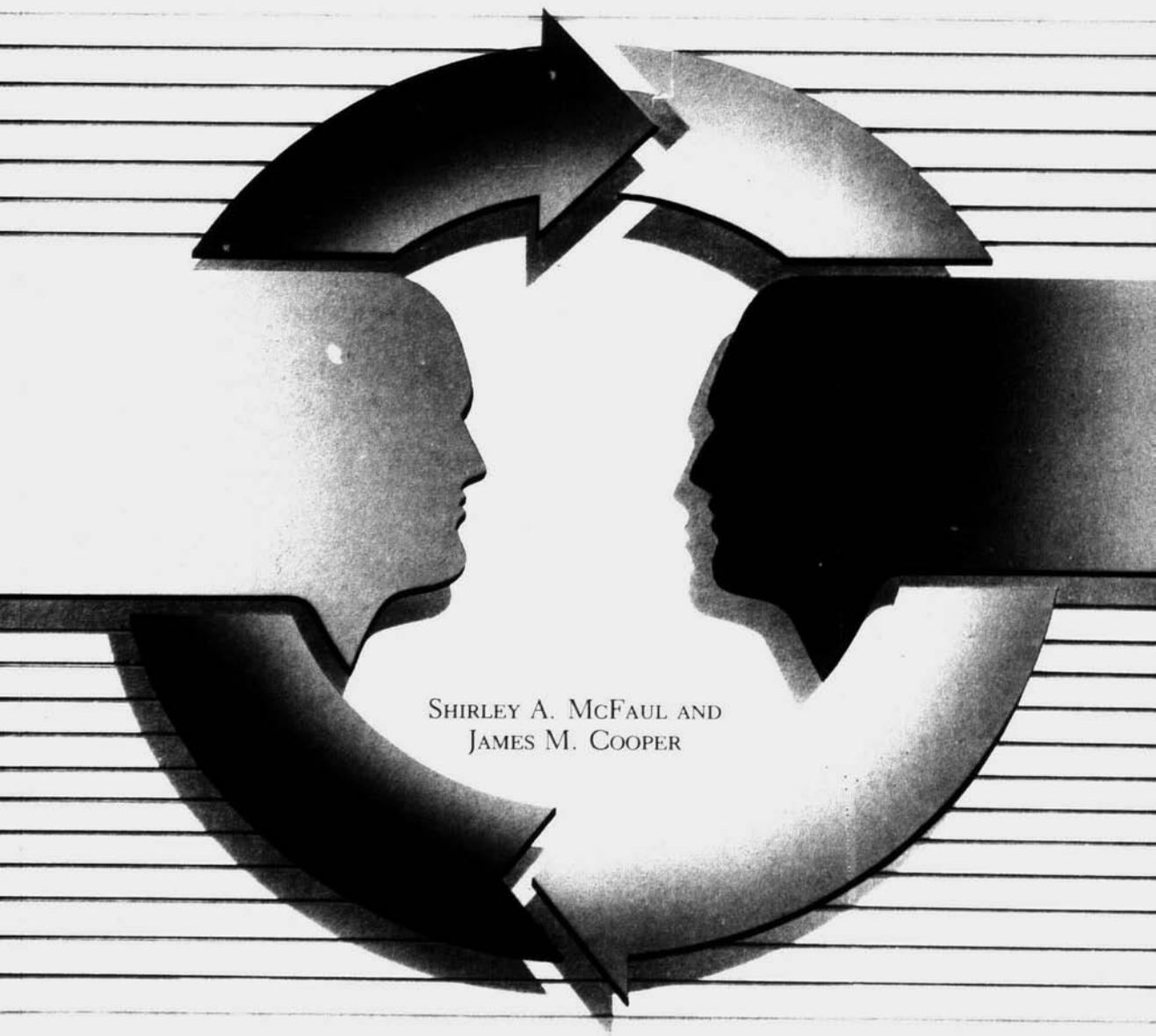


# Peer Clinical Supervision: Theory vs. Reality



SHIRLEY A. McFAUL AND  
JAMES M. COOPER

Few educational models have received more acclaim in recent years than the clinical supervision model developed at Harvard (Goldhammer, 1969; Cogan, 1973). According to Weller (1971), clinical supervision is "operationally defined, well-exemplified in practice, and considered by many educators to fit the criterion of 'best existing practice.'" Cogan (1973) claims that it offers the psychosocial support necessary for optimal teacher growth.

One would imagine that a model so highly acclaimed might have a sound research base. Not so. The lack of quality and quantity in clinical supervision research has been called "miniscule" (Newman, 1980), "thin" (Alfonso, 1977), and "absent" (Denham, 1977). Sullivan (1980) notes that "the research related to clinical supervision is sparse and that which does exist reflects a lack of rigor often associated with a new field of inquiry."

Given the lack of a sound research base, why has this model been theoretically so well received? Two major aspects of clinical supervision that enhance its acceptability relate to its *spirit* and *form*.

#### **Democratic Spirit and Structured Methodology**

*First, the spirit of the clinical supervision model reflects the democratic human resources perspective of supervision* (Sergiovanni, 1978). Developed in the late 1950s, the model incorporates the concepts of collegiality, collaboration, skilled service, and ethical conduct (Garman, 1982). It respects the integrity and individuality of teachers, and its psychological tone echoes McGregor's (1960) Theory Y. The supervisor's role is not to coerce, demand, or evaluate,

but rather to encourage, explore, and collaborate. Clinical supervision presumes the professionalism of teachers. This democratic human resources ethos is still generally accepted in most circles as the best supervision approach.

*Second, its form incorporates a specific, staged-cycle methodology that offers a concrete strategy for collecting data on real and personal classroom patterns.* The model is termed "clinical" because it deals with the reality of daily school life, not with simulated settings; it illuminates practices in the real world. Further, techniques for data collection, observation, and conferencing have been well developed (Acheson and Gall, 1980). The "tool skills" of clinical supervision (Goldhammer, 1969) enable teachers and supervisors to deal with descriptive information in an analytical format. For example, Sirois (1978) found that "the conditions imposed on both teachers and supervisors by the model of clinical supervision encourage greater verbal participation on the part of the teacher" (p. 232).

Thus, the spirit of clinical supervision affirms the teacher's individuality and necessary collaboration in analyzing teaching, while its form suggests a method for such collaborative behaviors and becomes a vehicle for uncovering teaching patterns. Active teacher involvement in pedagogical analysis is important because researchers have documented that teachers are often unaware of many of their own teaching behaviors (see Good and Brophy, 1978; Medwid,

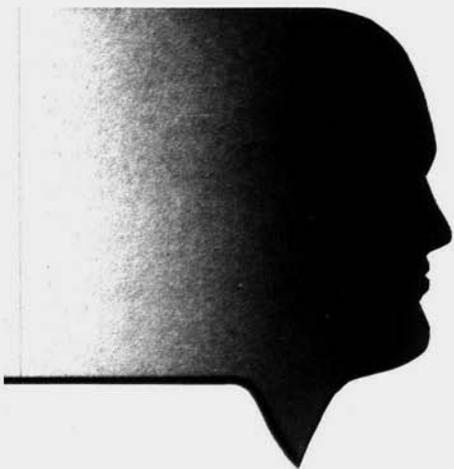
*Shirley A. McFaul is Assistant Principal, Friends School, Baltimore, Maryland; and James M. Cooper is Professor of Education, University of Houston, University Park, Texas.*

The ideals of clinical supervision are out of tune with the way things really are in some schools.



June Lynn Loving

"The clinical supervision model, with its emphasis on collegial analysis of observational data, seems to have face validity in teachers' eyes and offers the potential of raising teachers' awareness levels."



### Peer Clinical Supervision

The common reality of teacher-supervisor discord (Blumberg, 1980), however, coupled with substantial budget cuts of supervisory staff (ASCD *Update*, March 1981) limit use of the model. So, too, does the ratio of available supervisors to teachers and the burden of the many duties, aside from supervision, that are expected of school principals. One alternative approach examined by a few educators is peer clinical supervision (Simon, 1979; Thompson, 1978; Withall and Wood, 1979; and Goldsberry, 1981). Teachers trained in the rationale and methodology of clinical supervision act as peer supervisors with each other, collecting data and analyzing their meaning in post-observation conferences. Such an approach ought to capitalize on an existing support system. Blumberg (1980) and Alfonso (1977) note that teachers informally depend on their peers for support and instructional help; and DeAngelis (1979) documents that beginning teachers found their principals and supervisors somewhat helpful, but not as much as their colleagues.

Additionally, peer interaction using clinical supervision may benefit the observer as well as the teacher being observed. Goldsberry (1981) notes that "the experiences of systematically observing one's colleagues, analyzing collected data, and structuring and conducting conferences may well contribute as much or more to the professional development of the observer as to the refined practice of the teacher being observed" (p. 11). These seem to be logical arguments for exploring the worth of such an approach.

Other researchers, however, question whether peer clinical supervision is workable. Blumberg (1980) notes teachers' approach-avoidance response to supervision and their lack of training for

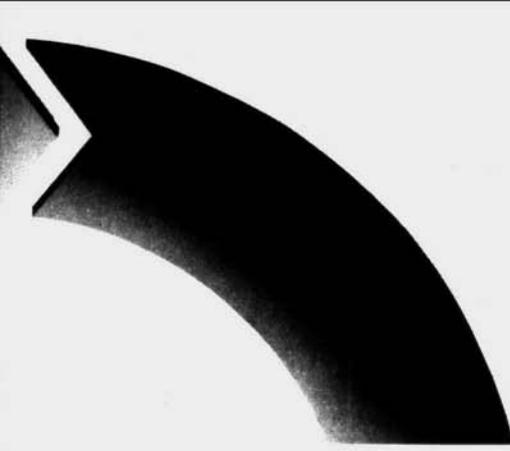
working in a problem-solving mode with peers. Cogan (1973) wonders whether local staffs can develop their own data collection instruments, and Simon (1979) questions the logistics of implementation. Alfonso (1977) states that the typical cellular structure of schools may inhibit peer clinical supervision attempts, and Harris (1976) notes that the model makes high demands in terms of teacher motivation, intelligence, and emotional stability. Additionally, Harris doubts whether teachers have the analytical abilities or awareness of alternatives to plan new actions, especially without new skill training. Glickman (1981) calls for a developmental view of supervision that is based on two teacher-controlled factors: level of abstraction and level of commitment. According to his paradigm, clinical supervision may be most workable with teachers who have high levels of both. The difficulty, of course, is that those teachers are not the only ones who need intensive supervisory help.

### A Case Study of Peer Clinical Supervision

In 1982, 12 teachers in an urban elementary school participated in a one-semester graduate-level course that included an eight-cycle process for implementing peer clinical supervision (McFaul, 1982). In four cycles each, the teachers played both the role of peer supervisor and supervised teacher. Research questions focused on (1) how implementation of the model varied among teachers; (2) the congruence of the model with the school setting; and (3) a critical analysis of the utility of clinical supervision for urban elementary teachers.

Study participants received training in developing instruments for data collection, videotaping teaching episodes, analyzing data for pertinent patterns and

1980). This finding is not surprising given the rapid pace of classroom teaching and the fact that teachers are rarely trained to analyze their own classroom pedagogy. The clinical supervision model, with its emphasis on collegial analysis of observational data, seems to have face validity in teachers' eyes and offers the potential of raising teachers' awareness levels. As Good and Brophy observe (1978): "Teachers are often unaware of much of what they do, and this lack of perception sometimes results in unwise, self-defeating behavior."



“Teachers appeared to honor an unwritten agreement that no one would be made uncomfortable in the process.”

issues, and conducting conferences. Numerous projects were completed to satisfy the objectives of the course. Data collection for the study included both ethnographic information and teacher interviews as well as full documentation of the eight cycles (for example, pre-observation agreement forms, data collection instruments, tape recordings of post-observation conferences). The case study approach was necessary because of the importance of contextual factors in the environment (Schiffer, 1980). A key question was: “Is the form and spirit of the model congruent with teachers’ attitudes and abilities as well as with the environment?”

Analysis of the peer clinical supervision cycles produced several findings. To varying degrees, all but one of the teachers were able to execute the *form* of peer clinical supervision; that is, they were able to participate in the staged cycles. Close examination of those cycles, however, revealed that most often clinical supervision was not done thoroughly. For example, pre-observation conferences were conducted cursorily, if at all. Teachers claimed there was little time in their busy schedules to allow for thoughtful planning. Although teachers were trained to use a variety of instruments, many of those developed contained insufficient data from which to draw meaningful generalizations. In-depth analyses occurred only in approximately 20 percent of the conferences. When an issue was raised participants often jumped from the data to one proposed solution, which was usually reinforced by the colleague. In many instances this led to simplistic solutions to complex problems.

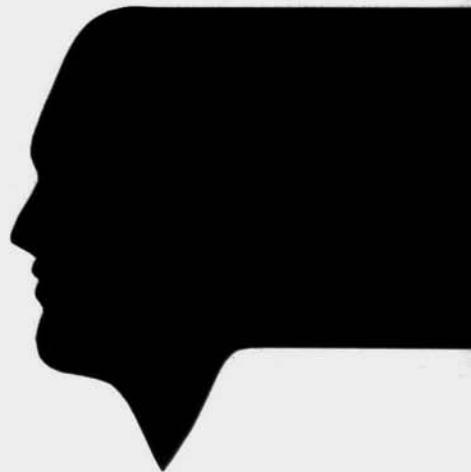
In the post-observation conferences, teachers seldom pursued the kind of thorough weighing of alternatives that was practiced in their course work. In fact, teachers appeared to honor an

unwritten agreement that no one would be made uncomfortable in the process. Not once during any of the completed peer cycles did any teacher dispute the collected data; there were merely minor differences in interpretation. The conference tapes called into question, therefore, teachers’ *willingness* or *ability* to substantively analyze their peers’ classroom behaviors. Without a strong analytical focus, clinical supervision loses much of its potency.

#### Model and School Context Incongruity

While variations in teachers’ use of the model were instructive, a thorough analysis of the ethnographic data produced the most important finding of the study: the underlying assumptions of the peer clinical supervision model were incongruent with the school context. This issue—the degree of congruence between model and environment—was included in design of the study because it was considered important, though not critical. In retrospect, however, the power of the environment appeared overwhelming. Four overriding contextual patterns were uncovered that appeared to have a substantial effect on implementation of peer clinical supervision in this urban setting: isolation and fragmentation, stratification, standardization, and reactionism. These themes were evident in classrooms, in teachers’ encounters, and in the building and district administrators’ styles.

*Isolation and fragmentation* were apparent in the school’s architecture and in the lack of interaction between teachers. There was little opportunity for teachers to work as teams; interactions were infrequent, and when they did occur they were primarily concerned with organizational management problems. Teachers spoke in terms of staff fragmentation: old-timers vs. new-tim-



ers, black teachers vs. white teachers, teachers in the main building vs. teachers in portables, teachers the principal liked vs. teachers she did not like. Field notes corroborated the impression that teachers at this school did not act as a cohesive, coordinated staff.

*Stratification* was experienced primarily through the principal’s actions toward her staff, though, in fact, district administrators also acted similarly toward their principals. For example, the principal unintentionally established a “pecking order” among teachers by singling out certain teachers to demonstrate lessons, complimenting them in staff meetings and rewarding them with

"preferred" classes; and by describing teachers as "those who care and do well, those who don't, and those who don't care." Teachers were aware of this hierarchy, and it appeared to reinforce their fragmentation.

**Standardization** was reflected primarily in the curriculum and pedagogy. Teachers were expected to conform to many standardized practices: lesson plans, approaches to teaching spelling, use of blackboards and bulletin boards, use of the newly adopted reading series, and so forth. In fact, teachers were required to attend demonstration lessons on how to use the new reading series "correctly." Therefore, many of the "patterns" teachers exhibited in their classrooms were not the personal, stylistic patterns that Goldhammer suggested reflect a teacher's philosophy, but, rather, ones imposed by the administration.

The **reactionism** theme related to teachers' decision-making stances. Faculty members demonstrated little sense of initiative or long-range planning. Several district factors, such as the fluctuating school population and abrupt policy changes, contributed to this posture, as did the principal's spontaneous style. She interrupted ongoing instruction by "popping" into classrooms, and often changed schedules or school routines without advance notice. These unanticipated changes and interruptions left teachers feeling like puppets on a string, in a reactive rather than an initiating posture.

All four factors—fragmentation/isolation, stratification, standardization, and reactionism—came into direct conflict with the model, which assumed an atmosphere of collegiality and equality, individualized teaching styles, and a sense of teacher professionalism. In reality the teachers were unanalytical, and the milieu muted rather than elevated the potential of the peer clinical supervision model.

### Clinical Supervision: Preached But Not Practiced

Wilsey and Killion (1982) claim that the principles of clinical supervision are important components of an effective staff development program. They note that the choice of supervisory approach depends on a teacher's stage of personal and professional development. However, Cawelti and Reavis' (1980) research on teachers' perceptions of the inadequacy of instructional supervision and inservice education demonstrates that 25 percent of urban teachers rated those

services as "high" and that only about 15 percent had had any experience with clinical supervision. Thus, while clinical supervision is highly acclaimed, it seems not to be implemented often.

An issue that has not been adequately addressed is whether the form and spirit of the model "fit" the reality of teaching in many urban contexts. Inner-city schools often evidence work-life stresses all their own. Bell (1979) identifies factors that epitomize urban schools in need of renewal and claims that "the conditions in which urban school people work are extreme" (p. 65). He cites three obstacles to renewal: hopelessness, helplessness, and depersonalization. Fuchs' (1969) study of neophyte teachers in urban schools also indicated a lack of a supportive, professional growth environment: "Teachers start their careers expecting further professional development and colleague relationships with their supervisors. It comes as a rude shock to them to find that they are treated as low-level bureaucratic functionaries" (p. 79). Attempting to change individual instructional approaches in a system that is unreceptive to collegial problem solving and teacher initiative may be futile. What is needed is an environment congruent with sustained professional development. The lack of such an environment in our study appeared to be a strong inhibitor of peer clinical supervision efforts. One cannot generalize from one case study, however, and it is difficult to know how widespread are the contextual patterns experienced in this case. But to the extent that the patterns in this school exist in others, clinical supervision, whether with peers or not, may be ineffective.

### Mutations of the Model

Snyder (1981) argues that clinical supervision holds more promise as a coaching system than as an inspection system, and expresses concern that it could evolve into little more than "a refined teacher inspection technology." As such it might retain the *form* while sacrificing the *spirit* of the model. Given a movement toward increased standardization, one should not be surprised to see clinical supervision undergo such a mutation. As such, however, it becomes hollow—like a song that has words but no music.

In our study, such a mutation was evident. The elementary principal had been trained in clinical supervision skills by the school district (apart from

the teachers); she was expected to employ those skills and at the same time evaluate teachers using the district's standardized evaluation form. In an era of teacher accountability, and in this urban setting of fragmentation, stratification, standardization, and reactionism, administrative use of clinical supervision incorporated a variation of the form and eliminated the spirit of the model.

This incongruence is particularly important considering the crucial role of the urban principal regarding morale, change, and performance (Hall, Hord, and Griffin, 1980; Shoemaker and Fraser, 1981; Corbett, 1982). Ornstein (1982) additionally notes the special financial hardships experienced by urban schools, hardships that in many respects conflict with any form of time-consuming supervision or collegial efforts.

### Implications

Many would argue that the use of clinical supervision, either with supervisors or peers, can be a key element in effective staff development. Our study suggests that such an approach, under certain circumstances, may be untenable. We clearly need to examine the congruence between the assumptions of clinical supervision and the reality of some school settings. Accountability, standardization, stratification, isolation, and unanalytical stances conflict with the thrust of the clinical supervision model. By definition the model includes a form and spirit that embodies a sense of professionalism, teacher initiative and collegiality, and a respect for individual teaching patterns. In some instances the tone, interactions, and expectations of the school environment may need to change before attention to individual teaching patterns will reap benefits.

The model demands extensive time commitments (Turner, 1976), sustained collegial interaction, and long-term efforts in an atmosphere of professional respect. The reality in many elementary schools includes little, if any, extra time in a tightly scheduled school day, isolation of faculty members from each other, changing demands from the district and society, and an eroded sense of professionalism. Improving instruction, the primary goal of clinical supervision, is not done quickly. Raising awareness of teaching patterns, analyzing their implications, and planning new approaches requires a sustained effort. That means that clinical supervision, whether performed by administrators or peers,

needs to be thoroughly integrated into the life of the school, a rather unlikely possibility unless many typical school structures and procedures are modified.

### The Meaning of Mutations

Developed in the late 1950s during a period of expansion and experimental programs and couched in a humanistic framework, clinical supervision embraced the belief that rational analysis of pedagogy would facilitate the self-actualization of teachers. The model emphasized respect for teachers' initiatives and expected them to be the primary decision makers regarding their teaching styles. The idea of using clinical supervision for evaluation purposes was untenable. Its purpose was to help teachers, not to judge them, and those two actions were deemed incompatible.

Presently, there is little evidence to suggest that clinical supervision as defined by Goldhammer and Cogan is being used widely by either district supervisors or teaching peers. Times and expectations have changed, and two hybrids of the model are emerging. One involves using the "tool skills" of clinical supervision to monitor and evaluate teachers. The other involves the use of "colleague consultation" (see Alfonso and Goldsberry, 1982), which incorporates the spirit and form of the model but does not stress the well-honed analytical methodology.

Studying the mutations of clinical supervision may tell us more about the present state of the school workplace than about the model. Goldhammer's hope was that clinical supervision would transform the schools. Consonant with Sarason's (1982) understanding of the power of contextual forces in school life, it appears more likely that clinical supervision, where used, will be molded and shaped to "fit" the reality of school life. It will be instructive to observe the transformation where it occurs and to reflect on its meaning. □

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