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ABSTRACT

In this paper on the use of teachers as reflective users of peer clinical supervision, a research and literature review relating to the assumptions of clinical supervision, fostering reflective practice through clinical supervision, and the special potential of peer clinical supervision is presented. Then, a personal account of a beginning teacher's views of and experience with clinical supervision is offered. It is concluded that clinical supervision, peer or otherwise, is bound to be misinterpreted and to give disappointing results if one asks whether it will do a better job with the familiar purposes of supervision. Neither the shortage of offical supervisors nor the apparent need to improve teaching are reasons to adopt peer clinical supervision. If a climate can be created in which teachers can genuinely explore the meaning and potential of "reflection-in-action" for improving their practice, then peer clinical supervision is a powerful way for the observation and analysis of teaching to proceed. (CB)

TEACHERS AS REFLECTIVE PRACTITIONERS IN PEER CLINICAL SUPERVISION

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The supervision of teachers has its roots of practice and tradition in the early decades of the century, when schooling developed fairly rapidly into the complex organizational arrangements we know today. Apparently, it was taken for granted that teachers needed to be observed at regular intervals by those in positions of authority or expertise to ensure the quality of teaching AND to foster a process of improvement that would not happen otherwise. Perhaps the greatest single impediment to taking "peer" supervision seriously is the tacit assumption that teachers lack the authority and expertise to help each other.

One of the many special obstacles to the development of teaching as a profession has been the lack of a body of specialized knowledge, such as that apparently available to doctors and lawyers. Everyone in society is familiar with the routines of schools, but that familiarity does NOT include talking with teachers about what they know, if one assumes that teachers can tell their professional knowledge. The process of moving from undergraduate education through professional courses in education and one's first three or four years of teaching experience seems to leave one quite unaware that one could acquire or has been acquiring professional knowledge.

In the last 20 years, there has been massive growth in research activity in education. The third edition of the Handbook of Research on Teaching (Wittrock, 1986) may leave one breathless, or overwhelmed, or both, but it leaves little doubt that there is research activity in education. Since research apparently leads to growth in the knowledge base for teaching, researchers seem to think they know something about teaching, but the question remains whether teachers share that view. The intriguing question is how the accumulated products of research activity relate to classroom teachers, including those who teach teachers in university settings. Interestingly, there is very little in the latest Handbook of Research on Teaching that relates in any way to the supervision of teachers. The names of many who are writing about clinical supervision are missing from the volume.

In this context, the present paper has two main purposes. The first is to explore the idea of peer clinical supervision from the perspective of fostering reflective practice by teachers. As argued elsewhere, education is rich in imagery that casts teachers as either "defective" or in need of being made more

"effective" through application of research results; quite different assumptions are involved in a "reflective" perspective that builds on teachers' own reactions to their work (Russell, 1985). Here the arguments of Schön (1983) in The Reflective Practitioner: How Professionals Think in Action guide discussion intended to develop more fully the potential of peer clinical supervision. The second purpose is to present the insights of a teacher (Spafford) whose first five years of teaching included significant encounters with clinical supervision, experiences that left her very favorably disposed to the potential of peer clinical supervision. No conclusion that peer clinical supervision is easy, proven effective, or a panacea is intended or implied. No strategy of supervision has attained those attractive but distracting characteristics. Indeed, to ask how effective clinical supervision (peer or otherwise) is in comparison to other forms of supervision is to misunderstand the nature of clinical supervision. The overall goal of the paper is to demonstrate the particular potential of peer clinical supervision for fostering reflective practice on the part of teachers.

The Assumptions of Clinical Supervision

Clinical supervision is frequently represented as a minor aberration on the main sequence of developments in the supervision of teachers. Clinical supervision's origins were at Harvard in the 1950s and 1960s and arose from the experiences of people associated with the Master of Arts in Teaching program. Goldhammer (1969) and Cogan (1973) are basic references. The term "clinical supervision" is itself problematic, because of "cold" and "critical" overtones associated with "clinical," yet the term persists as a convenient way to refer to an important set of assumptions about how supervision of teaching may be approached. Clinical supervision focuses on the data of teaching, on recorded events (see Acheson and Gall, 1980, for a number of recording strategies) that may be revisited by teacher and supervisor, separately and together. Clinical supervision develops the power of searching data for patterns of recurring behavior; there may be causal links between patterns of teacher and student behavior, and a pattern is more powerful than an individual event as a unit of analysis for assessing significance and developing alternatives.

The manner of analyzing teaching within clinical supervision is significant not only for its power but also for its intended impact on the teacher whose professional activities are being examined. Clinical supervision seeks to foster the autonomy and independence of the teacher, with a view to enabling the teacher to become more analytical of his or her own teaching behavior. The ultimate goal is a teacher who is more aware of the nature and impact of personal teaching actions and a teacher who has more deliberate control over those actions. Kilbourn (1982) cites three features--autonomy, evidence, and continuity--as "vital to the spirit of clinical supervision . . . . necessary, but not sufficient, conditions" (p. 2). Continuity refers to the extended time frame over which data will be collected and analyzed, in contrast to a single-visit strategy of supervision. Evidence refers to the nature of the observations and the data that are available for analysis. Autonomy refers to the deliberate goal of fostering the ability of the teacher to analyze and control personal teaching behavior. The actual chronology of events in a cycle of clinical supervision has been depicted in many variations; that by Smyth (1984b) is particularly clear and concise. A conference before an observation ensures that the

supervisor/observer is aware of the teacher's intentions and has a teacher-directed focus for the observation; a conference following analysis of the data by teacher and supervisor permits reconstruction of the lesson, sharing of interpretations, and planning for appropriate changes (if any) in subsequent lessons.

Fostering Reflective Practice through Clinical Supervision

Many find the term "clinical" awkward and misleading. The term "supervision" may be even more misleading because it suggests comparison to other strategies for supervision of teachers. "Clinical supervision" casts the observation and analysis of teaching in ways radically different from other strategies. Schön's (1983) analysis of "how professionals think in action" provides a perspective for which clinical supervision could be said to have been waiting. One could argue that clinical supervision was ahead of its time--a strategy for which the underlying "backing" had yet to be developed fully. Schön builds on the crisis of confidence in professional knowledge in our culture, pointing out that we have an overdeveloped faith in the knowledge that can be printed in books and research reports. Some problems cannot be solved by application of knowledge in some straightforward sense; progress is made only by "reframing" problems in response to "puzzles" and "surprises" in the domain of professional practice. Schön argues that professionals have "knowledge-in-action" that develops by a process he terms "reflection-in-action" (pp. 21-69). One of his major concerns is to demonstrate, through case-study illustration, that the process he terms reflection-in-action can be a rigorous one, and he describes three types of experimentation associated with reflection-in-action (pp. 141-156). The following quotation expresses the broad range of assumptions touched by Schön's arguments.

> When someone reflects-in-action, he becomes a researcher in the practice context. He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case. His inquiry is not limited to a deliberation about means which depends on a prior agreement about ends. He does not keep means and ends separate, but defines them interactively as he frames a problematic situation. He does not separate thinking from doing, ratiocinating his way to a decision which he must later convert to action. Because his experimenting is a kind of action, implementation is built into his inquiry. Thus reflection-in-action can proceed, even in situations of uncertainty or uniqueness. (pp. 68-69)

Few statements more concisely describe the type of analysis and the level of practitioner autonomy that clinical supervision seeks to foster in teachers. In addition to arguing for a new conceptualization of the nature of professional knowledge, with major implications for the relationship between "theory" or research-based knowledge and the events of "practice," Schön is also explicit about the consequences for the relationship between professional and client and the type of "contract" that exists between them. The implications are significant for the supervisor-teacher relationship as well as for the teacher- student relationship. The following quotations express the contrast; when we read the attitudes of the client in a "traditional" contract, we are reminded that teachers

have rarely extended to supervisors the confidence and credibility that has been associated with possessing specialized knowledge.

- o I put myself into the professional's hands and, in doing this, I gain a sense of security based on faith.
- o I have the comfort of being in good hands. I need only comply with his advice and all will be well.
- o I am pleased to be served by the best person available. (p. 302)

A "reflective" contract implies quite different possibilities for both client and professional, for teacher and supervisor.

- o I join with the professional in making sense of my case.
- o I can exercise some control over the situation. I am not wholly dependent on him; he is also dependent on information and action that only I can undertake.
- o I am pleased to be able to test my judgments about his competence. (p. 302)

The Special Potential of "Peer" Clinical Supervison

It has been only too easy to assume that teachers could not help each other in carrying out the purposes of supervision. With Schön's reconceptualization of professional knowledge and the manner in which it develops, we can no longer deny teachers the expertise that is required for supervision. It is experience of teaching that permits the sharing of meaning in analyzing and interpreting classroom events and in developing new possibilities for action. There has been such a long tradition of supervision involving an "expert" judging a teacher's actions and prescribing changes that it may be difficult for those who are not "peers"-- equal in position and the authority associated with that position--to work toward the reflective contract described by Schön and desired by proponents of clinical supervision. This possibility may come as a disappointment to those with considerable experience of supervision; however, their knowledge and experience may prove invaluable as they assist in the analysis and interpretation of what two peers have accomplished in attempting clinical supervision.

This century's traditions of research and supervision in education have made it easy to assume either that teachers use some behaviors that are inappropriate--the "defective" image--or that teachers could be using more appropriate behaviors that have the support of research--the "effective" image (Russell, 1985). This is a straightforward extension of the observation that much teaching is build on "telling" and "judging," and not surprisingly our strategies for supervision proceed on the same premises. While not denying the potential value to teachers of either experienced observers or reports of relevant research, clinical supervision centers on the process of improving the teacher's own analysis--a "reflective" image. Here it is less important and less appropriate to tell teachers their mistakes or ways they could improve and more important to assist the teacher in "reframing" puzzling or surprising events of practice. A colleague who is a consultant expressed the issue with impressive simplicity

and understatement: "We've achieved so much in our primary classrooms this year. The most I've done is provide the time, the place and an interested ear and lots of questions." (R. Davis, personal communication, February 1, 1986)

The experiences of one's first few years as a teacher are usually memorable, sometimes indelible. As a teacher moves into the professional world, leaving the safety of student life behind, it is often difficult to adjust to the professional requirements of teaching coupled with the supervisory process, which tends to be reminiscent of the student-teacher relationship. Clinical supervision can offer a form of interaction that facilitates the adjustment to the demands of the teaching profession while retaining the supportive features of collegial aid. Thus the new teacher has opportunity to establish a professional sense of self, caring and committed to teaching, while gaining from the expertise and knowledge of a colleague (supervisor). The following is an account of Spafford's experiences with clinical supervision during the first five years of her teaching career.

The Beginning Teacher and Clinical Supervision: A Personal Account

In this brief account, I endeavor to describe the impact clinical supervision had upon my fledgling attempts to become an effective teacher, and my reaction to participating in clinical supervision as contrasted with more traditional types of supervision. In 1981-82, clinical supervision was introduced to the staffs of the schools in my district in one of Canada's maritime provinces. The new form of supervision was greeted with something short of "dismay" and little more than "resignation." Many teachers were extremely reluctant to consider the new supervisory process, in large part because a very poor relationship existed between them and the school principal. A method of supervision that would mean working with this principal was viewed in a poor light.

My reaction to the "new" form of supervision was directly related to my previous year's experience with supervisors. My first year of teaching (in the same district) had been filled with unpleasant experiences from September through to June. The unpleasant experiences included 10 "visits" from everyone from the vice-principal right up to the superintendent himself. I had developed a very negative attitude towards the vice-principal and principal of my school, all the personnel at the district office, and myself as a teacher.

In my second year, I felt that any form of supervision different from that of the previous year had to be a potential improvement. My class fell somewhere within the meaning of the word "normal," and I was prepared to try to wipe clean the slate and start over again. Ten members of staff were needed to begin the process of initiating everyone into the "mysteries" of clinical supervision and I volunteered to be one in the group. We drew names to see whether we would be matched with our vice- principal or our principal. I drew the principal and we had our first informal meeting in November.

The focus of the supervision was to be determined by the teacher. I wanted to write a math curriculum (no standard one was available) for my Grade 2 class and in it implement ideas for enrichment, since I had a number of children who were gifted in the area of mathematics and needed challenging work. This

my focus for supervision was on math lessons and the enrichment opportunities made available to the gifted students.

Mr. B. (the principal) visited my classroom three times between November and April. After each visit, we would discuss the lesson and refer to my original objectives and aims to see how I was progressing. In April we each wrote a report detailing what we thought of the process as a whole and an individual perspective on how it had helped us as teachers. I liked this part of the process. It made me feel that I was thinking about myself and my teaching, and just knowing that Mr. B. was doing the same thing made it seem more a matter of teacher-to-teacher and less principal-to-teacher.

The clinical supervision that year had two major effects on me. Although I have never forgotten my first year of teaching and feel that I experienced many things I need not have, I value it in some ways. It made my second year of teaching even more significant. It is not easy to say just how much clinical supervision influenced the way I felt about myself at the end of my second year of teaching, but I do feel that the opportunity to work with my principal in a non-threatening, non-intimidating situation helped in my struggle to develop a better concept of myself as a teacher. Because I had an investment in the supervisory process, I felt less like a child and more like the professional adult I was supposed to be. Much of this progress depended on my experiencing clinical supervision so near the beginning of my teaching career. I could not guarantee that a teacher with many years of experience would feel the same way.

The second personal effect of clinical supervision involved my relationship with other teachers in the school. The "personality" of the staff was well established by the time I joined them. I was the youngest member of staff and I was viewed with quite a bit of suspicion, because I was "fresh out of college" and because I came from the "mainland" (as many maritimers still refer to Ontario). Most of the staff seemed to view my trials during my first year of teaching as some sort of "ritual of scarification," which was my due and only to be expected. When I volunteered for clinical supervision in my second year, it was considered a "breaking of the ranks" because it meant working more closely with the administration of the school, something some teachers were not eager to do.

Clinical supervision did have a great impact on me, in part because of my particular situation and needs, helped along by my own propensity for analyzing things and what my mother used to call "rehashing" them. Because I encountered so much skepticism among my colleagues in the school, I tried not to rhapsodize about the change in my attitude and how much better everything seemed to be. The teachers were quite accustomed to "enduring" an impromptu visit, twice a year, from the principal, vice- principal, or someone at the district office. The idea of prolonging or extending this contact was quite unappealing, and even more intimidating simply because it was different.

My last year of teaching at the K-6 level saw me involved in clinical supervision again, this time with the vice-principal and in the area of social studies. We did a lot of what might be called "peer tutoring" because she also taught Grade 6 and we would wander in and out of each other's classrooms, bringing our students together for certain lessons and helping each other write

a social studies curriculum for Grade 6. The only difference between us was that "officially" she was the vice- principal and supervisor and I was the teacher. We went through the process, but there were times when she was observing me and times when I was observing her. In that sense, it was not clinical supervision as we had been led to think of it. I felt I gained even more from this arrangement, because the vice- principal was actually a teacher in the school, with a class of "real live kids" just across the hall. I knew what she was trying to do, just as she knew my class and what I was attempting to do. This is where I think clinical supervision has real potential, in its peer supervision aspect.

By establishing a trusting relationship such as I had with my vice-principal, the conditions were right for formally beginning peer clinical supervision, had that term been applied to our particular arrangement. Other aspects of the process-- collection and analysis of data, explorations of alternatives and solutions--would , I think, have evolved and flourished. The benefits to the observer as well as to the one being observed are tremendous. When I worked with my vice-principal in the clinical supervision situation, she often expressed to me her enjoyment at being able to gather new ideas while observing in my class. The discussion and sharing of these ideas boosted my self-confidence as a teacher, as this led me to feel that I was making significant contributions to another staff member and was part of a meaningful learning environment.

Teachers in a single school are likely to have a variety of attitudes and dispositions toward their profession. Thinking and reflecting about what we actually are about in the classroom is not usually a conscious activity on the part of teachers; many are likely to regard notions such as Schön's "reflection-in-action" as little more than "new-fangled nonsense." It is my feeling that had the more reflective features of clinical supervision been emphasized when my staff was introduced to it, the dismay and resignation they demonstrated would have been in even greater evidence.

Teacher-centered activities, such as clinical supervision, seem to appear more intimidating than traditional supervision, possibly because it is incumbent upon the teacher participating in clinical supervision to direct and design the focus of the supervision. After four years of exposure to clinical supervision, it was not clear to me whether the staff I was part of held a more positive view of it. I consciously separated my own feelings from those expressed by staff members, in an effort to reduce possible curiosity or animosity. As I reflected upon why I felt I should be so guarded concerning my own experiences with clinical supervision, I began to realize that opportunities for peer clinical supervision were increasing as more interaction between classes was taking place. That this occurrence should coincide with the advent of clinical supervision was, perhaps, only coincidental, yet in retrospect it seems that the new awareness of confidence and significance that I was experiencing as a teacher was also permeating the staff.

I felt sure that the members of the staff represented a wide variety of experience and styles. In my first year, I was curious about the teachers on the staff who had been teaching for many years. I wished there were some way we could interact and share our thoughts on teaching. I am also sure the

curiosity extended both ways, for one teacher who had been teaching for over 20 years expressed interest in my ideas and methods, saying," You're straight out of college; you must have something interesting to show us!" However, there was no formal procedure to initiate a process of sharing between the one with the experience and the "intuitive" style and the one with all the "book facts" and the desire to begin creating a style of her own.

One example of peer-sharing that began to occur in the school was the story-telling time created between the Grade 3 classes and the Grade 1 classes. The Grade 3 Classes began to visit the Grade 1 classes once or twice a week to read their latest creative-writing efforts. The Grade 1 students enjoyed being read to by an older child, and the event was very much student-organized with little supervision by the teachers involved. After a few weeks of this, the Grade 1 classes decided they would like to become more than just passive participants in this time together, and they began sharing their stories with the Grade 3 students, sometimes acting out favorite stories or putting on puppet shows. The benefits to the two sets of students were many, and although no formal collegial sharing of ideas and styles went on between the teachers of the two grade levels, most of the six teachers involved expressed enjoyment just at being in someone else's classroom for a while to see what went on.

Situations such as this suggest the plausibility of introducing and supporting peer clinical supervision. Grounded in trust and confidence, the relationship between two colleagues can make teaching, reflecting, and improving a cyclic process that encourages growth and imparts to teachers a very real sense of professional "validity." If we are experiencing, as Schön suggests, a "crisis of confidence" in our profession, then the time has come to tap into the many resources in our own schools that are waiting to be mined. The potentially rich situation of teachers sharing with each other the problems and possibilities of their work could nurture the network of support, reflection and implementation that can, in turn, foster an atmosphere of caring and commitment--commitment to one's profession, to one's students, and to oneself.

Afterword

This exploration of relationships between peer clinical supervision and the idea of teachers as "reflective practitioners" (Schön, 1983) began, interestingly, in our conversations about McFaul and Cooper's (1984) "dismal" prognosis of the "reality" of peer clinical supervision. Others (Goldberry, 1984; Krajewski, 1984) have already pointed out the good reasons for not dismissing peer clinical supervision on the basis of the evidence and analysis provided by McFaul and Cooper.

This account of the impact of clinical supervision on one beginning teacher and of her estimate of the potential for peer clinical supervision organized on a school basis relates readily to many of the points raised by Alfonso and Goldsberry (1982) in their discussion of "colleagueship" among teachers in a school. We close with a caution that relates to Schön's (1983) account of the reflective practitioner. We believe that these ideas must not be set in the "frame" of more familiar methods of supervising teachers. Clinical supervision, peer or otherwise, is bound to be misinterpreted and to give disappointing

results if one asks whether it will "do a better job" with the familiar purposes of supervision. Neither the shortage of official supervisors nor the apparent "need" to improve teaching are reasons to adopt "peer" clinical supervision. If a climate can be created in which teachers can genuinely explore the meaning and potential of "reflection-in-action" for improving their practice, then peer clinical supervision is a powerful way for the observation and analysis of teaching to proceed.

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