THE REALITIES OF CLINICAL SUPERVISION

Polaroid Snapshot or *Star Wars* Movie?

The kind of clinical supervision described in the literature may seem like a fantasy in most schools, but it is consistent with research on leadership.

LEE F. GOLDSBERRY

What are the realities of clinical supervision? The professional literature on clinical supervision asserts that a primary function of supervisors is to help teachers refine classroom practices through direct observation and conferral. Yet, for many of us, personal experience supports the findings of Sullivan's (1982) research that supervision depicted in the literature bears little resemblance to the supervision actually occuring in schools.

Given the press of other work, such as relating to the public, completing required forms, allocating material resources, and relaying messages, those charged with educational supervision are often left with little time for observing teachers (Howell, 1981). When this scarce time is parcelled out over the many teachers to be supervised, the observations frequently resemble Polaroid snapshots—single perspectives, frozen in time, often posed, and seemingly objective, but actually depending on the photographer's ability to frame, focus, aim the camera in the proper direction, and capture relevant background. A movie from the *Star Wars* trilogy, on the other hand, is full of optimism and inevitably shows that persistence, faith, hard work, and a little luck lead to a happy ending—an entertaining fantasy. And that is precisely how some see the literature on educational supervision.

As a strong proponent of clinical supervision, and as a contributor to that literature, I am often challenged by school leaders to explain just how I think one could implement the process in schools. As these discussions pro-

Lee F. Goldsberry is Assistant Professor of Education, The Pennsylvania State University, University Park.

ceed, I am frequently troubled to discover that we are talking about different things. The majority of principals, supervisors, and other central office personnel charged with supervisory duties have not had the opportunity to explore the topic, and perceive clinical supervision simply as a sequence of pre-observation conference, observation, and post-observation conference. So, my challenge broadens to discuss the context and rationale for clinical supervision as well as how to implement it in schools.

Supervision for What?

Although the literature on educational supervision is indeed diverse, there is general agreement on its principal function—to improve teaching and thereby improve school effectiveness. But how?

Recently, research examining school effectiveness and successful innovation in schools has yielded several interesting, if unsurprising, conclusions. Researchers (Berman and McLaughlin, 1978; and Edmonds, 1982) have pointed to leadership, especially that exercised by building principals, as a powerful influence on change and effectiveness. While this information does not explain how they do it, it does support the idea that effective leaders do indeed positively influence the educational environment. This belief that they can influence the performance of others—this positive sense of efficacy—seems to be one important characteristic of effective leadership (Berman and McLaughlin, 1978; Fuller, Wood, Rapoport, and Dornbusch, 1982).

Another important contributor to school effectiveness is a clear sense of mission (Edmonds, 1982; Tyler, 1982; Vaill, 1981; and Weick, 1982). Indeed, Vaill suggests that contributing to clarity of mission is a characteristic of effective leadership in high performing systems in a variety of work settings. One way for supervisors to assist teachers in analyzing and improving their teaching is to help them examine the relationship between classroom performance and espoused goals (Sergiovanni and Starratt, 1979).

Two other factors observed by Little (1981) in her study of effective schools are norms of colleagueship and experimentation. By developing colleagueship in schools (Alfonso and Goldsberry, 1982) supervisors can build collaboration among teachers, thus capitalizing on the most expensive and potentially powerful resource—the people in enterprise. When colleagueship takes direction from a common sense of inquiry and focuses on exploring, testing, and evaluating innovative strategies and tactics for refining teaching practice, and when a norm of collegiality is accompanied by a norm of experimentation in a school, Little suggests that the school is apt to be effective.

Supervision for what? I believe supervision should work toward the collaborative and innovative pursuit of clearly developed goals. Clinical supervision offers one approach to these ends.

Supervision in Perspective

Before exploring how clinical supervision can contribute to goal clarity, colleagueship, and experimentation, the relationship between a school's supervisory program and other components of the organization warrants brief mention. A supervisory approach is unlikely to affect norms in an organization unless other organizational interventions, such as staff development, curriculum development, and teacher evaluation, are in harmony. To be effective, the introduction of clinical supervision must be accompanied by direct and thoughtful attention to meaningful organization development.[1]

Clinical Supervision

Clinical supervision (Acheson and Gall, 1981; Cogan, 1973; Goldhammer, Anderson, and Krajewski, 1980) is a structured system for observing and conferring with teachers. Clinical supervision is more than a mechanical sequence of observations and conferences. Five characteristics are both crucial to the concept and often overlooked: (1) relationship to teacher's goals, (2) cyclical nature, (3) a data-based foundation, (4) joint interpretation, and (5) hypothesis generation and testing.

First, an initial and continuing task for the clinical supervisor is to understand what the teacher values in terms of educational goals and procedures. This set of beliefs regarding ideal consequences and means of instruction is an indispensable reference point for collecting and interpreting relevant information. Second, because such information cannot be gleaned from a single conference or observation, clinical supervision occurs in repetitive cycles that permit a systematic building upon earlier learnings and the development of a collaborative relationship. During the observation, the supervisor's job is to

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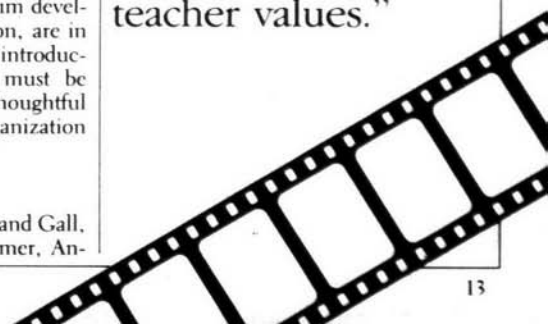

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collect previously agreed-upon descriptive data germane to the teacher's goals. This third characteristic, the collection of descriptive information rather than judgmental appraisals, forms the basis for meaningful change. Next, these data are interpreted by teacher and supervisor in a post-observation conference. Finally, from these collaborative interpretations, hypotheses may be formed to be tested in subsequent observations.

In short, clinical supervision consists of both a focused problem-solving procedure involving identifying, collecting and interpreting information explicitly germane to the educational goals accepted by teacher and supervisor, and a congruent and permeating spirit of personal commitment to growth through colleagueship and collaboration (Garman, 1982). To be done well it is necessarily time consuming. These three elements—focus, feeling, and time—are identified by Vaill (1981) as characteristic of effective leadership based on his study of high-performing systems in a variety of work settings. Indeed, clinical supervision may be characterized as a partnership in leadership squarely targeted on discovering and refining ways to enhance students' learning.

Such a partnership is not easily established in a school where "supervision-by-inspection" and professional isolation of teachers has long prevailed. Organizational inertia poses a formidable obstacle to any change, but especially to those involving norm reversals. Trying to initiate and realize the benefit of clinical supervision in a brief time is like trying to move a tree by throwing a snowball at it. Not only is the tree unlikely to travel very far, but the snowball will probably be demolished. If, however, we start that same snowball at the top of a mountain and roll it toward a tree from a distance, it will take longer to hit but the likelihood of making an impact seems more favorable. The "quick fix" approach to educational improvement has as much chance to survive as a small snowball. . . .

Beyond patience, what can be done to increase the probability that clinical supervision will have the desired impact? To reiterate, effective leadership, especially from the building principal, is crucial. Moreover, organizational consistency, readiness, and introspection seem essential. As mentioned above, if the teacher evaluation program of a school district contradicts its own supervisory approach, if supervision is unrelated to staff development and to curriculum development, and if teachers are routinely excluded from educational decision making and isolated from one another, clinical supervision is severely, and probably fatally, impaired. To develop norms of collegiality and experimentation, school leaders must *consistently demonstrate*, not merely advocate, their commitment to these ends. The behavioral indicators of colleagueship and experimentality must be *modeled* by those leaders who hope to establish them in others.

Modeling behaviors is far more likely to succeed if conceptual clarity regarding those behaviors is consciously and directly abetted. Probably the most common downfall of attempts to initiate clinical supervision is the lack of direct attention to readiness (Wood, Thompson, and Russell, 1981; Cogan, 1973). Teachers and supervisors alike must be prepared for clinical supervision. Clinical supervision requires skills that are typically undeveloped in school supervisors. Preparation in the procedures and rationale for the approach is essential to acquire a conceptual grasp of clinical supervision; practice and feedback are necessary for applying these concepts. Apart from preparing supervisors for a new role, teachers must also be readied for a new approach. A history of flash-in-the-pan innovations and ineffectual supervision has left teachers with an understandable skepticism of new approaches. The expectations, procedures, and assumptions of clinical supervision should be clearly depicted to all teachers in a school *prior to* the first pre-observation conference with the first teacher. If teachers know the intents and means of clinical supervision prior to initiation, they can provide valuable feedback to their supervisor regarding his or her performance. This *reciprocity of service* characterizes a truly collegial relationship and facilitates supervisory introspection.

When a supervisor is openly introspective and actively solicits and accepts the teacher's perceptions of his or her own effort, both collegiality and experimentation are modeled. Not only is this

likely to encourage similar behavior from teachers, but it also enables the supervisor to acquire data regarding his or her own performance, which is essential to supervisory improvement.

To the practitioner who is weary of abstract suggestions, such as patience, organizational consistency, readiness, and introspection, I offer in Figure 1 some more specific (and therefore more subject to adaptation) suggestions for introducing clinical supervision in a single school.

Back to the Question

What, then, is supervision—a Polaroid snapshot or a *Star Wars* movie? If we look at current practices, the answer might be the snapshot—a single perspective, frozen in time, posed, and camouflaged as objective. On the other hand, if we look at the literature we might conclude that it's a *Star Wars* movie—seen from multiple perspectives, approximating continuity, and neatly scripted so that good wins out. Alas, my quest for the right metaphor has not ended. Neither will do, for educational supervision is a complex mix of person-to-person interaction to operationalize and realize value-laden educational goals. Perhaps if we combine the rich spirit and optimism of a *Star Wars* movie with the reality of cinema verité. . . .□

[1]The intent here is simply to note the importance of integrating organizational improvement efforts. For an overview of organizational functions consistent with the rationale for clinical supervision, the reader is referred to Ouchi (1981), Pascale and Athos (1981), and Sergiovanni (1982). For a consistent perspective on organizational development in schools, see Pajak (1981). For a complementary approach to staff development, see Wood, Thompson, and Russell (1981). For a supplementary approach to formal clinical supervision, see Warren and Goldsberry (1982).□

Figure 1. Suggestions for Implementing Clinical Supervision in Schools

1. Amply prepare supervisors. They should feel comfortable with the concepts and practices of clinical supervision *before* trying them out.
2. Start with very few teachers—about two volunteers per supervisor. Make clear to those teachers not only the rhyme and reason of clinical supervision, but also that their help in assessing and refining the process will be greatly appreciated.
3. Inform *all* teachers in the building of the nature of the pilot effort, expressing the hope that it will prove useful and that if it does seem helpful they, too, will have the opportunity to participate.
4. During early cycles, emphasize *process* goals, those aims for establishing clear communication and collaboration with the pilot teachers, more than *product* goals, those aims for changing classroom behavior.
5. Find out which aims teachers strongly advocate for their own teaching *prior* to planning the first observation. Question teachers to determine (a) the cognitive and affective consequences they desire for students, (b) the strategies and tactics they plan to use to achieve those consequences, and (c) their concept of an ideal learning climate.
6. Discuss with each teacher your own approach to supervision, what you want to accomplish, how you will try to do it, and your concept of an ideal supervisory climate.
7. Actively seek feedback from the pilot teachers regarding supervisory performance and their perceived benefits from participating.
8. Allow teachers the privilege of focusing on trivial concerns at the beginning.
9. After several cycles (four to six), ask the pilot teachers to candidly evaluate clinical supervision as a professional resource, preferably in a faculty meeting so that all can hear. Ask each supervisor to do the same.
10. Encourage other teachers to try it out.

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