

Research in Review

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Research in Review/Clinical Supervision: A Review of the Research

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Clinical supervision has been described by Fred Wilhelms as a system of supervision "with enough weight to have impact and with the precision to hit the target."¹ Clinical supervision was developed in the late 1950s by Morris Cogan, Robert Goldhammer, and Robert Anderson as they attempted to become more effective in their supervision of fifth-year interns at Harvard. Beginning slowly at first, professional interest in clinical supervision has accelerated until at present it has grown to a movement. The movement was first given impetus with the publication of Goldhammer's book *Clinical Supervision*² in 1969. This was followed in 1972 by Cogan's book, also entitled *Clinical Supervision*.

Since then, there have been a number of publications devoted to the process, including ASCD's *Supervision in a New Key*,³ the Winter 1976 issue of *Journal of Research and Development in Education*,⁴ which presented a number of concept papers on clinical supervision, and a Phi Delta Kappa Fastback scheduled for publication in April 1978.⁵ In addition, ASCD has included clinical supervision in its National Curriculum Study Institutes for the past several years. Programs and action labs at the national ASCD conferences for the past few years have also presented clinical supervision.

The dominant pattern that has emerged for clinical supervision appears to be the five-step process proposed by Goldhammer:

1. *Preobservation conference*. In this conference, the supervisor is oriented to the class, objectives, and lesson by the teacher. Then the teacher and supervisor decide on a contract (purposes of the observation).

2. *Observation*. The supervisor observes the lesson, taking verbatim notes as much as possible or recording the lesson by mechanical means.

3. *Analysis and strategy*. The supervisor considers his or her notes with respect to the contract emphasis and also to discover any patterns, either favorable or unfavorable, that might characterize this teacher's behavior. After the lesson has been analyzed, the supervisor considers this teacher, his or her level of self-confidence, maturity, experience, and so on, decides on a strategy for the conference.

4. *Postobservation conference*. The supervisor implements his or her strategy. He or she deals with the contract items first and, with the consent of the teacher, may introduce comments on patterns not a part of the original contract that he or she has identified. Planning with the teacher for a future lesson that incorporates mutually agreed-upon changes may also occur.

5. *Postconference analysis*. The supervisor analyzes his or her own performance and makes plans for working with this teacher in a more professional, productive manner in the future.

Both Goldhammer and Cogan emphasize that just going through the five steps in a mechanical fashion will not result in substantially improved supervision or improved teacher behavior. There must be a genuine air of collegiality and mutu-

¹ Morris Cogan. *Clinical Supervision*. Boston, Massachusetts: Houghton Mifflin, 1972.

² Robert Goldhammer. *Clinical Supervision*. New York: Holt, Rinehart and Winston, 1969.

³ Fred Wilhelms. *Supervision in a New Key*. Washington, D.C.: Association for Supervision and Curriculum Development, 1973.

⁴ *Journal of Research and Development in Education* 9: Winter, 1976.

⁵ Charles Reavis. *Clinical Supervision*. Bloomington, Indiana: Phi Delta Kappa, 1978.

ality in the relationship. The supervisor must see his or her role as trying to help the teacher achieve purposes in a more effective efficient manner, not imposing pet theories and methods.

Those who support clinical supervision claim that its implementation will result in more democratic behavior on the part of the supervisor, an improved teacher attitude toward the process of supervision, and genuine interest on the part of the teacher in improving instruction, rather than just trying to please the supervisor, or worse, defensively trying to justify to the supervisor why his or her behavior does not need to change. The bottom line in supervision is, of course, changed teacher classroom behavior and ultimately improved pupil learning. If clinical supervision is to deserve the attention that it is currently attracting, it must ultimately make a difference in one or more of the above areas.

What evidence exists that clinical supervision actually deserves the attention it is receiving and achieves the effects that have been suggested by the literature? Several studies have been conducted examining various aspects of clinical supervision. Some of this research has been flawed in that there is a real question about the care with which the researcher ensured that clinical supervision procedures were followed and to what degree the participants were unaware of the expected results (thereby being able to influence the results, either consciously or unconsciously). On the other hand, in field research all the variables are difficult to control, and, if a number of studies reach a level of significance with respect to an important issue, reasonable confidence in the results would seem to be in order.

Teacher Attitudes Toward Clinical Supervision

Three studies have been conducted to gain information on this topic. Eaker⁶ conducted a

study in 1972 in which he attempted to determine the acceptance by teachers and administrators of the basic assumptions and procedures of clinical supervision. He found that:

1. Most teachers and administrators agreed with the basic assumptions of clinical supervision.
2. Teachers tended to agree with the assumptions of clinical supervision more than with actual procedures.
3. Administrators tended to agree more strongly with the assumptions and procedures of clinical supervision than did teachers.

While the above study makes some contribution to our knowledge of the acceptability of clinical supervision, it was weak in two respects. It failed to study teacher acceptance of clinical supervision contrasted with other forms of supervision, and it was measuring teacher reaction to a hypothetical description rather than an actual experience of the teacher.

Reavis⁷ conducted a study on teacher attitudes toward clinical supervision in which one sample of teachers experienced three clinical supervision cycles and another sample experienced three cycles of traditional supervision. Both types of supervision were conducted by the same supervisors. In the traditional model, the supervisors conducted in-class observation and a follow-up conference, with the supervisor making most of the suggestions for change. An attitude survey revealed the following:

⁶ Robert E. Eaker. "An Analysis of the Clinical Supervisory Process as Perceived by Selected Teachers and Administrators." Unpublished doctoral dissertation, The University of Tennessee, 1972.

⁷ Charles Reavis. "A Test of the Clinical Supervision Model." *Journal of Educational Research* 70:311-15; July-August, 1977.

1. Teachers favored clinical supervision in all six criteria studied (communication, conferences, observations, suggestions for improvement, self-perception, and supervisor helpfulness).

2. In two categories—communication and self-perception—the clinical procedure was rated significantly better than the traditional.

"In summary, on the basis of research conducted thus far, one may say with reasonable confidence that teachers favor the clinical supervision approach."

3. Traditional supervision was not preferred in any category.

This study could be criticized in that the same supervisors conducted both the clinical and traditional supervision cycles, thus they could have biased the results toward clinical supervision. A random monitoring of tapes of the conferences did not, however, suggest this was the case.

Teacher self-image, self-understanding, and skill in self-analysis as a result of clinical supervision has been studied by Shuma.⁸ Three teachers received clinical supervision for one semester and another six, the control group, received none. Shuma found significant, positive differences between the two groups favoring the experimental group on the factors studied. However, as the control group received no special treatment, the differences between the two groups may be the result of a Hawthorne effect; that is, the treatment group was responding to the extra attention they were receiving, rather than clinical supervision.

Change in Actual Teaching Behavior

Garman⁹ conducted a study in which five college English-teaching assistants were given a 12-week teaching seminar in conjunction with clinical supervision, and five other teaching assistants were exposed to the teaching seminar, but with no supervision. The findings indicated that four of the five teaching assistants who received clinical supervision were able to implement the teaching behaviors discussed in the seminars, whereas only one of the five who did not receive clinical supervision was able to implement the behaviors. This study is weak, however, in that it contrasts clinical supervision with no supervision at all, rather than with traditional supervision. Still, it does lend some support to the effectiveness of clinical supervision.

Skarak¹⁰ has compared the effectiveness of clinical supervision alone compared to clinical supervision used in conjunction with immediate secondary reinforcement of a preselected teacher behavior. Immediate reinforcement of a desired behavior is a very powerful training tool in behavior modification. Few question its effectiveness therefore, this may be a measure of clinical super-

⁸ Karen Shuma. "Changes Effectuated by a Clinical Supervisory Relationship Which Emphasizes a Helping Relationship and a Conference Format Made Congruent with the Establishment and Maintenance of This Helping Relationship." Unpublished doctoral dissertation, University of Pittsburgh, 1971.

⁹ Noreem Garman. "A Study of Clinical Supervision as a Resource for College Teachers of English." Unpublished doctoral dissertation, University of Pittsburgh, 1973.

¹⁰ N. D. Skarak. "The Application of Immediate Secondary Reinforcement to Classroom Teaching Observations in Clinical Supervision." Unpublished doctoral dissertation, University of Pittsburgh, 1973.

in changing behaviors. The question of whether it would make any additional increment in changed teacher behaviors beyond that accomplished by clinical supervision alone is a compelling one.

The experiment was conducted in two phases. First, the teacher and supervisor preselected a behavior following which the supervisor observed five consecutive lessons, supplying an oral or visual reinforcer each time the teacher produced the desired behavior. After this sequence, the teacher and supervisor selected a similar but different behavior, and the supervisor observed five consecutive lessons, supplying no secondary reinforcers. In both phases, that utilizing the secondary reinforcers and that not utilizing the secondary reinforcers, the clinical supervision sequence was followed. Skarak concluded that there was no difference in the amount of changed teacher behaviors: Clinical supervision alone was just as effective as clinical supervision used in conjunction with the potentially powerful immediate secondary reinforcement strategy.

Shuma¹¹ was interested in the change in teacher behaviors in organization of tasks, congruity of pupil and teacher objectives, and teacher's response to pupil communication, among other factors, as these were perceived by the pupils. There was an experimental and control group of teachers and pre- and post-measures on several different scales were gathered. Shuma concluded that there was a significant difference between the two groups in the above-mentioned areas and in each instance the difference favored the clinical treatment group. However, the clinical group received extra treatment and attention not extended to the control group; therefore, the extra attention the experimental group received may have accounted for some of the differences. Also, the control group received no additional supervision;

vision versus no supervision, rather than clinical supervision contrasted to traditional supervision.

Krajewski¹² has reported on his work with two groups of 20 teachers each. The experimental group received training in Flanders Interaction Analysis and clinical supervision visits, during which time their lesson was videotaped and analyzed using Flanders' category system. The control group received regular supervisory visits, but no videotaping or training in Flanders' system. At the end of one year, the experimental group showed significant gains in indirect verbal patterns (the preferred pattern), positive attitude gains, and better pupil rating as compared to the control group. However, the research may be flawed in that this research study may be measuring the results of training versus no training in the Flanders system. The gains in attitude and pupil rating may be the result of a Hawthorne effect since the control group received no extra clinical visits and no videotaping. There is some question as to whether the clinical visits actually followed the pattern generally recognized as the clinical pattern. The study may be understood to affirm that training in a particular procedure produces more change than no training. The clinical approach may or may not have contributed to the results obtained.

Verbal Behaviors

In the study by Reavis,¹³ described earlier, audiotapes of the post-observation conferences

¹¹ Karen Shuma, *op. cit.*

¹² Robert Krajewski. "Clinical Supervision: To Facilitate Teacher Self-Improvement." *Journal of Research and Development in Education* 9:58-66; Winter 1976.

¹³ Charles Reavis, *op. cit.*

between supervisors and teachers in both the clinical and traditional cycles were analyzed. Supervisors and teachers were unaware of the actual focus of the study, believing instead that the focus of the study was changed teacher classroom behaviors. The purpose of the analysis was to discover any differences between the democratic/autocratic verbal behaviors of supervisors in the two styles. No significant differences in verbal behavior were found in 11 of the 13 categories between the clinical and traditional treatments. Significant differences were found, however, in two categories—"Supervisor accepts or uses teacher's ideas" and "Supervisor asks for teacher's opinions." The verbal analysis model used for this study was based upon Flanders' Interaction Analysis model. In his model, the category "Teacher accepts or uses ideas of pupils" was found to be significant in producing pupil learning gains. This category, as well as "Supervisor asks for teacher's opinions" would be democratic, growth-promoting behavior. The results of Reavis' study may be interpreted to mean that, while verbal analysis suggests similar verbal exchanges between supervisors and teachers in both the clinical and traditional patterns, the exchanges are significantly different favoring the clinical style in two dimensions, and these may be highly significant in promoting teacher motivation for classroom behavior change.

In summary, on the basis of research conducted thus far, one may say with reasonable confidence that teachers favor the clinical supervision approach. This has been confirmed by three different studies. No study has found traditional supervision favored, and national surveys of teachers have tended to show teachers as distrustful of the supervisory process as traditionally practiced.^{14, 15} The results with respect to actual changes in teacher behavior or pupil performance

are less clear. However, on balance, considering the studies available, one can safely say that no study has found traditional supervision effective in changing teacher behaviors when compared to clinical supervision, and the finding by Skarak that secondary reinforcement produced no more changes in teacher behavior than clinical supervision alone is a significant finding. The study of verbal behavior in the supervisor-teacher conference as an indicator of improved supervisory practice is a rather new area. However, the conference is the arena where attempts to influence teacher behavior are often exercised, and the finding that the difference in preferred verbal behavior patterns consistently favored the clinical treatment strongly suggests that clinical supervision is a pattern of supervision that in the words of Wilhelms does indeed have, "enough weight to have impact and the precision to hit the target." [E]

¹⁴ Joseph Walker. "Georgia Teachers Test Irritating Supervisory Habits." *Phi Delta Kappan* 57(5):350; January 1976.

¹⁵ Arthur Blumberg. *Supervisors and Teachers: A Private Cold War*. Berkeley, California: McCutchan Publishing Corp., 1974.



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