Goldhammer's Clinical Supervision a Decade Later*

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and
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Clinical supervision might be accepted more readily if it were called something else. In any case, teachers will find it more acceptable if they understand the concept and believe they will benefit from it.

When Robert Goldhammer died in 1968, with his book nearly ready for publication, the term "clinical supervision" was not yet in wide use and its literature was only beginning to take shape. In fact, another five years were to pass before the milestone volume of the same title by Morris Cogan (Goldhammer's principal mentor) would appear. Even today, the ideas and practices associated with clinical supervision are insufficiently known and appreciated. All the same, much has happened over the past decade within the parent field of general supervision and also in the area of face-to-face supervisor/teacher interactions.

For those who have been close to the ongoing research, development, and publications over the decade, this has been a fruitful and exciting time. We assume that if Goldhammer had lived to be a part of that excitement, he would have undergone both some changes of heart and some bolstering of previously-held convictions, as we did. Having taken on the task of updating the original Goldhammer volume, we found ourselves wondering how Goldhammer himself would have chosen to do so; and, in our speculations and fantasies, eventually invented the idea of a three-way interview through which could be revealed at least one set of predictions or estimates of Goldhammer's viewpoint were he still alive.

What follows, then, is a partially-imaginary discussion. Our questions and statements are authentic enough, and we hope that most of the views ascribed to a revivified Goldhammer are also authentic, or at least highly likely given what is known about his history and his beliefs.

In this setting, the three of us are assembled around a conference table, on which are copies of the 1969 volume and several tentative outlines of the projected revision. Anderson is reading a portion of the 1969 Foreword to refresh his memory. Krajewski turns to Goldhammer.

Krajewski: Bob, a lot of water's passed over the dam in the past ten years. Many exciting arguments and discussions, both profound and superficial, have been addressed to the topic of clinical supervision, a number of which can be attributed to your fine book.

* Adapted from Robert Goldhammer, Robert H. Anderson, and Robert J. Krajewski, *Clinical Supervision: Special Methods for the Supervision of Teachers*, 2nd ed. (New York: Holt, Rinehart and Winston, 1980).

Bob Anderson and I have been inspired to follow up that work, concentrating in part on how teachers' and supervisors' needs, attitudes, and perspectives toward this important subject have changed. Recently, ideas seem to be falling into a pattern. We think supervisors and teachers want less emphasis on the *methods* and more on the *concept* of clinical supervision. That should enable them to work together more productively and formulate their own processes, which may better fit their environment.

Goldhammer: When I wrote my book, schools were in great need of immediate instructional improvement. I thought it more useful to present a basic method to which teachers and supervisors could turn, thereby speeding up the growth of clinical supervision within the school systems. You may recall that I wrote:

> In its present stage of development, the clinical supervision that our minds can formulate and which we practice does not completely fulfill the ideology that occupies our imaginations. Day by day we know, better, what it is, in life and in professional life, that we're after. And, by small increments, we are getting to know, better, how to get what we're after. (p. 55)

I did indeed have in mind how essential the "concept" of clinical supervision was, but felt at that time it was more relevant to begin with the method, giving the supervisor and teacher something solid to grasp and use.

Anderson: Bob, you remember the old days at Harvard when we talked about clinical supervision with Cogan[1] and several others. It was during the time of the Harvard-Newton Summer Program[2] and later the Harvard-Lexington Summer Program. We talked at length about the "concept" of clinical supervision, but in those days we thought it better to put a version of clinical supervision into practice. Since we were working with training programs, our minds were centered around practical aspects of the concept, and not necessarily around the concept itself.

By Any Other Name

Goldhammer: And there was yet another problem. Right from the start, clinical supervision received slow acceptance, probably due in part to the name itself. Perhaps if it had been called by a different name, teachers would have been less reluctant to accept it, and the growth of clinical supervision could have been more rapid and more extensive than it was then or is presently.

Krajewski: As you were implying, for some persons a word like *clinical* may at first be troublesome. It carries different meanings for different people, most of them having to do with the medical field. In effect, people tend to think of the word negatively. It suggests cold, formal, uniform, cut-and-dried procedures that leave out the personal elements of human contact.

Anderson: Let's discuss what the term *clinical* actually means and how we can best get this meaning across accurately to teachers and supervisors.

Goldhammer: Clinical supervision means there is a face-to-face relationship between supervisor and teacher. Clinical supervision is sometimes confused with ordinary supervision, which has in the past been thought of as supervision conducted at a distance, with little or no direct teacher contact, by someone such as a supervisor of curriculum development. Clinical supervision methods can include group supervision between several supervisors and a teacher or a supervisor and several teachers. When discussing what clinical supervision actually means, we envision a relationship developing between a supervisor and a teacher that is built on mutual trust.

[1] Morris Cogan is given credit for coining the term *clinical supervision* during his work at Harvard.

[2] The Harvard-Newton Summer Program, first offered in 1955, brought recent college graduates without education training into an intensive student-teaching experience, usually four or five under direction of the same master teacher. Cogan and Anderson were faculty members in this program, within which Cogan developed various clinical, peer-supervision technologies. The Harvard-Lexington Summer Program, by contrast, was offered in the summers of 1961 through 1965 to experienced teachers and administrators seeking training in team teaching. The five-stage model of clinical supervision was developed in that program.

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Anderson: When clinical supervision is mentioned, I think mostly about those things that involve the deliberate and direct intervention by a skillful observer into the professional performances or episodes of teaching behavior in which the person being helped engages. Usually that happens in a class; if it's for a counselor, it happens in a guidance office. There are other settings, but for the most part we are talking about a teacher who is in a school building working with students. The clinical part refers to the hands-on or eyes-on aspect of the supervisor who is attempting to intervene in a helpful way.

Goldhammer: That's congruent with my idea of clinical supervision.

Krajewski: Similarly, I think of clinical supervision as a subset of instructional supervision. The supervisor must establish and maintain rapport between self and teacher; that rapport must extend throughout the entire supervision program or method.

Anderson: It is difficult for supervisors and teachers to grasp the concept, given the present name of clinical supervision. Perhaps we should seek to find a better name—maybe something related to counseling and guidance. Whatever the wording used, it should include the idea that this kind of supervision is observational, meaning that the supervisor actually observes the teacher's classroom behavior and then discusses the behavior afterward with the teacher in a counseling-guidance setting. The goal of clinical supervision, in my mind, is to help teachers better perform a job according to their capabilities. I like to think of the supervisor as a teacher of teachers.

Concept and Method

Anderson: Of course, even when the concept is well understood by school personnel, it may be difficult to implement. The implementation ought to follow some plan that is owned psychologically by both the supervisor and the teacher. Also, we must use method as an instrument for measuring how well the teachers and the supervisor are accomplishing the objectives and goals of clinical supervision.

Goldhammer: That's why I put the most emphasis on method in my book. Krajewski is right when he says it all comes back to understanding concept. That is essential and must be accomplished first. However, we must not concentrate only on it and lose sight of how important the method is as a tool for accomplishing improvement in instruction. I can see the two working hand-in-hand for the best results.

Anderson: With respect to method, do you still feel that teachers need some fairly structured, step-by-step procedures to follow of the sort emphasized in the book?

Goldhammer: Yes, I feel that on the whole clinical supervision should be systematic. But there are times when the teacher and supervisor must be flexible and not stick to a systematic pattern day in and day out. A patterned routine such as that can lose its effectiveness. The method is probably always changing, or should be, to allow for changes occurring in the outside factors that teachers must deal with. I'm talking about changing technological and social conditions affecting both teachers and students, which are beyond the school system's control but which do affect students' learning and interests.

Anderson: Although we've said the method should be jointly determined by the teachers and the supervisor, I think the supervisor should be the one to start the ball rolling. The supervisor must have more expertise in the analysis of teaching and in applying principles of learning than do the teachers. It is difficult for him/her to gain respect without that knowledge and understanding. The teachers shouldn't fear the supervisor or regard him/her as egotistical,

but at the same time they shouldn't consider the supervisor to be just another teacher. There should be a notable difference between the supervisor and the teachers, in higher skills and in the ability to analyze and understand the overall view of the school system's needs. The supervisor must be able to observe skillfully and therefore detect more in a teaching sequence than a teacher is able to. The supervisor has a certain amount of responsibility for ensuring that there is a positive school climate and for keeping the teachers working on improving their teaching—in an informal operational manner. He/she has to create and maintain an atmosphere conducive to change. If the teacher is convinced that he/she will benefit from the observations and recommendations, then a close working relationship between the supervisor and teacher can develop.

Teachers might understand the concept of clinical supervision, but it's putting the concept into practice that is the hardest part. A particular problem for *some* teachers is being observed and critiqued by other professionals. As we mentioned before, observation will not look so scary once teachers know the concept behind it and realize that it is to their benefit to be observed in the classroom. In fact, I don't think you can have too much observation; but the supervisors usually have so many other responsibilities—especially if they are principals—that an opportunity to observe a classroom occurs only once every couple of months, if even that often. So the teacher who is not used to a supervisor's visit may become disturbed, and thus think something is wrong because the supervisor is observing his/her classroom.

Krajewski: Putting clinical supervision into practice may appear to be the hardest part only because of this lack of understanding of what is to be accomplished. That is why most of the methods fall apart, especially in the analysis area. What we are aiming for, then, is total knowledge, for both teachers and supervisors, of the concept of clinical supervision in order to make the methods work in school systems today.

Goldhammer: I put it another way in the first edition of *Clinical Supervision*: The aims of clinical supervision will be realized when, largely by virtue of its own existence, everyone inside the school will know why they are there, will want to be there, and will feel a strong and beautiful awareness of their individual identity and a community of spirit and enterprise with those around them. These are the values that motivate our work and give rise to our ambitions. While we cannot, obviously, make promises that are as large as our dreams, we can proclaim those dreams and let ourselves be guided by them. EL