who believes that she hears God's voice talking directly to her - in some groups this would be quite acceptable if not admired, while in other groups this would be considered quite bizarre.

COMMON DELUSIONS

Paranoid (characterized by a belief that one is being watched, followed, controlled, cheated, poisoned, persecuted, attacked)

Grandiose (centered on the belief that one is an exalted figure, often political or religious, and that one can exert mind control over others)

Thought control (one's thoughts are being broadcast over the radio or television, or other people are controlling your thoughts)

Arguing about a delusion only leads to mistrust or anger. Try to realize that delusions are a result of illness and not stubbornness or stupidity.

Altered sense of self means blurring of the person's feeling of who he or she is. This is due to difficulty in synthesizing and sorting visual and tactile stimuli, which enable us to differentiate our bodies from the external world of objects. It may be a sensation of

being bodiless, or non-existent as a person. The individual may not be able to tell where his or her body stops and the rest of the world begins. Body parts may be experienced as dissociated or detached, with lives of their own.

Movement. People with schizophrenia can be clumsy and uncoordinated. They may also exhibit involuntary movements and may grimace or exhibit unusual mannerisms. They may repeat certain motions over and over, or experience tremors in their arms or legs.

Restlessness may be a secondary effect of the drugs. This kind of restlessness usually appears as a shaking of the legs and a need to pace the floor. People move from one foot to the other or, when sitting, shake their legs up and down on the ball of the foot.

Suicidal Thoughts and Tendencies. Suicide is a real and tragic consequence for many people with schizophrenia- about 40% will make at least one attempt, and between 10% and 15% actually succeed in killing themselves. A major factor is depression, which is a common companion of schizophrenia disorders. Support providers can help by being very aware of depressive and suicidal tendencies, especially in those individuals recently recovering from an episode or a relapse.

[Have participants turn their packets over and see how many of the positive symptoms they can remember. You can do this as a large group, or have people work individually or in pairs.]

“Negative” Symptoms of Schizophrenia

[5-7 minutes to cover the next two pages. You can go through the material in lecture format, have participants read the sections to themselves, or take turns reading them out loud.]

The term "negative symptoms" refers to reductions in normal emotional and behavioral states; things like immobile facial expression, monotonous voice, lack of pleasure in everyday life, diminished ability to initiate and sustain planned activity, and speaking infrequently. Because it is not as obvious that negative symptoms are part of a psychiatric illness, people with schizophrenia are often perceived as lazy and unwilling to better their lives. As a general rule, negative symptoms do not respond to medication treatment as well as positive symptoms do.

Apathy/lack of motivation: Although many people believe that these sorts of behaviors are due to side effects or a lack of will on the part of the person, most often they are another symptom of the disorder. When you consider that schizophrenia impacts the way an individual senses and perceives the world, it's easier to see why that person might avoid any sort of stimulation. One person suggested a comparable situation: two guys are climbing a mountain, but one is carrying a backpack full of tennis balls and one is carrying a backpack full of rocks. It may seem that the one is lazier for not going at the same pace, but he's got a heavier burden to carry (from www.schizophrenia.com).

Blunted feelings or flat affect refers to a flattening of the emotions. Because facial expressions and hand gestures may be limited or nonexistent, the person seems unable to feel or show any emotion at all.

Depression involves feelings of helplessness and hopelessness, and may stem in part from realizing that schizophrenia has changed one's life, from realizing that the "special feeling" experienced in the psychotic state is an illusion and that the future looks bleak. Often the person believes that he has behaved badly, has destroyed relationships, and is unlovable. Depressed feelings are very painful and may lead to talk of, or attempts at, suicide. Biological changes in the brain may also contribute to depression.

Social withdrawal may occur as a result of depression, as a result of a feeling of relative safety in being alone, or as a result of being so caught up in one's own feelings and fears that one cannot manage the company of others. People with schizophrenia often have trouble with common social cues that most people do and recognize without thinking - body language, eye-contact, gesturing, varying the tone of the voice, etc. They don't realize they are missing these basic cues, and their absence can make the person seem much more withdrawn and cold than they intend to be. ['Coping with schizophrenia: social deficits'](http://mentalhealth.com) from mentalhealth.com has good explanations and suggestions for dealing with this.

Cognition and organization: People with schizophrenia often have unusual thought processes. One dramatic form is disorganized thinking, in which the person has difficulty organizing his or her thoughts or connecting them logically. Another form is "thought blocking," in which the person stops abruptly in the middle of a thought. When asked why, the person may say that it felt as if the thought had been taken out of his or her head. Because thinking is disorganized and fragmented, the person's speech is often incoherent and illogical or the person might make up unintelligible words.

Schizophrenia is frequently accompanied by inappropriate emotional responses: words and mood do not appear in tune with each other. The result may be something like laughing when speaking of somber or frightening events.

Other cognitive symptoms include:

- poor "executive functioning" (the ability to absorb and interpret information and make decisions based on that information),
- inability to sustain attention, and
- problems with "working memory" (the ability to keep recently learned information in mind and use it right away)

Some people get involved in preoccupations: fixed ideas, not necessarily false (like delusions) but overvalued. They take on extraordinary importance and take up an inordinate amount of thought time. One idea often returns and returns. Frequently it is a worry about doing the right thing or doing it well or in time. Characteristically, the worry grows and becomes unrealistic. A common sequence of events is for the worry to take up so much of a person's time that the "right thing" does not get done and its not being done is then attributed to the bad motives of others. It may be rationalized as God's wish, or the person may decide he's physically unable to carry out the task.

[Have participants turn their packets over and see how many of the negative symptoms they can remember. You can do this as a large group, or have people work individually or in pairs.]

The Stigma of Schizophrenia

(This section provides some context for the stigmatization of mental illness in our culture. If time is tight, you might want to assign this for outside reading. If you want to go more deeply into this issue, there are some good examples and resources at <http://www.cinemaniastigma.com/cinemaniamania/psychotropicads.html>)

“While normals can speak openly and even casually about cancer or heart disease, the topic of schizophrenia elicits primarily emotional reactions like fear or derisive humor. Normals are not comfortable with the thought of a seriously mentally ill person living in their neighborhood, being in school with them, or being in their workplace. We still frighten them. They do not know what to expect from us.” From Frederick Freese, 1993, http://www.mentalhealth.com/story/p52-sc04.html#Head_1e

Schizophrenia is a disease that is not well understood and is greatly feared. Most of what people think they know about schizophrenia is wrong. People confuse schizophrenia with split or multiple personality. They believe that people with schizophrenia are violent and dangerous. A limited number are, of course, but media publicity about crimes of violence committed by people with mental disorders has left the public with the impression that most persons with schizophrenia are violent. Wide differences in the effect that schizophrenia has on different people and the difficulty in understanding the actions of someone in a deeply psychotic state reinforce the public's concern. Some believe that people with schizophrenia have weak personalities and have "chosen" their madness; or that it is the result of bad parenting and childhood trauma.¹

The term "schizophrenia" was introduced in 1911 by a Swiss psychiatrist, Eugen Bleuler. The word comes from the Greek schizo meaning "split" and phrenia meaning "mind." Bleuler wanted to convey the split between what is perceived, what is believed, and what is objectively real. He did not mean that the person with schizophrenia is split into two personalities, but that there is a splitting away of the personality from reality. The concept of "split," however, has led to schizophrenia being confused with multiple personality, a less common and very different psychiatric disorder.

Two other theories contributed to the mythology surrounding schizophrenia. The American psychoanalyst Thomas Szasz pronounced that schizophrenia is a set of behaviors, not a disease. The late R.D. Laing, a British psychiatrist, suggested that it is really a "healthy" response to an insane world. People burdened with terrible stress act "crazy" in an effort to adapt. Scientific research and factual data have discredited these theories. Unfortunately, they were all popular enough at one time to have gained public attention.

Aside from the history of blame, the symptoms of the illness itself can often add to the stigma of schizophrenia. The odd and unpredictable behavior, poor functioning, or lack of good health habits

¹ <http://healthlink.mcw.edu/article/1016050014.html>

can be disturbing to others. News coverage on acts of violence or suicides committed by people reported as having schizophrenia serve to add to the stigma, even if unintentionally.²

² <http://www.phac-aspc.gc.ca/mlh-sm/pubs/schizophrenia-schizophrenie/chpt02.htm>

Treatment of Schizophrenia

[5-7 minutes to cover the next two pages. You can go through the material in lecture format, have participants read the sections to themselves, or take turns reading them out loud. You might ask participants to respond to the questions in blue as you go along.]

When acutely ill, people with schizophrenia are sometimes briefly **hospitalized**. This provides the setting needed for observation, testing, differential diagnosis, and initiation of medication under the supervision of trained staff. It also protects the person from injury to self or to others and gives family members some respite.

Since illnesses like schizophrenia are caused by brain chemistry imbalances, **medication** to modify that imbalance is an important treatment component. "Antipsychotic drugs for schizophrenia are exactly the same as insulin for diabetes or digitalis for heart failure - they are drugs needed by the body to restore the functioning of the respective organs (brain, pancreas, and heart) to more normal levels" (Surviving Schizophrenia, p. 118). Medications are not a cure, but for most people they do control the disease, reducing the symptoms, length of hospital stay, and chance of rehospitalization.

Medications are not without their problematic issues. These include:

- < It is hard to predict which medication will be effective - identification of the most effective medication (or combination, or dose) often involves trial and error since people respond differently.
- < Medications take time to work. The impact on symptoms may not be apparent for several days or even weeks. If the first or second medication, dose, and/or combination is not effective, it may thus take weeks or months before the individual is stabilized. Likewise, if the person quits taking the medications, it may be several days before symptoms re-escalate. The person may not even make the connection between symptom increase and discontinuation of the medical treatment.
- < The amount needed will vary over time. Such factors as weight gain or loss, stress, and dietary habits can impact the effect of the medication on symptoms.
- < Side effects may discourage consistent use of medications, and may also present impediments to vocational success. Uncomfortable effects such as akinesia (slowing of movements), akathisia (restlessness), weight gain, constipation, dry mouth, and blurred vision can be problematic. There are also less common but potentially dangerous side effects like tardive dyskinesia (permanent involuntary movement) and agranulocytosis (a deficiency of granular type white blood cells).

- < Positive symptoms are more easily controlled than negative ones. Symptoms such as hallucinations or manic periods are often reduced or controlled, but things such as flattened affect, confused thinking, apathy, and slowness of movement continue despite medical treatment.
- < Medications are less likely to make any huge, noticeable changes in life; instead they should make things generally "easier." Once a person finds a medication that seems to work, the voices/hallucinations may gradually fade away and disappear - or they may not. Sometimes these voices quiet down to a point where they are not harmful or debilitating and many people with schizophrenia make a decision at this point that living with these quieter voices in the background is preferable to going through the pain of more medication and more side-effects.

[What are some of the medication issues you've seen?]

Practical, supportive services (individual or group) which offer friendship, advice, and help with everyday living management can be a useful adjunct to drug therapy. People with schizophrenia may benefit from skills training in vocational and social areas, assistance in identifying and developing compensatory strategies, support for seeking and maintaining employment, involvement in peer groups for people seeking or involved in employment, and so on. Some people may also need assistance with housing, health care, education, accessing income support, and all the other challenges that go along with being poor and disabled.

***Exercise: Instruction and Support Strategies
(5 minutes to develop list)***

The next page will offer some strategies for helping people with schizophrenia learn on the job. Before reviewing this section, ask the group to brainstorm strategies and approaches they've found successful in supporting individuals with schizophrenia. You may want to create a list on flip chart paper or a white board as you solicit ideas from the group. When you have developed your list, move on to review the suggestions on the next couple of pages and see how they compare.

Employment Support Strategies

Effective strategies to assist people with schizophrenia in accessing and maintaining employment often involve the same types of job matching; job analysis, structuring and modification; skill development; and resource development that is done to assist people with other disabilities. This section outlines some approaches to addressing common learning issues.

Intrusion of Internal Events (hallucinations, delusions, illogical thinking)

- Present information in small units
- Monitor thought processes by frequent questions; have worker think aloud
- Use thought stopping or other intrusive stimuli to break into perseveration

Distractibility - Decreased ability to filter and process important information from the environment and ignore unimportant events

- Keep tasks and steps brief and focused
- Use frequent prompts
- Redesign work area to limit distractions and clutter
- Post simple graphic charts or other enhanced cues
- Use visual instructions as well as verbal

Overloading - Information is too complex or too varied to be assimilated at the speed at which it's being presented.

- Use task analyses to break down tasks
- Reduce novelty through repetition of tasks, steps
- Present information in multiple formats; OR limit the number of formats used

Stress Reactions - stress increases symptoms, interferes with comprehension

- Pace training individually, keeping demands low and feedback positive
- Plan a positive way to deal with anxiety
- Allow for escape or time out from training when needed

Misinterpreting Social Interactions - causing confusion and distraction

- Monitor thought processes - have worker think aloud
- Use written instructions as cues
- Have worker record concerns in journal to be shared later
- Roleplay/rehearse social interactions

Lack of ability to generate alternate approaches - due to confused thought processes or

limited work experience

- Cooperatively develop alternate approaches
- Develop decision making rules
- Develop or identify on the job resources for problem solving

Guidelines for Communication

These approaches (from the Community Psychiatric Clinic in Seattle) will assist you in communicating with people with schizophrenia.

- ✓ Help the person organize his thoughts
- ✓ When the person is tangential, help him return to the central point
- ✓ Provide sufficient time for the person to respond to questions without prolonging the silence
- ✓ Adjust the length of the work session
- ✓ Remember that confused verbalizations don't always mean the person doesn't have a meaningful opinion.
- ✓ Don't get caught up in debating delusional material

Internet References on Schizophrenia

<http://www.schizophrenia.com/>

<http://www.mentalhealth.com/book/p40-sc01.html>

<http://www.nimh.nih.gov/publicat/schizosph.cfm>

http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23036&Istid=327

<http://mentalhealth.samhsa.gov/publications/allpubs/ken98-0052/default.asp>

Tips for Helping People who have Schizophrenia

adapted from "Tips for Coping with Having a Family Member who has Schizophrenia" by Rex Dickens of the NAMI Sibling and Adult Children Network (<http://www.schizophrenia.com/family/60tip.html>)

1. You cannot cure a mental disorder for another person.
2. A delusion will not go away by reasoning and therefore needs no discussion.
3. Don't forget your sense of humor.
4. Success for each individual may be different.
5. Acknowledge the remarkable courage the person you're supporting may show in dealing with a mental disorder.
6. The mental illnesses, like other diseases, are a part of the varied fabric of life.
7. The mental illnesses are not on a continuum with mental health. Mental illness is a biological brain disease.
8. You cannot correct a physical illness such as diabetes, the schizophrenias, or manic-depression with talk, although addressing social complications may be helpful.
9. Symptoms may change over time while the underlying disorder remains.
10. The disorder may be periodic, with times of improvement and deterioration, independent of your hopes or actions.
11. An identical diagnosis does not mean identical causes, courses, or symptoms.
12. Strange behavior is symptom of the disorder. Don't take it personally.
13. You have a right to assure your personal safety.
14. Mental health professionals, family members, and the disordered all have ups and downs when dealing with a mental disorder.
15. From Surviving Schizophrenia (Torrey): "Schizophrenia randomly selects personality types, and families should remember that persons who were lazy, manipulative, or narcissistic before they got sick are likely to remain so."
16. Recognizing that a person has limited capabilities should not mean that you expect nothing of them.
17. Don't be afraid to ask your client if he is thinking about hurting himself. A suicide rate of 10% is based on it happening to real people. A person you know could be one. Discuss it to avoid it.

Wrapping up the Session

[It is important to spend a few minutes (5 minutes or so) bringing the lesson to a sensible close. Usually the focus will be on emphasizing the most important point(s), relating how the information could be integrated into current services. Here are some suggestions for wrap-up questions:]

- ❖ What did you learn today that surprised you?

- ❖ Was there a specific person or persons you had in mind as we reviewed the information about schizophrenia?

- ❖ What else should we learn about this disability?

30 Minute Lesson: Feedback Form

Please let us know what you think of this product, so we can continue to better meet your training needs. Fax or mail to Laurie Ford at 6912 220th SW, Suite 105, Mountlake Terrace, WA 98043; Fax (425) 774-9303

Topic of Lesson _____

- Facilitator Version
- Participant Version
- Non-Facilitated Group Version
- Self-Study Version

1. On a scale of 1 to 5, please rate the relevancy of these materials to your job _____ (1 is worst, 5 is best)
2. On a scale of 1 to 5, please rate the positive impact of these materials on your professional skills, knowledge, and abilities (1 is worst, 5 is best) _____
3. On a scale of 1 to 5, please rate the positive impact of these materials on your organization (1 is worst, 5 is best) _____
4. What was the most useful part of the lesson?
5. What was the least useful part of the lesson?
6. How could this lesson be improved?
7. What additional topics would you like to see in a 30 Minute Lesson?