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CLINICAL SUPERVISION, CONSULTATION, AND COUNSELING: A COMPARATIVE ANALYSIS FOR SUPERVISORS AND OTHER EDUCATIONAL LEADERS

HOWARD M. KNOFF, *University of South Florida*

Over the last 15 years, clinical supervision has become one of several supervision models that are an integral part of the training and practice of administrators and other educational leaders.[1] The clinical supervision *model,* however, must be contrasted with the clinical supervision *process* that often is used procedurally within the model. In its most simplistic form, the clinical supervision process involves (1) the ongoing development of a sound working relationship between the supervisor and the supervisee, (2) the continual identification of supervisee strengths and weaknesses related to his profes sional development or instructional role, (3) the joint planning of job related activities that reinforce supervisee strengths and systematically improve weak nesses, along with the implementation of these activities by the supervisee as observed by the supervisor, and (4) the joint analysis of these activities in a feedback conference using formative evaluations to acknowledge newly devel oped and observed supervisee skills and additional skills that will further improve his professional practice. Though a fairly straightforward process, it sometimes becomes confounded because the clinical supervision model being used requires or shifts into either a consultation or counseling model. This shift should not occur casually—it can potentially interfere with the supervi sory relationship, complicate the goals and activities of the supervision pro cess, and decrease its overall effectiveness.

To analyze the implications of confounding the clinical supervision, con sultation, and counseling models, an understanding of their similarities and differences is paramount. So far, specific distinctions between the conceptual definitions and goals, the characteristics and activities, and the qualifications to do clinical supervision versus consultation versus counseling have not been made Recognizing that components of these models overlap at times, this

[1]Morris L. Cogan, *Clinical Supervision* (Boston Houghton-Mifflin, 1973), Robert Goldham mer, Robert H Anderson, and Robert J Krajewski, *Clinical Supervision: Special Methods for the Supervision of Teachers,* 2nd ed. (New York. Holt, 1980), Thomas J Sergiovanni and Robert J Starratt, *Supervision Human Perspectives* (New York. McGraw Hill, 1983)

article still addresses them differentially and, to a certain extent, puristically It also provides a conceptual model toward the analysis of their specific skills and processes. The ultimate goal is to make supervisors sensitive to the informal boundaries of clinical supervision through an increased understanding of consultation and counseling. Thus, supervisors will understand the implications of introducing consultation and counseling into the supervisory relationship, will recognize the need to clarify their roles and objectives with supervisees, and will identify instances when referrals to others for needed consultation or counseling services are more desirable than the disruption of the supervision process.

DEFINITIONS AND GOALS

Clinical Supervision

Collapsing across a number of previous definitions, clinical supervision can be defined as an intensive, hierarchical, interpersonally focused relation ship involving a supervisor who oversees the development of a supervisee's professional knowledge, skill, confidence, objectivity, and interpersonal inter actions on behalf of or with a specified client for the purpose of facilitating and improving competence and effective service delivery and promoting accountability in the field. This definition has several significant conceptual and pragmatic components. First, clinical supervision, as a model, involves a hierarchical relationship between supervisors and supervisees, where the former has some degree of power over the latter. At its most basic level, superintendents, department chairs, and principals who clinically supervise professionals below them on their district's organizational chart exemplify the hierarchical, power relationship inherent in supervision. While clinical supervision is conceptualized as a helping relationship and while it is most effective when supervisors and supervisees share rapport, trust, openness, and honesty, these supervisors are still administratively responsible for eval uating their charges and for requiring change where appropriate. Thus, super intendents, department chairs, and principals practicing clinical supervision still evaluate supervisees' effectiveness in their professional or instructional roles, and they work coordinately with supervisees to maintain or improve this effectiveness. Yet they also make recommendations or decisions involving their supervisees' annual reviews, tenure, promotion, merit pay, and continu ing employment.

At a more global level, clinical supervision is but one model of supervi sion, and not all supervisors observe and evaluate professionals functioning below them organizationally. Further, some individuals might use the clinical supervision process, but not be functioning formally as supervisors. For example, master teachers who "supervise" less experienced teachers toward more effective teaching and instructional specialists who provide colleagues with

their specialized skills and expertise may interact using the clinical supervision process, yet they are really acting as consultants rather than supervisors. That is, unless they are in an administrative or organizational position that gives them the right to require that supervisees change or supplement the professional behaviors targeted during the clinical supervision process, they should not be considered supervisors in the strictest sense of the word.

The clinical supervision definition next identifies the specific domains that facilitate supervisee effectiveness: professional knowledge, skill, confidence, objectivity, and interpersonal interactions on behalf of or with a specified client—ultimately in education, the student body. Without the positive presence of all these domains or characteristics, supervisees will not be maximally effective in their professional roles. For example, a new teacher might have the technical knowledge, the objectivity, and the positive interpersonal interactions needed to successfully teach but lack the confidence in her abilities and the skill to channel her knowledge into effective lessons. The supervisor (e.g., the principal) must analyze these two weak domains with the teacher (now a supervisee) and help her to develop approaches and tech niques that increase her teaching skill and to recognize and experience the professional and personal success that translates into greater self-confidence Or an administrative director might demonstrate a lack of objectivity and appropriate interpersonal interaction in working with a group of principals to implement a new discipline code A superintendent here might use clinical supervision to help the director to see the principals' points of view and to suggest an interpersonal approach that might facilitate the entire change process Thus, supervisors must systematically (1) evaluate the complex facets of professional knowledge, skill, confidence, objectivity, and interpersonal interactions in supervisees' unique work settings; (2) tailor them to supervisees' specific job requirements and to specific environmental and situational realities, and (3) guide them toward sound educational practices and effective service-delivery approaches. This process often involves identifying supervi sees' skill and performance deficits, but if done in the spirit of clinical super vision, the experience can be constructive and positive.

The last component of this definition involves a supervisor's responsibility to advocate for those receiving the supervisee's services. That is, supervisors need to ensure that students receive the best possible educational services from their teachers. Supervisors, then, become active guardians of accountability in the educational process, especially as they use the clinical supervision process to maintain or upgrade their supervisees' professional effectiveness. At times, however, this guardianship extends to recommendations for a teacher's dismissal when he is unable to teach effectively and has failed or resisted all attempts at supervision and remediation. In both cases, educational accountability has been served—either the supervisor has helped a previously unsuccessful teacher to improve so that his instruction now positively affects hundreds of more prepared and educated schoolchildren,

or the supervisor has ensured that an unqualified teacher is unable to negatively affect the schoolchildren and their educational careers.

From this conceptual definition, five specific goals of supervision can be identified for the supervisor:

- to develop a supervisory system, process, or style that encourages supervisees to seek and respond to the supervisory process
- to evaluate, formatively and summatively, supervisees in the professional knowledge, skill, confidence, objectivity, and interpersonal interactions domains to determine their current developmental levels and professional strengths and weaknesses
- to enhance supervisees' growth in necessary, identified areas so that their provision of services and job and self-satisfaction improves
- to monitor the welfare of clients served by supervisees
- to provide training so that supervisees can develop their own supervision skills

Specific to the last goal, some supervisees may have aspirations to climb the educational career ladder and become supervisors themselves. Since this request may be infrequent in the context of supervision, the fifth goal may be less apparent than the other four. Still, supervisors can provide this more advanced supervision and training, when appropriate, by teaching supervisees the fundamental skills and processes associated with good supervision. Thus, supervisees can broaden their educational and professional skills beyond their current roles or statuses, and the field of supervision can benefit by welcoming new supervisors who have experienced the supervisee's frustrations and rewards and have learned about supervision through the mentoring of another supervisor.

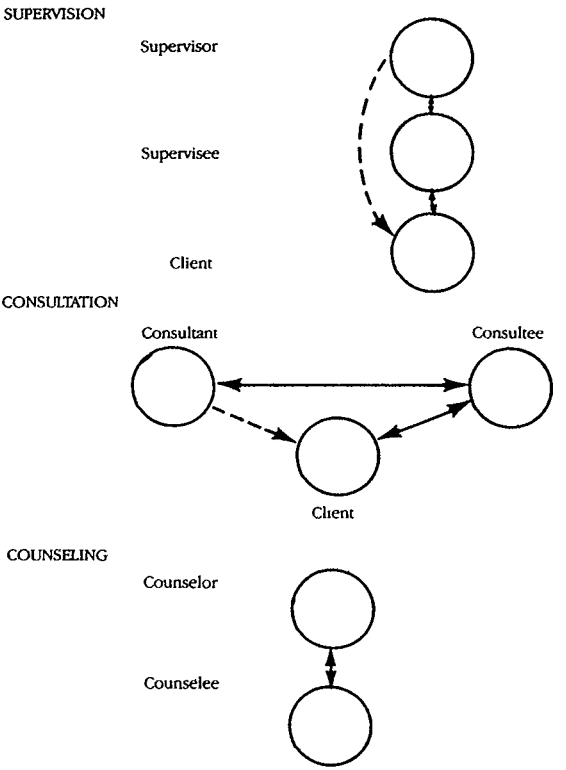
Figure 1 depicts the hierarchical, interactive nature of the relationship between the supervisor and supervisee and, in turn, the supervisee and the client or recipient of services. It illustrates the indirect relationship that the supervisor has with the client, a relationship that may involve observing the client (e.g., a student) in a specific setting (e.g., the classroom) but no direct interaction of a professional nature.

Consultation

Consultation has its modern roots in the writings of Gerald Caplan, who worked primarily in psychiatric and other mental health settings [2] Numerous professional groups working in educational settings (e.g., school psychologists, social workers, school counselors) have since embraced consultation, and it is now a significant component of many professional training programs

[2]Gerald Caplan, *The Theory and Practice of Mental Health Consultation* (New York Basic Books, 1970)

Figure 1. Supervision, Consultation, and Counseling Processes



and curriculums. According to a current, accepted definition, consultation is "a collaborative problem-solving process in which two or more persons [consultant(s) and consultee(s)] engage in efforts to benefit one or more other persons [client(s)] for whom they bear some level of responsibility, within a context of reciprocal interactions.[3]

[3]Michael J Curtis and Joel Meyers, "Best Practices in School-Based Consultation. Guidelines for Effective Practice," in *Best Practices in School Psychology*, ed Alex Thomas and Jeff Grimes (Washington, D.C. National Association of School Psychologists, 1985), p 80

Consultation is a collaborative process involving two *peer or collegial* professionals in a *non-hierarchical* relationship. The consultant has no administrative or supervisory responsibility for the consultee's work, and the dynamic or variable of power should be absent in the consultant-consultee relationship. A common example of professional consultation in the schools involves a school psychologist (as consultant) assisting a classroom teacher (as consultee) to deal with a child (as client) who is having difficulty maintaining behavioral control. In this case, the consultant may have more knowledge or expertise in classroom-management techniques, yet the consultee is under no compulsion to accept the consultant's recommendations or guidance. Parenthetically, consultation also may occur when two professionals simply choose to work together on a difficult case that one is experiencing; the consultant here acts more as a confidant or a sounding board and has no formal (i.e., administrative) or informal influence over the consultee who requested help. An example here might involve two teachers with similar experience and background working together on tailoring one teacher's curriculum for a specific group of difficult students.

The definition of consultation also specifies a problem-solving process that typically involves four components: problem identification, problem analysis, intervention, and evaluation.[4] During problem identification, the consultant delineates and operationally defines the client's problem, ensures that the problem is indeed the client's, and proceeds with problem analysis where a comprehensive understanding of the problem becomes the consultative focus. At times, the problem is identified not as the child's but as the consultee's. In these instances, and when the consultee agrees to continue the consultation process, the consultant's problem analysis focuses on the consultee's professional knowledge, skill, confidence, objectivity, and interpersonal interactions and how they might be causing the problem. Intervention occurs when the consultant recommends specific programs or techniques to alleviate the problem, regardless of whether it is the child's or the consultee's. Again, the consultee can reject any analysis or interpretation by the consultant concerning the problem, its existence, and its significance. Similarly, the consultee can dismiss any projected recommendations. Finally, if an intervention is tried, the evaluation component of the process assesses the consultee's satisfaction with the consultation process and its positive effect on the identified problem.

The end of the consultation definition implies that both consultant and consultee somehow share some level of responsibility for the client who is the focus of the problem-solving process. From an administrative perspective, the consultee, who initially approached the consultant with the problem, always maintains the primary responsibility over the client and the problem-

[4]Joel Meyers, Richard D. Parsons, and Roy Martin, *Mental Health Consultation in the Schools* (San Francisco: Jossey-Bass, 1979)

analysis and intervention procedures related to the client. The consultant, meanwhile, assumes an ethical responsibility (1) to suggest appropriate problem-analysis approaches or intervention techniques specific to the client problem and (2) to oversee the professional well-being of the consultee (i.e., his knowledge, skill, confidence, objectivity, and interpersonal relationships) during the consultative contact. Ultimately, consultants are evaluated on their effectiveness in guiding consultees toward better problem-solving and service-delivery approaches and their ability to resolve the specific difficulties that existed between consultees and their clients.

From this conceptual definition, three specific goals of consultation can be identified for the consultant:

- to help consultees to understand the current work difficulty and to improve their knowledge, skill, confidence, objectivity, or interpersonal relationship abilities to resolve its specific issues or conditions
- to help consultees to be able to handle similar problems that may happen in the future
- to focus on consultees' job performance, not their sense of emotional well-being

This last goal specifically contrasts consultation with counseling and is explored further below.

Counseling

As a process to facilitate, increase, or maintain an individual's psychological or social-emotional development and well-being, counseling takes on many different forms depending on the individual delivering the services and the setting where those services are being provided. For example, the counseling styles and orientations of the clinical, counseling, and school psychologist may differ from those of the psychologist, clinical social worker, marriage and family therapist, and guidance or mental health counselor. Similarly, counseling in a school versus community mental health versus psychiatric hospital setting will necessarily differ because of the unique goals and conditions of those settings. Despite these real differences, a broad, working definition of the counseling process is possible: an intensive, intra- and interpersonally focused problem-solving process involving a helping professional and a client who acknowledges that he is unable to cope or would like to cope more effectively with some affect, behavior, interpersonal relationship, or other life crisis. The professional acts as a support system for the client, providing direct or indirect help (depending on psychological orientation) and addressing the overt and covert reasons for the difficulty so that the client's concerns are changed or resolved.

As contrasted with supervision and consultation, counseling is a hierarchical relationship, not between peer professionals, but between a client who

generally functions outside the psychological or mental health domain and a counselor who assumes an expert role geared to alleviating some difficulty the client is having. In the case of a teacher experiencing severe emotional problems across multiple settings, that teacher needs the counseling services and, therefore, is considered the client. While we assume that a teacher's students may indirectly benefit from a positive counseling experience, they are rarely included in the rationale that prompts the need for counseling services, nor are they identified in the representational model of the counseling process (see Figure 1). Counseling, therefore, addresses a client's dysfunctional intra- or interpersonal relationships as they relate to his own affect, behavior, functioning, or life existence. It does not attempt to solve a client's specific work-related problems unless they significantly interfere with his psychological or social-emotional development or stability. Further, counseling assumes that, without the counselor's expert support and guidance, the client will not be able to resolve the problem. Thus, while a client may reject a counselor's suggestions, it is probably not in his best interests, the client initiated the counseling relationship to obtain these suggestions, and their rejection only interferes with the objectives and success of the counseling process.

Counseling, then, differs substantially from both supervision and consultation. Its primary purpose is to address, overtly or covertly, a client's personal pattern of functioning, to help the client to see the need for change, and to facilitate emotional and behavioral expression so that dysfunctional patterns are changed and more adaptive patterns are learned, exhibited, or reproduced. These patterns of functioning, consistent with supervision and consultation, involve the client's self-knowledge, self-efficacy skills, objectivity (or orientation toward reality), confidence (or self-concept and assertiveness), and interpersonal relationship functioning. Counseling also involves an intensely private problem-solving relationship that depends on the counselor's ability to create an atmosphere of trust and openness so that clients can comfortably express significant conflicts or feelings and risk changing long-standing patterns of behaviors, attitudes, or beliefs. The skills needed to facilitate this atmosphere and relationship include empathy; positive regard; respect and warmth; congruence, genuineness, and authenticity; and an ability to use confrontation positively and strategically.[5] While these skills are generic to all helping relationships—and thus are equally significant to the success of supervision and consultation—their use in counseling is tailored to its goals and objectives, the counselor-client relationship, and the process of therapeutic change. The problem-solving change process entails problem identification, problem analysis, intervention, and evaluation by the counselor.

[5]Allen E. Ivey and Lynn Simek Downing, *Counseling and Psychotherapy Skills, Theories, and Practice* (Englewood Cliffs, N.J. Prentice-Hall, 1980)

Table 1. Primary Characteristics of Supervisors, Consultants, and Counselors

Characteristic	Supervisors	Consultants	Counselors
Role	Administrator/overseer	Collaborator	Therapeutic expert
Perspective	Related professional in subordinate position	Peer professional	Client
Style	Directive	Helping	Therapeutic
Focus	Work related	Work related	Interpersonal or intrapersonal
Goals	Understand defenses	Support defenses	Weaken defenses
	Present work-related problems	Address consultee's work-related problems	Address overt or covert psychological problems
	Deal strategically with emotions	Do not probe for emotions	Facilitate emotional expression
	Build in new work-related skills	Support the development of work-related skills	Build in and support the development of work-related, interpersonal, and intrapersonal skills
	Change the problem	Facilitate consultee problem resolution	Resolve the problem internally or externally

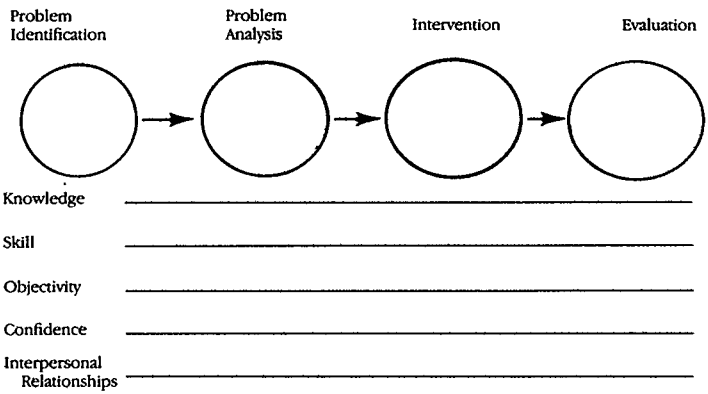
Many professions and settings are involved in the counseling process. Similarly, there are many different psychological orientations and counseling styles. Still, three discrete counseling goals that transcend the many professions, settings, and orientations are suggested in summary.

- to help the client to change in some psychological or social-emotional domain or area of functioning
- to provide the client with adaptive skills, behaviors, attributions, cognitions, or attitudes that can generalize to new situations or environments, thus preventing any psychological or social-emotional difficulties from recurring
- to maintain the client's privacy and confidentiality while building an atmosphere of trust, openness, and acceptance of reasonable change

A COMPARATIVE ANALYSIS OF SUPERVISION, CONSULTATION, AND COUNSELING

Clinical supervision, consultation, and counseling all differ significantly in distinct areas. Table 1 can be integrated with the representational diagrams in Figure 1 to provide a good overview and comparative analysis of these three activities. Missing, however, is a model outlining the step-by-step processes that the three activities share—the four-stage problem-solving process and the five domains of supervisor, consultant, and counselor analysis. Knowl-

Figure 2. A Composite Problem-Solving Process for Supervision, Consultation, and Counseling with the Five Domains of Functional Analysis



edge, skill, objectivity, confidence, and interpersonal relationships. This model is shown in Figure 2.

The model in Figure 2 suggests that every stage of the problem-solving process should involve a consideration of each of the five domains that relate to the supervisee's, the consultee's, or the counseling client's effectiveness That is, for a specific supervision, consultation, or counseling problem or issue, a supervisor, consultant, or counselor should identify the possibility that deficient knowledge, skill, objectivity, confidence, or interpersonal relationships (one or more in combination) is a predominant and causal problem. After that, each identified problem domain should be analyzed as needed so that a comprehensive understanding of the problem is attained (supervision, consultation, or counseling), interventions to resolve the analyzed difficulties in these domains should be implemented, and evaluations of the short- and long-term effects of these interventions should be completed. Generally, only those domains implicated during the problem-identification and analysis stages will receive intervention attention. The evaluation, however, may focus again on all five domains to determine the comprehensive effects of the intervention program on the supervisee, consultee, or counseling client.

The model in Figure 2 also reinforces a primary thesis of this paper: that the clinical supervision, consultation, and counseling models share this generic problem solving process and additional qualitative similarities (e g , the five domains of individual effectiveness), but that clinical supervision can become inefficient and even ineffective when confounded with consultation or coun seling. In fact, to be most effective, it may be best that the clinical supervision *model* as implemented by a supervisor remain independent of the consulta

tion and counseling models, even though the clinical supervision *process* may be shared among the models. This suggestion is important because a move from a clinical supervision model to either a consultation or counseling model has conceptual, pragmatic, and ethical implications. At best, the use of more than one of these models in a single supervisory relationship confuses the entire process—one cannot return to a "pure" supervisory relationship after acting as a consultant or counselor with the same person. At worst, the entire supervisory relationship can be up-ended, rendering future effective supervision impossible.

During clinical supervision, supervisors are attempting to evaluate, and then enhance, supervisees' professional knowledge, skill, confidence, objectivity, and interpersonal interactions so that effective service delivery is attained from both an administrative and an educational perspective. This ongoing, systematic process depends on and is facilitated by the professional, hierarchical relationship between the supervisor and supervisee. While clinical supervision often uses a skills-based, helping orientation, the administrative realities that certain instructional skills and competencies are required and that supervisees are evaluated periodically require that the hierarchical relationship of supervision be maintained throughout the process. At times, however, supervisors will assist supervisees with difficult cases, making curricular and technical recommendations outside of the scope of supervision. While these brief "consultation" contacts are inevitable, the supervisor must be sure (1) to explicitly clarify the relationship as consultative, (2) to provide the (now) consultee with all the rights of the consultation process (e.g., to reject any suggestions deemed unusable), and (3) to ensure that consultation and supervisory processes are not overtly or covertly confounded. This latter point will be the most difficult to accomplish because some supervisors believe that any interaction with a supervisee is available to administrative evaluation and that all their suggestions should be implemented, even those that occur during consultation. Given the tenets of the consultation model, however, these feelings, expectations, and practices would be inappropriate.

Thus, supervisors may not want to allow consultation interactions into the supervision relationship. They may want to maintain a continuous supervisory relationship, not to allow the relationship to become non-hierarchical at any time, and not to confuse the supervision process with other processes that may later interfere with the administrative realities of supervision. For example, what would happen if a supervisor, consulting with a supervisee, were to uncover an instructional practice that needed clear, immediate change? Could the supervisor stop the consultation process and begin a supervision process that would require this change? Would the supervisee be correct in insisting that this issue was inappropriate for supervision because it arose during consultation? Would the supervision relationship between these two individuals ever return to the level of trust and respect that was characteristic before this occurrence? These questions become both pragmatic and ethical

regarding the boundaries between consultation and supervision—questions that must be considered before these two models are confounded. Should supervision and consultation roles and activities be kept separate, and can the supervision relationship be re-established after critical information arises during consultation? These questions are still empirical, however, they need immediate attention and consideration so that clinical supervision can proceed toward its highest potential.

To move from clinical supervision to counseling presents even more serious questions and implications. Counseling conceptually involves an expert, psychologically oriented relationship, where the client in counseling poten tially reveals extremely personal, emotional information that extends beyond the job environment. Supervisors involved in the process and privy to such information may no longer relate to their supervisees in only a professional manner—they may lose their objectivity, their opportunity to openly critique and instruct the supervisee, their ability to make needed administrative deci sions. Supervisees may withdraw from the supervision relationship because of embarrassment, may fear that they have jeopardized their jobs, and may be angry that their supervisor misused her power and "forced" such personal information to be revealed. Thus, it may be best that supervision and coun seling models, roles, and activities be kept separate and that supervisees needing counseling support be referred to appropriate professionals outside of the work setting and environment. Again, though still an empirical question, confounding supervision and counseling may be so significant that a return to a "pure" supervisory relationship may be difficult, if not impossible

From a different perspective, supervisors often are not trained or licensed as professional counselors or psychologists. Just as clinical supervisors receive specific training and supervision on how to implement, successfully and effectively, supervision and supervisory processes, so too, counselors and psychologists train in their areas of expertise Supervisors should not engage in activities for which they are untrained. They should refer their supervisees to outside professionals when counseling or psychotherapy services are needed. In toto, this constitutes an ethical responsibility of supervisors throughout the field. Integrating counseling services and issues into the supervisory relation ship significantly changes the entire relationship, potentially exposes the supervisee to unqualified and damaging services, potentially places the super visee in double jeopardy and the supervisor in a conflict-of interest situation, and is clearly inappropriate. Although supervision and counseling share cer tain characteristics as helping activities, counseling supervisees in areas of psychological and social-emotional dysfunction is well outside the boundary of the supervision relationship.

SUMMARY AND FUTURE DIRECTIONS

This article discusses the similarities and differences among the clinical supervision, consultation, and counseling models and why supervisors should

be wary of confounding two or three of these models together. Included in this discussion is the development of a conceptualization integrating the three models into a problem-solving process, stressing the need to monitor the development of supervisees', consultees', and counseling clients' professional knowledge, skill, confidence, objectivity, and interpersonal relationship skills.

Much of this article, however, is conceptual; there is a critical need to test many of the stated hypotheses empirically and in the field. Future studies, therefore, might investigate (1) the shared variables that influence the effectiveness of clinical supervision, consultation, and counseling; (2) the effects of consultation or counseling as they are introduced into the clinical supervision relationship; (3) the necessary training experiences so that clinical supervisors can effectively discriminate between these three models and their practices; (4) the types and characteristics of specific professional situations that require clinical supervision rather than consultation or counseling. But now, even conceptual distinctions between clinical supervision, consultation, and counseling are needed.

HOWARD M. KNOFF is Associate Professor of Education and School Psychology, College of Education, University of South Florida, Tampa, Florida 33620.

Altbach, Philip G *The Knowledge Context Comparative Perspectives on the Distribution of Knowledge* Albany. State University of New York Press, 1987. 203 pp. $34.50/$10.95.

Altbach explores several dimensions of the international knowledge system journal and book publishing; data bases; libraries; the knowledge-dissemination system as a whole; the dominance of metropolitan centers in North America and Western Europe; the inequalities of the system as it affects the Third World; the dominance of English-language research and publication, problems of the copyright system, multinational publishers, minipublishers, the shortage of curriculum materials and textbooks, the centrality of knowledge distribution for educational purposes; and the interrelationships among scholars, teachers, editors, publishers, libraries, and the public.

Apple, Michael W. *Teachers and Texts: A Political Economy of Class and Gender Relations in Education.* New York Routledge and Kegan Paul, 1986 259 pp. $19 95.

In this volume, Apple continues to develop perspectives begun in *Ideology and Curriculum* (1979) and *Education and Power* (1982). In addressing interrelated topics such as teachers, texts, control, "women's work," humanism, curriculum, educational reports of the 1980s, and technology, Apple advances the complexity, clarity, and cogency of his argument that greater attention must focus on inequalities derived from gender, class, and race. Without thorough attention to these matters, democracy will be greatly impeded Apple's emphasis inspires reflection on some of the most profound issues of our time.

—William H. Schubert