INSTITUTIONALIZATION OF CLINICAL SUPERVISION
IN THE PUBLIC SCHOOLS OF NORTH CAROLINA

by

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(ABSTRACT)

During the 1982-83 school year, public school districts in North Carolina were given the option of using clinical supervision as part of a state-wide performance appraisal process. This option resulted in considerable variation in the implementation and institutionalization of clinical supervision in schools and provided the opportunity to study variables associated with the institutionalization of change in school systems.

Berman's (1981) implementation paradigm was used to identify and categorize predictors of institutionalization. A set of five variables was selected as having the best potential for accounting for the variation in institutionalization of clinical supervision in the public schools of North Carolina.

1. Principal's perception of the amount of time required to perform one clinical supervision cycle.
2. Amount of internal support for clinical supervision.
3. Amount of training in clinical supervision.

4. Principal's belief in the effectiveness of clinical supervision.

5. Type of school administered.

A Principals' Survey was developed and mailed to a random sample of 450 public school principals in North Carolina. Information was received from 288 principals (64%). A follow-up survey of nonrespondents verified the representativeness of the original respondents. Principals responding to the follow-up survey were added to the original respondents for a total sample of 300 principals (67%). Multiple regression analysis was applied to the data with institutionalization as the dependent variable. The multiple R was .30 and \( R^2 \) was .09 (\( F = 4.03, p < .00 \)). Internal support was the only significant predictor of institutionalization (\( b = .20, t = 3.62, p < .05 \)).

Two demographic variables, age and sex, were added to the multiple regression as a side analysis. With these variables added, an \( R^2 \) of .10 was obtained (\( F = 3.37, p < .001 \)). Age was determined to be a statistically significant predictor of institutionalization (\( b = -.06, t = -2.48, p < .05 \)).
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CHAPTER 1

THE PROBLEM

Background of the Problem

Reviewers have concluded that limited research has been conducted on clinical supervision (Newman, 1980; Sullivan, 1980; McFaul & Cooper, 1984), but the research that has been done tends to support its effectiveness (Reavis, 1978a; Sullivan, 1980; Thompson, 1979). Although clinical supervision is not widely used in schools (Sullivan, 1980; McFaul & Cooper, 1984), North Carolina’s General Assembly passed legislation that resulted in the incorporation of clinical supervision as part of North Carolina’s state-wide performance appraisal system.

In 1980, the Second Session of the 1979 North Carolina General Assembly adopted an Appropriations Act. Section 35 of this act (cited in *North Carolina State Department of Public Instruction (NCSDPI), 1981*) read:

The State Board of Education, in consultation with local boards of education, shall develop uniform performance standards and criteria to be used in evaluating professional public school employees. It shall develop rules and regulations to insure the use of these standards and criteria in the employee evaluation process. The performance standards and criteria shall be adopted by the Board by July 1, 1981, and may be modified in the discretion of the Board.

Local boards of education shall adopt rules and regulations by July 1, 1981, to provide for annual evaluation of all professional employees defined as teachers by G. S. 115-142 (a) (9). Local boards may
also adopt rules and regulations requiring annual evaluation of other school employees not specifically covered in this section. All such rules and regulations adopted by local boards shall utilize performance standards and criteria adopted by the State Board of Education pursuant to the first paragraph of this section; however, the standards and criteria used by local boards are not to be limited to those adopted by the State Board of Education. (Appendix J)

During the 1981 session of the North Carolina General Assembly, a Special Provision of the Appropriations Act substituted "1982" for "1981" in two places of Section 35 of the Appropriations Act of the 1979 General Assembly (Public School Laws, 1983, p. 133). The General Assembly justified this date change as follows:

By allowing for the delay in implementation of this section, the General Assembly intends to allow time for testing the standards and criteria in up to 24 local school administrative units and for proper and necessary training of personnel involved in the implementation. It is also the legislative intent that standards and criteria utilized in the initial programs include the use of test scores of teachers as one of many possible measures of performance. (Section 29.12)

In response to the General Assembly mandates, the North Carolina State Board of Education in June 1981 adopted "Recommendations for Action by The State Board of Education Regarding the Public School Employee Performance Appraisal System" (NCSDPI, 1981). These recommendations included:

1. [Implement the performance appraisal system] on a pilot field-test basis during the 1981-82 school year in twenty-four local school systems... desiring to participate in the field-test.
2. Adopt for pilot field-testing the performance appraisal system which consists of the procedures manual, job descriptions for teachers and principals, performance appraisal instruments for teachers and principals, and the training program.

3. Authorize the recommended follow-up, standardization, and validation studies that need to be conducted by personnel in the Department of Public Instruction. (Appendix K)

To comply with the State Board of Education’s recommendation for a procedures manual, the personnel relations area of the North Carolina Department of Public Instruction developed a Handbook for Conducting Performance Appraisal. One of the expressed purposes of the Handbook was to “help local school personnel develop and/or refine their skills in effectively conducting the tasks and activities associated with the performance appraisal function” (NCSDPI, 1981, p. 1). Additionally, the preface specifies that materials contained within the Handbook, “are not to be considered as mandatory requirements [emphasis added], but only as suggestions in preparing personnel to implement and carry out a performance appraisal process with people in the local school system (NCSDPI, 1981, p. 1).

The Handbook was used during the 1981-82 school year with the twenty-four pilot systems that were field testing the performance appraisal system. During the 1982-83 school year, it was used in conjunction with a state-wide training program for public school administrators in North
Carolina. This training program encompassed a familiarization with the state-adopted teacher performance appraisal instrument, the teacher job description, and the performance appraisal procedure.

Trainers introduced workshop participants to the performance appraisal procedure by using a version of the Individual Performance Appraisal Cycle Flow Chart in Figure 1. This was the first mention of the clinical supervision components of preobservation conference, formal observation, and postobservation conference. These components are used to define clinical supervision for the study and are the same as those of Cogan (1973) and Goldhammer (1969) who pioneered the development of clinical supervision.

Clinical supervision is sometimes used as a part of the evaluation process by principals who are responsible for rating the job performance of teachers. This inclusion of clinical supervision in the evaluation process is both feasible and practical according to Sullivan (1980) but contrary to the beliefs of Cogan (1974) and McFaul and Cooper (1984).

The recommended use of the clinical supervision components by local school districts was explained in the introduction to the section on the performance appraisal procedure in the Handbook (NCSDPI, 1981):

The following is a step-by-step procedure for con-
Figure 1. Individual performance appraisal cycle flow chart. Adapted from the Handbook for conducting performance appraisal (p. 6) by North Carolina State Department of Public Instruction, 1981, Raleigh: Author.
ducting a performance appraisal process. This is not designed to restrict local creativity and initiatives in any way but to provide suggestions [emphasis added] which will help to assure the conduct of an effective performance appraisal process. (p. 5)

This left the implementation of the clinical supervision components optional for local school districts.

During the 1981-82 school year, the performance appraisal procedure for teachers and principals was field-tested. The Special Provision of the Appropriations Act of the 1981 General Assembly allowed the State Board of Education to "spend up to twenty-five thousand dollars ($25,000) for the implementation of the performance standards and criteria" (NCSDPI, 1983, p. 1). This $25,000 also included expenses incurred for the field-test. Fifty-four North Carolina school districts volunteered and twenty-four were selected for the field-test. Three school districts were selected from each of the eight educational regions. These districts were a representative sample of large/small, rural/urban, western/piedmont/coastal districts (NCSDPI, 1983).

After the field-testing period, no major changes were made in the performance appraisal procedure. The Personnel Services Division of the State Department of Public Instruction then planned and provided three-day performance appraisal workshops for all 143 school districts. Ten people from the Personnel Services Division conducted the workshops. The length of the
workshops eventually had to be reduced because of the General Assembly's time constraints for implementation. Length of the workshops was four days during the field-test, which was reduced to three days for the initial training workshops, and then to one and one-half days for the last workshops. The cost, other than during the field-test period, was assumed under the staff budget of the Personnel Services Division (NCSDPI, 1983).

Thus, the North Carolina State Department of Public Instruction, in its hurried attempt to satisfy the General Assembly's mandate to develop uniform performance standards and criteria to evaluate professional public school employees, incorporated components of clinical supervision to aid in the performance appraisal process. Use of these components was optional and ultimately led to many variations in its implementation.

**The Problem**

When given the choice, some school districts and principals opted not to use clinical supervision. Others decided to use some of the forms that were provided but not the process. Still others decided to use the process but not the forms. This resulted in various degrees of implementation of clinical supervision in the public school districts throughout North Carolina. Because of this uneven implementation, the institutionalization, defined as the routinization of an educational change,
varied considerably among the school districts. The variables associated with this variation in the institutionalization of clinical supervision in the public schools of North Carolina are the focus of this study.

**Purpose of the Study**

The variation of institutionalization of clinical supervision in the North Carolina public schools presents the opportunity to explore the variables associated with educational change within schools. In this study, variation in institutionalization of clinical supervision in the public schools of North Carolina is documented, variables that may account for the variation are identified, and tests of how well the variables, as a group and individually, predict the level of institutionalization are performed.

**Perspective of the Study**

Explaining the variance in institutionalization of clinical supervision in the public schools of North Carolina is a problem of explaining an educational change. House (1981) states that innovations can be studied and explained from technological, political, or cultural perspectives. He summarizes each as follows:

Underlying the technological perspective is the image of production. Concepts like input-output, flow diagrams, and specification of tasks are commonly
employed. Innovation is conceived as a relatively mechanistic process. The social relationships are based on technological necessity. The concern is economic and the primary value that of efficiency.

Underlying the political perspective is the image of negotiation. Concepts such as power, authority, and competing interests are employed. Social relationships are conceived as voluntary and as resting on contractual arrangements. Individual and group interests are conceived as often in conflict. Distribution of resources in a legitimate and acceptable manner is important. The concern is political, and a primary value is the legitimacy of the authority system.

Underlying the cultural perspective is the image of community. People are bound to one another through shared meanings resting on shared values. Social relationships are traditional. Integrity of the culture is a primary value. Within a given culture, conformity to the culture’s values may be important. Across cultures, tolerance of other cultures’ values is critical if cultural integrity is to be maintained. From the multicultural perspective, autonomy of separate cultures is paramount. Although relationships within a culture may be binding and obligatory, relationships across cultures are relativistic. (p. 19)

While the technological perspective is predominant among the different disciplines, Whyte (cited in House, 1981) believes a shift is being made away from it. The perspective that is emerging is one that blends the political and cultural perspectives with the technological perspective (House, 1981). Berman (1981) developed an implementation paradigm for educational change that focuses on implementation from a combination of political, cultural, and technological perspectives. This paradigm will serve as the perspective for this study.

Berman’s (1981) paradigm is characterized by three
statements that "refer to ways of thinking about educational change" and are "not specific hypotheses" (p. 261). These statements are referred to throughout the paradigm as meta-propositions:

Meta-Proposition 1: Educational change typically involves an implementation-dominant process. Meta-Proposition 2: The educational change process consists of three complex organizational subprocesses--mobilization, implementation and institutionalization--that are loosely, not linearly, coupled. Meta-Proposition 3: Outcomes of educational change efforts tend to be context-dependent and time-dependent. (p. 261)

Meta-Proposition 1 identifies an educational change as being an implementation-dominant process. In such processes, events that occur after the adoption of a technology--in this case, the adopted technology was clinical supervision--and not the technology itself are responsible for the outcomes related to it (Berman, 1981). Using Berman's (1981) paradigm as the perspective for this study, careful attention was given to the identification of events that occurred after the adoption of clinical supervision. Some of these events considered were change in a district's supervisory process, realignment of a district's supervisory goals, change in the supervisory behavior of a district's supervisors, and change in the support of the central office for the supervisory process. These events and their ramifications, as related to the outcomes of the implementation
of clinical supervision, were used to generate variables to explain the variance in the institutionalization of clinical supervision in the public school districts in North Carolina.

Berman (1981) states another quality of an implementation-dominant process as, "The outcomes of change efforts...[are] uncertain regardless of the organizational setting within which they are implemented" (p. 261). This is due in part to changes in behaviors, roles, and procedures within the organization and the concurrent development of new behaviors, roles, and procedures. Exactly what these new behaviors, roles, and procedures will be cannot be accurately specified in advance for there is considerable leeway provided to the person developing them. Therefore, the outcomes of the implementation of clinical supervision are uncertain and this helps account for variation in its institutionalization.

Another basis for the variation in institutionalization of clinical supervision can be found in the following Berman corollary:

The interaction of an educational innovation with its setting (that is, its implementation) generally results in changes in the initially conceived innovation. (p. 263)

One aspect of this interaction is the principal's adaptation of clinical supervision. It was expected that some
principals would partially implement or even omit some of
the recommendations, while others would substitute or
find shortcuts to the components.

Changes in clinical supervision due to implementation
also could result from misunderstandings by principals as
to their roles and procedures they were to use during
implementation. Varying degrees of knowledge or skills
of principals during implementation of clinical super-
vision could lead to still further changes in the ori-
ginal concept of clinical supervision.

All of these changes and adaptations of clinical
supervision were expected since interaction had to take
place between clinical supervision and the school during
implementation.

Meta-Proposition 2 considers educational change to be
based on the three subprocesses of mobilization, imple-
mentation, and institutionalization. Mobilization and
implementation are both prerequisites to institutionali-
zation. Therefore, it would follow that the greater the
degree of institutionalization of clinical supervision in
the public schools of North Carolina, the greater the
degree of mobilization and implementation there would
have been. Factors relating to mobilization and imple-
mentation of clinical supervision therefore directly
relate to the degree of institutionalization and thus
must be included in any measure of institutionalization.
Clinical supervision is an educational change and as such is characterized by Berman (1981) as having no rational planning or progressive flow from event to event. Choices have to be made as this change occurs. The change takes place within an organizational system--school system--that is characterized as being loosely coupled rather than linearly coupled. That is, school districts are considered loosely coupled because teachers work to some degree autonomously from other teachers and administrators. Also, schools work autonomously from other schools and central administrators. Because of this loose coupling, principals are relatively free to choose how they will implement an innovation such as clinical supervision. This relative freedom of choice creates variation in implementation and institutionalization of any innovation.

Mobilization is the preparation for change. The focus of mobilization in this study was the installation of the new state-wide performance appraisal system that included clinical supervision. The preparation for the new system by the North Carolina State Department of Public Instruction included development of the performance appraisal system, development of the regulations for the use of the performance appraisal system, and the development of a training program to implement the new performance appraisal system. Additionally, the state
department adopted clinical supervision as a part of this new appraisal system. This adoption required the development of clinical supervisory forms and the training of trainers to work with the principals in North Carolina. These developmental activities represent just a portion of North Carolina's mobilization effort for clinical supervision.

Mobilization also includes the functions of internal and external support generation. These functions imply that an organization's intentions are defined and communicated to those audiences, both internal and external, that are necessary for support of the innovation.

External support generation for the performance appraisal system was derived from a nationwide perception that politicians and the public-at-large had concerning schools. This perception was that schools were producing substandard students in a substandard environment. It received national thrust from the Reagan Administration and resulted in many commission reports. The North Carolina General Assembly, in an attempt to raise school standards and change this perception, passed legislation that required annual evaluations of all professional public school employees and required the development of uniform performance standards and criteria on which to base these evaluations. Using clinical supervision to aid in the new performance appraisal process was the idea
of Dr. Jerry Bellons, a consultant to the North Carolina State Department of Public Instruction, and Dr. Craig Phillips, the State Superintendent for Public Instruction of North Carolina. Dr. Phillips was the primary supporter at the state level who recommended that public school districts use clinical supervision as part of the performance appraisal process. This gave impetus to the notion that the state was trying to change this perception and at the same time provided external support for clinical supervision.

Internal support for clinical supervision could be generated, as Berman (1981) suggests, from board members, teachers, and administrators. Berman and McLaughin (cited in Berman, 1981) argue that educational change can be supported by central administrators independent of support from school staff. They also suggest that high levels of support from central administrators and users of the educational change is necessary for the change to be successful. This internal support is complex because school districts and schools can act, to some degree, autonomously. Weick (1976) refers to this autonomy as "loose coupling." A result of this loose-coupling is the generation of varying degrees of internal support for the institutionalization of clinical supervision. Additionally, loose-coupling of schools allows the institutionalization of clinical supervision to take different forms.
in different amounts in different schools and districts.

Implementation as a subprocess of educational change contains two major activities—adaptation and clarification. Both contain factors that help explain variance in the implementation of clinical supervision that directly affects the institutionalization of clinical supervision.

Adaptation considers the extent to which both the organization and the innovation adapt. The school districts and, in some instances, the principals in North Carolina were given the option to implement clinical supervision. If the option to implement were exercised, adaptation of the clinical supervision model could occur to some extent by both the school district and the principal. The extent of adaptation probably would be linked to a belief that the innovation, in this case clinical supervision, would meet whatever expectations were set out for it. Principals who believe that clinical supervision helps teachers teach more effectively would probably adapt more of the components of clinical supervision than principals who believe that it will not help teachers. This variation in beliefs would lead to variations in the adaptation of clinical supervision and also to variations in the implementation and institutionalization of clinical supervision.

Clarification of an innovation is necessary, according to Berman (1981), because "users need to be clear
about the change effort if it is to be effectively implemented" (p. 272). Clarification in this study was attempted by the State Department of Public Instruction in North Carolina which provided workshops conducted by ten staff personnel to aid in the dissemination of information about the performance appraisal system and clinical supervision. Additionally, public school districts promulgated goals and policy statements in an attempt to clarify their respective positions on clinical supervision. As a result of the state department using ten different people to conduct workshops and public school districts developing different goals and policies, the attempt to clarify the implementation of clinical supervision, in effect, led to confusion. This confusion led to variations in implementation that in turn resulted in variations in the institutionalization of clinical supervision in the public schools of North Carolina.

Institutionalization as a subprocess of educational change implies that a change has become incorporated or routinized (Yin et al. cited in Berman, 1981) within the organization. Berman and McLaughlin (cited in Berman, 1981) stated:

Loose coupling within school districts implies that institutionalization involves different processes at the user and district levels. Teachers and school staff need to assimilate what they have learned during implementation; districts need to incorporate new routines engendered by the innovative process into
decision making about budget, personnel, support services, and instruction. (p. 274)

Therefore, institutionalization can be partially measured by the emphasis a district gives to clinical supervision. This emphasis could be in the form of follow-up activities and the extent of monitoring that is used in relation to clinical supervision. An absence of follow-up activities or a small amount of monitoring would result in less institutionalization.

Meta-Proposition 3 is concerned with how the researcher should think about explaining the variation in outcomes (Berman, 1981). Standard explanations of research have been concerned with identifying variables and explaining their effects on outcomes. Berman (1981) contends that explanations of research outcomes would be better stated conditionally so that they are known to apply in particular situations and organizational settings. When explaining the variation in institutionalization of clinical supervision in North Carolina, the outcomes must be considered as dependent on particular situations and organizational settings (context-dependent) that are operating within the schools of North Carolina. Therefore, these outcomes are not widely generalizable, and vary over time (time-dependent), from the moment the decision is made to implement to the actual implementation.
Berman (1981) suggests that variables of a study be categorized to clarify their contextual and time dependency. This categorization includes the following groups of variables:

I. Local contextual conditions
II. Primary attributes of change efforts
III. Local policy choices
IV. Endogenous variables
V. External factors (outside variables subject to change during implementation)

Local contextual conditions are, for the most part, relatively fixed variables. Included in this category are variables that characterize the community, school district, individual schools, and students. One contextual condition was used in this study: type of school administered (elementary, middle or junior high, high school). Berman and Pauly (cited in Berman, 1981) found that effectiveness of implementation strategies varied between elementary schools and secondary schools. Some implementation strategies that are effective at elementary schools are not effective at secondary schools and vice versa. The notion also exists that the majority of educational changes take place in elementary schools. Therefore, elementary schools should be more conducive to change than junior high, middle, or high schools. The same notion holds true in comparing the junior high and middle schools with the high schools. The type of school
has been included in this study because of the belief that elementary schools will institutionalize clinical supervision to a greater degree than either junior high, middle, or high schools. Also, junior high and middle schools will institutionalize clinical supervision to a greater degree than high schools.

Primary attributes of change efforts are variables associated with the innovation that do not change over time. For example, the concept of clinical supervision as an educational innovation will begin and end as clinical supervision. It will be an option of the public school districts in North Carolina and will remain a low-budget item. None of these variables will change appreciably over time and are thus examples of primary attributes.

Local policy choices are variables that deal with choices that school districts and their personnel make. This would include policy choices related to the internal support and training that North Carolina districts and schools provided for the implementation of clinical supervision and, more importantly, the basic decisions each district made on whether or not to adopt and whether or not to mandate the use of clinical supervision. Both internal support and training variables were expected to help explain variance in the institutionalization of clinical supervision.
Amount of internal support contains two components. The first component is the support that central office administrators provide for the institutionalization of clinical supervision. The second component is the commitment of a district to clinical supervision. Both components affect the degree of institutionalization of clinical supervision by principals.

Berman (1981) argues that internal support is a key component for educational change and that one source of this support comes from central office administrators. Central office administrators can mandate the use of clinical supervision, monitor and assist with the implementation, and plan follow-up activities.

Snyder, Johnson, and MacPhail-Wilcox (1982) summarized information on implementation of innovations that was presented by Bruce Joyce at a National Curriculum Study Institute by stating that "on-the-job coaching and assistance are necessary for widespread implementation of a practice introduced in a workshop" (p. 1). Their own informal findings concur with those of Joyce in that there will be a lesser degree of implementation of clinical supervision if there is no planned follow-up to the initial workshops.

The Greensboro, North Carolina, school district was part of a study on the institutionalization of the clinical supervision model (Snyder, Johnson & MacPhail-Wilcox,
The Greensboro district was found to have a greater degree of institutionalization of clinical supervision when compared to the eleven other school districts in the study. The researchers hypothesized that this greater degree of institutionalization was due in part to "a strong central office expectation and a plan for assistance in implementation" (p. 8). The conclusions of this study stated:

Furthermore, Greensboro schools are more likely to continue practicing clinical supervision in years to come because of the serious-minded approach COA (Central Office Administrators) have adopted for district-wide implementation of clinical supervision. At the least, we can say that training helps to alter some practices (in this case, the supervision of teachers), but when training is accompanied by strong central office involvement, there will be greater skill development and institutionalization of clinical supervision. (p. 13)

Berman and McLaughlin (cited in Berman, 1981) suggest "that high levels of support from both the district level and the actual users of an innovation are necessary to successful innovations" (p. 270). Support from the district level could come in the form of a district goal that could be either expressed or implied. This goal infers a commitment on the part of the school district, and the greater the commitment of a school to a goal, such as clinical supervision, the greater the degree of institutionalization (Snyder, Johnson, & MacPhail-Wilcox, 1982).
In an ASCD publication entitled "Supervision in Teaching" (Firth & Eiken, 1982), the authors suggest that any change in the school's supervisory practice must be preceded by a change in the district's priorities from the old supervisory practice to a favorable commitment to the new. If the district does not commit its support for clinical supervision, institutionalization could be inhibited (Goldsberry, 1984a; McFaul & Cooper, 1984). Internal support as it relates to the variance in institutionalization of clinical supervision is manifested in the central office administrator's support for and the district's commitment to clinical supervision.

Another local policy choice that a district can consider is the amount of training that a principal will receive in clinical supervision. Without the proper readiness (Wood, Thompson, & Russell, 1981; Cogan, 1973) and training of principals and other supervisory personnel, there will be little chance for successful implementation of clinical supervision (Krajewski, 1984; Goldsberry, 1984b; Snyder, Johnson, & MacPhail-Wilcox, 1982). Therefore, the amount of training becomes important in explaining the variance in institutionalization of clinical supervision.

The inservice training that a principal receives must include both the process and concepts of clinical supervision (Krajewski, 1984; Goldsberry, 1984b).
Goldsberry (1984b) also stated:

Preparation in the procedures and rationale for the approach is essential to acquire a conceptual grasp of clinical supervision; practice and feedback are necessary for applying these concepts. (p. 14)

The principal must, in order to effectively practice clinical supervision, be well trained in the concepts and process of clinical supervision.

Snyder, Johnson, and MacPhail-Wilcox (1982) hypothesized that one reason the Greensboro, North Carolina, schools were more completely institutionalized clinical supervision in comparison to eleven other districts in their study was the number of days of training. Greensboro administrators received 10 days of training over two years compared to 1 to 4 days of training for the other administrators. They concluded that this extra training led to "greater skill development and institutionalization of clinical supervision" (p. 8). The amount of training can be considered as one of the variables associated with the variance in institutionalization of clinical supervision.

Endogenous variables are those variables that deal with the attitudes and behaviors of the key actors in the educational change. One of the endogenous variables for this study includes the principals' beliefs about clinical supervision. These beliefs either promote or hinder the institutionalization of clinical supervision.
A principal's belief in the effectiveness of clinical supervision is necessary to achieve a high degree of institutionalization. This belief is classified by Berman (1981) as an endogenous variable because the principal's belief or attitude about clinical supervision is not an intrinsic property of clinical supervision but rather a component of the adopting organization—in this instance, the school district.

Snyder, Johnson, and MacPhail-Wilcox (1982) found that principals trained in clinical supervision "agreed strongly" that clinical supervision is a technology for helping teachers. Further, the authors concluded that the "motivation to help teachers" dominates current efforts by principals to use clinical supervision.

An air of colleagueship and mutual trust must exist in the relationship between the principal (supervisor) and the teacher. Concomitantly, the principal's role must be viewed as one of helping the teacher (Reavis, 1978b). Unruh and Turner (1970) concluded, "To produce realistic and lasting change, supervisors and teachers must accept each other's strengths and contributions to the instructional program," (p. 36). Garman (1982) referred to this acceptance as "collegiality." Collegiality necessitates a belief on the part of the principal that clinical supervision will help the teacher. This belief could help explain the variance
in the institutionalization in clinical supervision.

The principal's perception of time is a second endogenous variable that considers the amount of time a principal perceives that it takes to perform the components of clinical supervision. This is congruent with the general consensus that exists among authors (Ryan, 1971; Sullivan, 1980; Reavis, 1978a; Howell, 1981) that clinical supervision requires more time than the more traditional forms of supervision. The more time a principal perceives that clinical supervision takes, the greater the chance that there will be less than full institutionalization of clinical supervision.

Given the number of different administrative tasks that must be performed, clinical supervision places an increased burden on the principal because more time is required with each teacher (Ryan, 1971; Sullivan, 1980; Reavis, 1978a; Howell, 1981). Additionally, when a principal is faced with a district policy requiring a given number of observations and evaluations, clinical supervision may be neglected so that the principal can attend to these required administrative tasks (Snyder, Johnson, & MacPhail-Wilcox, 1982).

One dimension that may have increased the perceived time required to do a clinical supervision cycle resulted from the State Department of Public Instruction's time recommendations for some of the components. For the pre-
observation conference, it was suggested that "adequate time" be allotted to cover the preobservation information. The formal observation was recommended to be a minimum of 30 minutes, but a "more desirable period of time" would be 60 minutes or a full class period (NCSDPI, 1981). No specific time was recommended for the postobservation conference or the completion of forms. The specific time recommendation for the formal observation, along with the nebulous time recommendation for the preobservation conference and no time recommendation for the postobservation conference, could have led to the perception that clinical supervision takes much time. Such a perception could hinder the institutionalization of the procedure.

The additional time taken with clinical supervision allows fewer teachers to be served (Sullivan, 1980). But Garman (1982) argues that the amount of time might not be as important a factor as is the quality of time. No matter which view is taken, the ultimate effect of the institutionalization of clinical supervision is that more time is taken during the supervisory process, and if a principal perceives this time as excessive, complete institutionalization of clinical supervision will be less likely. Therefore, two endogenous variables that can be associated with the variance in institutionalization of clinical supervision are a principal's belief that
clinical supervision will help a teacher and a principal's perception of the time required to perform clinical supervision.

The last category of variables affecting the educational change process are external variables. These variables are subject to change during institutionalization and include funding, federal and state regulations, and such episodic changes in context as the hiring of a new principal. External variables would help explain why new principals who lacked initial readiness training and principals who had no training at all in clinical supervision would institutionalize clinical supervision to a lesser degree than principals who did. This lack of training as it relates to new principals is included with the measurement of the variable dealing with the amount of training a principal has in clinical supervision that is categorized as a local policy choice. Other external variables are too unique to each district to accurately assess their relationship with the institutionalization of clinical supervision.

Thus, the variables used in this study to explain the extent of institutionalization of clinical supervision in North Carolina public schools were drawn from the preceding theoretical perspective and, therefore, can be classified using Berman's categories of (a) local contextual conditions, (b) local policy choices, and (c) endogenous
variables.

**Variables**

The variables of this study are classified and defined using the Berman categories and are as follows:

**Local Contextual Conditions**

The one variable in the study that is classified as a local contextual condition is the type of school administered. The type of school administered is defined as a public elementary, middle or junior high school, high school, or other type of school in North Carolina.

**Local Policy Choices**

Two variables in the study are classified as local policy choices. The first variable is the amount of internal support for clinical supervision and is defined as the support that central office administrators provide for the institutionalization of clinical supervision and the commitment a school district gives to clinical supervision. The second variable is the amount of training a principal receives in clinical supervision and is defined as the number of clock hours of all training experiences that a principal has had in clinical supervision and the period of time in months between the first and last training session.

Both variables represent policy decisions that must
be made at the local district level to determine how much and to what extent clinical supervision will be supported.

**Endogenous Variables**

The study contains two endogenous variables. The first variable is the principal's belief in the effectiveness of clinical supervision and is defined as the principal's belief that clinical supervision makes a teacher's teaching more effective. The second variable is the principal's perception of the amount of time required to do a cycle of clinical supervision. This is defined as the amount of time that a principal perceives that it takes to perform the components of clinical supervision.

In the study, the variables and their corresponding explanations were selected to explain the variance in institutionalization of clinical supervision. Full institutionalization of clinical supervision is considered to be the complete use of all the components of the clinical supervision process with all teachers for every evaluation. These components of clinical supervision include: holding a preobservation conference, completing a preobservation conference form, conducting a formal observation, holding a postobservation conference, and completing a postobservation conference form. Anything less than the complete use of these components of
clinical supervision with all teachers for every evaluation is a variance in institutionalization of clinical supervision.

Due to their basis in theory and research, the variables selected for this study seem to be those that will possibly explain a good share of the variance in institutionalization of clinical supervision in the public schools of North Carolina. A model of the concatenated relationships among these variables appears in Figure 2.

Summary of Chapter 1 and Overview of Succeeding Chapters

Chapter 1 contains the background for understanding the variation in the institutionalization of clinical supervision by principals in North Carolina. Predictor variables for explaining the variance in institutionalization were derived from theory and were supported by the research and literature on clinical supervision. A model was then developed of the relationships between the predictor variables—perception of time, amount of internal support, amount of training, belief in effectiveness, and type of school—and the criterion variable institutionalization of clinical supervision.

The succeeding chapter presents the methodology for testing how well the predictor variables predict, together and alone, the institutionalization of clinical supervision. The analysis and results of the testing are
presented in Chapter 3, and the conclusions, implications, and recommendations are reported in Chapter 4.
Figure 2. Model of concatenated relationships among variables.
CHAPTER 2

METHODOLOGY

An explanation of why variance in institutionalization of clinical supervision exists in the public schools of North Carolina was presented in Chapter 1 and variables were identified that could possibly explain this variance. This chapter describes the population, sample, data collection procedures and instrument, and the data analysis procedures for the study.

Variables

This study is concerned with five predictor variables:

1. Principal's perception of the amount of time required to do clinical supervision
2. Amount of internal support for clinical supervision
3. Amount of training a principal received in clinical supervision
4. Principal's belief in the effectiveness of clinical supervision
5. Type of school administered

These predictor variables are used to predict one criterion variable: institutionalization of clinical supervision.
Population

The universe used in the study is all elementary, middle or junior high, and high school principals in the public schools of North Carolina as listed by the State Department of Public Instruction in the *North Carolina Education Directory, 1984-85*.

Sample

The sample size for the study is based on forty-five responses for each predictor variable. This number is a guideline used by Jimmie Fortune, Professor of Educational Research, at Virginia Polytechnic Institute and State University. Given the five predictor variables for the study, a sample size of 225 subjects was necessary. Assuming a return rate of 50%, the sample size was doubled to 450. This expected return rate allows a reasonable margin to account for uncertain responses when one considers that response rates for surveys generally run between 60 and 65 percent (Dillman, 1978).

A stratified random sample was drawn from the population of principals to ensure an adequate representative response from principals in elementary, middle or junior high, and high schools. The sample size approximated the percentage of each group of principals when compared to the entire population of principals (Table 1).

Schools were assigned numbers in the order listed in
Table 1

Number and Percentage of Principals in the Population and Sample by Type of School

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Population</th>
<th></th>
<th>Sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Elementary</td>
<td>1244</td>
<td>65</td>
<td>292</td>
<td>65</td>
</tr>
<tr>
<td>Junior High and Middle</td>
<td>349</td>
<td>18</td>
<td>81</td>
<td>18</td>
</tr>
<tr>
<td>High School</td>
<td>322</td>
<td>17</td>
<td>77</td>
<td>17</td>
</tr>
<tr>
<td>Totals</td>
<td>1915</td>
<td>100</td>
<td>450</td>
<td>100</td>
</tr>
</tbody>
</table>
the North Carolina Education Directory, 1984-85. The 1915 public schools were listed alphabetically under the heading of the county or city district in which each is located. County and city districts were also listed alphabetically. Elementary schools were assigned numbers from 1-1244, middle and junior high schools were assigned numbers 1-349, and high schools were assigned numbers 1-322. A table of random numbers was entered and used to select the schools and their corresponding principals for participation in the study.

**Hypotheses Tested**

The hypotheses tested in this study include:

1. The more time a principal perceives clinical supervision to take, the less the institutionalization of clinical supervision.

2. The more internal support a principal receives for clinical supervision, the greater the institutionalization of clinical supervision.

3. The more training a principal receives in clinical supervision, the greater the institutionalization of clinical supervision.

4. The more a principal believes that clinical supervision will help teachers be more effective, the greater the institutionalization of clinical supervision.

5. Principals of elementary schools will institution-
alize clinical supervision to a greater degree than
middle, junior high or high school principals, and middle
and junior high principals will institutionalize clinical
supervision to a greater degree than high school
principals.

**Measurement of Variables**

Institutionalization of clinical supervision was
measured by a set of items requesting information on the
extent to which the principal used each procedure in
clinical supervision. The response to each item was
considered independent of and equal in value to each of
the other items measuring institutionalization. The five
responses and their scoring weights were: (1) never, (2)
seldom, (3) sometimes, (4) often, and (5) always. The
items from the Principals' Survey that elicited responses
for the criterion variable of institutionalization were:

(17) I schedule a preconference with each teacher
for each formal observation to discuss and
clarify the upcoming observation.

(18) I discuss with each teacher every item on a
preconference form and then fill it in prior to
each formal observation.

(19) I collect data during each in-class observation
pertaining to objectives and activities that
were discussed at the preconference.
(20) I schedule a postobservation conference with each teacher for each formal observation to discuss the teacher’s strengths and weaknesses and to make specific job performance recommendations.

(24) I fill in and discuss with each teacher every item on a postobservation conference form after each formal observation.

(22) I spend a minimum of 30 minutes during each formal observation.

**Principal’s Perception of Time**

The measurement of the variable of the principal’s perception of time was obtained by adding the number of hours per teacher, on the average, that the principal reported that it took to perform one cycle of clinical supervision to the value of the following Likert items measuring the principal’s perception of time (An asterisk means that the item was reversed in scoring.):

(23) Clinical supervision takes too much time to justify its use.

* (26) The time that it takes to perform clinical supervision is not excessive.

(29) Clinical supervision would be used more if it were not so time consuming.

* (33) Clinical supervision does not take that much
extra time when compared to the benefits derived from it.

**Amount of Training in Clinical Supervision**

The variable representing the amount of training a principal has in clinical supervision was measured by an index. The index was calculated by multiplying the approximate number of clock hours of training a principal has in clinical supervision by the span of time, in months, between the first and last training session or workshop. This product is then multiplied by the value of item 30 on the **Principals' Survey**:

(30) The training I received in clinical supervision was sufficient for me to implement all of the procedures.

**Type of School Administered**

(7) Check the type of school you administer.

- [ ] Elementary or Primary
- [ ] Middle School or Junior High School
- [ ] Senior High School
- [ ] Other. Specify type and list grades

The remaining variables were measured with Likert items. The five responses and their respective scoring weights as given on the **Principals' Survey** were: (1) strongly disagree, (2) disagree, (3) undecided, (4) agree, and (5) strongly agree. The variables and their item statements follow (Items with an asterisk were reversed
Amount of Internal Support for Clinical Supervision

(24) I am required to use clinical supervision as a part of the performance appraisal process.

(27) My central office administrators check to be sure that principals use clinical supervision.

(31) My district helps principals become more competent in using clinical supervision.

(34) My central office staff provides no help to the principals who use clinical supervision.

(36) I am evaluated on how well I perform clinical supervision.

Principal’s Belief in the Effectiveness of Clinical Supervision

(25) Use of clinical supervision increases student learning.

(28) Clinical supervision helps teachers become more effective.

(32) Teachers who are not clinically supervised will be less effective than those teachers who are clinically supervised.

(35) Use of clinical supervision results in better teaching.

(37) Teachers who are coached improve to a greater extent than teachers who are not coached.
Reliability of the Scales

Cronbach's alpha was the measure of reliability used with the survey's multi-item scales. A preliminary analysis resulted in three questions being discarded to increase the reliability of the scales. These questions were:

1. Question 22 - I spend a minimum of 30 minutes during each formal observation (Institutionalization).
2. Question 29 - Clinical supervision would be used more if it were not so time consuming (Perception of Time).
3. Question 37 - Teachers who are coached improve to a greater extent than teachers who are not coached (Belief in Effectiveness).

After deleting these three questions, the alpha coefficients ranged from .67 to .84 (Table 2).

Data Collection Procedures

The Principals' Survey (Appendix A) was reviewed by three elementary, three junior high, and three high school principals to determine the clarity of items and the readability of the survey. This review resulted in the recommendation that the term formal observation be used rather than observation in questions 17, 18, 20, 21, and 22. The survey was then mailed to the stratified random sample of 450 principals during the second week of October, 1985. Enclosures included
Table 2

Alpha Reliability Coefficients for Multi-Item Scales in the Principals’ Survey

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of Items</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalization</td>
<td>5</td>
<td>.67</td>
</tr>
<tr>
<td>Perception of Time</td>
<td>3</td>
<td>.77</td>
</tr>
<tr>
<td>Internal Support</td>
<td>5</td>
<td>.73</td>
</tr>
<tr>
<td>Belief in Effectiveness</td>
<td>4</td>
<td>.84</td>
</tr>
</tbody>
</table>
with the survey were a letter that requested the survey be returned within ten days after receipt (Appendix B) and a stamped return envelope. All initially mailed surveys were coded for follow-up purposes. Principals not returning their surveys within two weeks were sent a follow-up letter and an additional survey (Appendix C).

A total of 288 surveys (64%) were returned from the initial mailing and follow-up. To ensure that the responses were representative of the entire random sample, a survey of nonrespondents was conducted. Principals for this survey were randomly selected from districts possessing the highest percentage of nonrespondents and having more than one principal in the sample. Participants in the nonrespondent survey were asked to give the reasons why the original survey was not completed and were asked again to complete the survey. A total of 12 principals participated, giving a grand total of 300 respondents to the Principles' Survey, or a total return rate of 66.7 percent. The percentage of responses in each strata--elementary, middle or junior high, and high school--closely approximated the actual percentages in the population of principals (Table 3).

**Nonrespondent Survey**

The results of this study need to be generalizable to the entire population of principals in public schools of
Table 3

Number and Percentage of Principals Responding to the Principals’ Survey by Type of School

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Respondents</th>
<th>Nonrespondent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Elementary</td>
<td>185</td>
<td>7</td>
<td>192</td>
</tr>
<tr>
<td></td>
<td>64.2%</td>
<td>58.3%</td>
<td>64.0%</td>
</tr>
<tr>
<td>Junior High and Middle</td>
<td>55</td>
<td>4</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>19.1%</td>
<td>33.3%</td>
<td>19.7%</td>
</tr>
<tr>
<td>High School</td>
<td>48</td>
<td>1</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>16.7%</td>
<td>8.3%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Totals</td>
<td>288</td>
<td>12</td>
<td>300</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>99.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>
North Carolina. Therefore, it was important to be as sure as possible that the responses given by the principals who responded to the survey were representative of the population and that respondent bias was not present (Schroeder, Sjoquist, Stephan, 1986). To ensure the representativeness of responses in this study, a survey of principals who did not respond was conducted. Variables of the respondent and nonrespondent surveys were compared using t-tests (Table 4) to determine whether the two groups differed on the dependent variable or on any of the independent variables. For all variables, the probabilities associated with the t-statistics exceed the .05 alpha level; thereby, supporting the equivalence of the respondent and nonrespondent groups. The responses did seem to represent the entire sample, thus, the results of the study can be generalized to the population of public school principals in North Carolina.

**Data Analysis Procedures**

Multiple regression was used to test for the amount of variance in institutionalization of clinical supervision that could be accounted for by principal’s perception of time, amount of internal support for clinical supervision, amount of training in clinical supervision, principal’s belief in the effectiveness of clinical supervision, and differences among school levels.
Table 4

Means, Standard Deviations, and t-Statistics for
Comparisons Between Respondent and Nonrespondent Survey Scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respondents</td>
<td>288</td>
<td>22.25</td>
<td>(2.97)</td>
<td>.29</td>
</tr>
<tr>
<td>Institutional-</td>
<td>Nonrespondents</td>
<td>12</td>
<td>22.00</td>
<td>(3.33)</td>
<td></td>
</tr>
<tr>
<td>Perception of Time</td>
<td>Respondents</td>
<td>256</td>
<td>13.94</td>
<td>(8.70)</td>
<td>.40</td>
</tr>
<tr>
<td></td>
<td>Nonrespondents</td>
<td>10</td>
<td>13.40</td>
<td>(3.95)</td>
<td></td>
</tr>
<tr>
<td>Internal Support</td>
<td>Respondents</td>
<td>288</td>
<td>16.17</td>
<td>(3.82)</td>
<td>-1.56</td>
</tr>
<tr>
<td></td>
<td>Nonrespondents</td>
<td>12</td>
<td>17.25</td>
<td>(2.26)</td>
<td></td>
</tr>
<tr>
<td>Amount of Training</td>
<td>Respondents</td>
<td>272</td>
<td>2166.85</td>
<td>(5999.69)</td>
<td>-1.26</td>
</tr>
<tr>
<td></td>
<td>Nonrespondents</td>
<td>11</td>
<td>10102.91</td>
<td>(20876.92)</td>
<td></td>
</tr>
<tr>
<td>Belief in</td>
<td>Respondents</td>
<td>288</td>
<td>15.16</td>
<td>(3.59)</td>
<td>.08</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Nonrespondents</td>
<td>12</td>
<td>15.08</td>
<td>(2.61)</td>
<td></td>
</tr>
</tbody>
</table>

*Note. Standard deviations are in parentheses.*
The multiple regression model was:

\[ Y = a_0 + b_1 X_1 + b_2 X_2 + b_3 X_3 + b_4 X_4 + b_5 X_5 + b_6 X_6 + e \]

where \( Y \) = institutionalization of clinical supervision; \( X_1 \) = principal's perception of time; \( X_2 \) = amount of internal support for clinical supervision; \( X_3 \) = amount of training in clinical supervision; \( X_4 \) = principal's belief in the effectiveness of clinical supervision; \( X_5 \) = a dummy variable scored 1 if an elementary school, 0 otherwise; \( X_6 \) = a dummy variable scored 1 if a junior high or middle school, 0 otherwise; \( e \) = error; \( b \) = partial slope; and \( a_0 \) = the value of \( Y \) when each independent variable equals zero.

**Summary**

The population of North Carolina's public school principals was sampled and surveyed using the Principals' Survey to collect data on five predictor variables--perception of time, internal support, amount of training, belief in effectiveness, and type of school--and one criterion variable, institutionalization of clinical supervision. Survey information was received from 288 principals (64%) out of 450 principals in the original survey sample. Twelve additional principals were sampled from the pool of nonrespondents for a follow-up survey to determined whether respondent bias was present. No bias was found.
Internal support and belief in effectiveness were measured by summing the values of a set of Likert items pertaining to the variable. Perception of time was measured by adding the number of hours a principal perceived a clinical supervision cycle to take to a summed set of Likert items. Amount of training was measured by multiplying the clock hours of training by the span of time in months between the first and last training session. This product was then multiplied by the principal's perception of the effectiveness of the training. Type of school administered was identified by a check mark and was dummy coded for the multiple regression analysis.

Prior to the statistical analysis of the survey data, reliability coefficients were computed for each multi-item variable. This resulted in data from three questions being deleted from the statistical analysis. Alpha coefficients ranged from .67 to .84.

Chapter 3 contains the results of the analysis of the data.
This chapter contains the analysis of data obtained from 300 public school principals in North Carolina on five predictor variables pertaining to the institutionalization of clinical supervision.

Variables and Hypotheses

Data for analyzing the institutionalization of clinical supervision in the public schools of North Carolina was obtained from the Principals' Survey, the components of which were discussed in detail in Chapter 2. Multiple regression was used to analyze the contribution of the five predictor variables to the variance in institutionalization. The predictor variables were (a) principal's perception of the amount of time required to do clinical supervision, (b) amount of internal support for clinical supervision, (c) amount of training a principal received in clinical supervision, (d) principal's belief in the effectiveness of clinical supervision, and (e) type of school administered. Descriptive statistics for these variables and others in the study appear in Table 5.
Table 5

**Descriptive Statistics for Variables in the Study**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalization</td>
<td>288</td>
<td>22.33</td>
<td>2.93</td>
<td>6.00</td>
<td>25.00</td>
<td>25.00</td>
</tr>
<tr>
<td>Perception of Time</td>
<td>256</td>
<td>13.92</td>
<td>8.66</td>
<td>7.00</td>
<td>106.00</td>
<td></td>
</tr>
<tr>
<td>Internal Support</td>
<td>288</td>
<td>16.29</td>
<td>3.23</td>
<td>5.00</td>
<td>25.00</td>
<td></td>
</tr>
<tr>
<td>Amount of Training</td>
<td>272</td>
<td>2708.35</td>
<td>7573.76</td>
<td>0.00</td>
<td>17504.00</td>
<td></td>
</tr>
<tr>
<td>Belief in Effectiveness</td>
<td>288</td>
<td>15.07</td>
<td>2.74</td>
<td>4.00</td>
<td>20.00</td>
<td></td>
</tr>
<tr>
<td>Type of School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>192</td>
<td>64.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle/ Junior High</td>
<td>59</td>
<td>19.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>49</td>
<td>16.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>297</td>
<td>45.22</td>
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<td>7.40</td>
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</tr>
<tr>
<td>Male</td>
<td>245</td>
<td>82.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>53</td>
<td>17.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following hypotheses were tested:

1. The more time a principal perceives clinical supervision to take, the less the institutionalization of clinical supervision.

2. The more internal support a principal receives for clinical supervision, the greater the institutionalization of clinical supervision.

3. The more training a principal receives in clinical supervision, the greater the institutionalization of clinical supervision.

4. The more a principal believes that clinical supervision will help teachers be more effective, the greater the institutionalization of clinical supervision.

5. Principals of elementary schools will institutionalize clinical supervision to a greater degree than middle, junior high or high school principals, and middle and junior high principals will institutionalize clinical supervision to a greater degree than high school principals.

**Multiple Regression**

To determine if multicollinearity existed at an unacceptable level, the tolerance of each variable was inspected (Table 6). Since the tolerance level for each variable ranged from .55 to .99, it was determined that high proportions of variance existed in each independent
Table 6

**Tolerances of Predictor Variables**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of time</td>
<td>.99</td>
</tr>
<tr>
<td>Internal support</td>
<td>.96</td>
</tr>
<tr>
<td>Amount of training</td>
<td>.99</td>
</tr>
<tr>
<td>Belief in effectiveness</td>
<td>.95</td>
</tr>
<tr>
<td>Type of school administered</td>
<td></td>
</tr>
<tr>
<td>Dummy 1</td>
<td>.55</td>
</tr>
<tr>
<td>(Elementary = 1; Otherwise = 0)</td>
<td></td>
</tr>
<tr>
<td>Dummy 2</td>
<td>.55</td>
</tr>
<tr>
<td>(Middle or Junior high = 1;</td>
<td></td>
</tr>
<tr>
<td>Otherwise = 0)</td>
<td></td>
</tr>
</tbody>
</table>
variable after subtracting the shared variance held with the other independent variables (SPSS-X, 1983). Therefore, multi-collinearity was determined not to be a problem. The multiple regression (Table 7) using institutionalization of clinical supervision as the dependent variable produced a multiple R value of .30 and an \( R^2 \) of .09 (\( F = 4.03, p < .00 \)).

To assess the contribution of each predictor variable to the prediction of institutionalization (to test the hypotheses), unstandardized coefficients were inspected (Lewis-Beck, 1980). Table 8 summarizes the statistics obtained from the regression of the criterion variable on the predictor variables.

Internal support was the only independent variable that was statistically significant in predicting institutionalization (\( b = .20, t = 3.62, p < .01 \)). The remaining predictor variables—perception of time, amount of training, belief in effectiveness, and type of school administered—produced results that were not significant (\( p > .05 \)).

Two demographic variables, age and sex, were reported on the Principals' Survey and were added to the multiple regression as a side analysis when the initial regression accounted for only 9 percent of the variance in institutionalization of clinical supervision. With these variables added, an \( R^2 \) of .10 was obtained (\( F = 3.37, \))
Table 7

Analysis of Variance for Regression of Institutionalization on Perception of Time, Amount of Internal Support, Amount of Training, Belief in Effectiveness, and Type of School

<table>
<thead>
<tr>
<th>Variable</th>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Squares</th>
<th>F</th>
<th>p</th>
<th>Multiple R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>6</td>
<td>193.32</td>
<td>32.22</td>
<td>4.03</td>
<td>.00</td>
<td>.30</td>
</tr>
<tr>
<td>Residual</td>
<td>249</td>
<td>1991.12</td>
<td>8.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8

Summary Table for Variables in Multiple Regression Equation Predicting Institutionalization of Clinical Supervision

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>SEb</th>
<th>Beta</th>
<th>t</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of time</td>
<td>-.00</td>
<td>.02</td>
<td>-.00</td>
<td>-.06</td>
<td>-.02</td>
</tr>
<tr>
<td>Internal support</td>
<td>.20</td>
<td>.06</td>
<td>.22</td>
<td>3.62**</td>
<td>.25</td>
</tr>
<tr>
<td>Amount of training</td>
<td>-.00</td>
<td>.00</td>
<td>-.01</td>
<td>-.16</td>
<td>-.01</td>
</tr>
<tr>
<td>Belief in effectiveness</td>
<td>.11</td>
<td>.07</td>
<td>.11</td>
<td>1.71</td>
<td>.16</td>
</tr>
<tr>
<td>Dummy 1</td>
<td>.93</td>
<td>.50</td>
<td>.15</td>
<td>1.87</td>
<td>.13</td>
</tr>
<tr>
<td>(Elementary = 1;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Otherwise = 0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dummy 2</td>
<td>.41</td>
<td>.59</td>
<td>.06</td>
<td>.69</td>
<td>-.05</td>
</tr>
<tr>
<td>(Middle or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior high = 1;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Otherwise = 0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < .01.
p < .001) (Table 9). Age proved to be significant
(b = -.06, t = -2.48, p < .05), but accounted for only 1
percent of variance (Table 10). Sex proved not to be a
significant variable in predicting institutionalization.
Table 9

Analysis of Variance for Regression of Institutionalization on Five Predictor Variables, Age, and Sex

<table>
<thead>
<tr>
<th>Variable</th>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean of Squares</th>
<th>F</th>
<th>p</th>
<th>Multiple R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>8</td>
<td>216.44</td>
<td>27.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.37</td>
<td>.00</td>
<td>.32</td>
</tr>
<tr>
<td>Residual</td>
<td>242</td>
<td>1945.32</td>
<td>8.04</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Table 10

Summary Table for Side Analysis Variables in Multiple Regression Equation Predicting Institutionalization of Clinical Supervision

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>SEb</th>
<th>Beta</th>
<th>t</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of time</td>
<td>-.01</td>
<td>.02</td>
<td>-.02</td>
<td>-.34</td>
<td>-.05</td>
</tr>
<tr>
<td>Internal support</td>
<td>.14</td>
<td>.05</td>
<td>.18</td>
<td>2.93**</td>
<td>.18</td>
</tr>
<tr>
<td>Amount of training</td>
<td>.00</td>
<td>.00</td>
<td>.01</td>
<td>.18</td>
<td>.02</td>
</tr>
<tr>
<td>Belief in effectiveness</td>
<td>.12</td>
<td>.07</td>
<td>.11</td>
<td>1.77</td>
<td>.16</td>
</tr>
<tr>
<td>Dummy 1</td>
<td>.97</td>
<td>.52</td>
<td>.16</td>
<td>1.88</td>
<td>.13</td>
</tr>
<tr>
<td>(Elementary = 1; Otherwise = 0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dummy 2</td>
<td>.30</td>
<td>.60</td>
<td>.04</td>
<td>.50</td>
<td>-.05</td>
</tr>
<tr>
<td>(Middle or Junior high = 1; Otherwise = 0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.06</td>
<td>.03</td>
<td>-.16</td>
<td>-2.48*</td>
<td>-.11</td>
</tr>
<tr>
<td>Sex</td>
<td>-.76</td>
<td>.50</td>
<td>-.10</td>
<td>-1.52</td>
<td>-.12</td>
</tr>
</tbody>
</table>

*p < .05.  **p < .01.
SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Chapter 4 contains a summary of the study, conclusions that have been deduced from the multiple regression analyses, and implications and recommendations from the results.

Summary

The purpose of the study was to provide a plausible explanation for the variation in institutionalization of clinical supervision in the public schools of North Carolina by exploring variables that were associated with this educational change.

Berman's (1981) paradigm served as the perspective of the study. A basic tenet of the paradigm contended that an educational change consists of the organizational subprocesses of mobilization, implementation, and institutionalization. It was through these subprocesses that the institutionalization of clinical supervision was studied.

Variables thought to predict institutionalization were gleaned from the literature and included the principal's perception of the amount of time required to do clinical supervision, the amount of internal support, the amount
of training a principal received, the principal's belief in the effectiveness of clinical supervision, and the type of school administered by the principal. A separate exploratory analysis was conducted that included age and sex with the original predictors.

A Principals' Survey was developed to collect data on the institutionalization of clinical supervision and its predictor variables. The Principals' Survey was mailed to a random sample of 450 public school principals and 288 (64%) responded. A survey of nonrespondents was conducted, and a comparison of nonrespondents and respondents verified the representativeness of the original responses. The nonrespondents participating in the follow-up study were added to the original respondents. This provided an overall sample of 300 (67%) respondents.

Two multiple regressions were used to analyze the data obtained from the Principals' Survey. Both multiple regression analyses used the institutionalization of clinical supervision as the criterion variable. Five predictor variables gleaned from the literature were used in the first multiple regression. The second analysis included the five original predictors plus age and sex.

Findings and Conclusions

The variables gleaned from the literature were used to develop five hypotheses to account for the variation
in institutionalization of clinical supervision in the public schools of North Carolina. The conclusions reached after testing each hypothesis follow:

1. The more time a principal perceives clinical supervision to take, the less the institutionalization of clinical supervision.

Data obtained from the statistical analysis did not support this hypothesis. The unstandardized coefficient (b = -.00) for perception of time was not statistically significant (t = -.06, p > .05) when variance held in common with other predictor variables was removed. The perception of time required to do clinical supervision seems not to make a difference in the institutionalization of clinical supervision by principals.

2. The more internal support a principal receives for clinical supervision, the greater the institutionalization of clinical supervision.

Data from the statistical analysis supported this hypothesis (b = .20, t = 3.62, p < .00). For each unit increase in internal support a principal receives for clinical supervision, the institutionalization of clinical supervision is predicted to increase by .20 of a unit. The internal support a principal receives for clinical supervision does seem to lead to a greater degree of institutionalization.
3. The more training a principal receives in clinical supervision, the greater the institutionalization of clinical supervision.

Data obtained from the statistical analysis did not support this hypothesis. The unstandardized coefficient ($b = -.00$) for the regression of institutionalization of clinical supervision on the amount of training was not statistically significant ($t = -.16$, $p > .05$) when variance held in common with other predictor variables was removed. The amount of training a principal receives in clinical supervision seems not to make a difference in the institutionalization of clinical supervision.

4. The more a principal believes that clinical supervision will help teachers be more effective, the greater the institutionalization of clinical supervision.

Data obtained from the statistical analysis did not support the hypothesis. The unstandardized coefficient ($b = .11$) for the regression of institutionalization of clinical supervision on belief in effectiveness was not statistically significant ($t = 1.71$, $p > .05$) when variance held in common with other predictor variables was removed. A principal's belief that clinical supervision helps teachers to be more effective seems not to make a difference in the institutionalization of clinical supervision.
5. Principals of elementary schools will institutionalize clinical supervision to a greater degree than middle, junior high or high school principals, and middle and junior high principals will institutionalize clinical supervision to a greater degree than high school principals.

The comparison of elementary principals with high school principals on institutionalization of clinical supervision was not significant ($b = .93$, $t = 1.87$, $p > .05$) when variance held in common with other predictor variables was removed. The comparison of junior high school principals with high school principals also was not significant ($b = .41$, $t = .69$, $p > .05$). There seems to be no difference in the degree of institutionalization of clinical supervision by elementary, junior high and middle, and high school principals.

When the demographic variables of age and sex were added to the multiple regression equation, they accounted for 2 percent of the variance in institutionalization of clinical supervision.

The regression of institutionalization of clinical supervision on age proved statistically significant ($b = -.06$, $t = -2.48$, $p < .05$). When variance held in common with other predictor variables was removed younger principals tend to institutionalize clinical supervision to a greater degree than older principals.
The sex of a principal as a variable when regressed on the institutionalization of clinical supervision was not statistically significant ($b = -.76, t = -1.52, p > .05$). Both demographic variables proved to be weak predictors of the institutionalization of clinical supervision.

The data from the multiple regression analysis, without the demographic variables, showed a weak but significant relationship between the five predictor variables and institutionalization of clinical supervision. Only nine percent ($R^2 = .09$) of the variance was accounted for, leaving 91 percent unexplained. The addition of age and sex as predictor variables to the multiple regression equation yielded two percent of variance, but the the seven variables, in sum, were weak predictors of the institutionalization of clinical supervision.

**Implications**

The conclusions presented have implications for Berman's paradigm that was used as the basis for this study and for the other literature from which variables of this study were derived and justified.

Berman’s (1981) paradigm contended that internal support is a key component in any educational change. Snyder, Johnson, and MacPhail-Wilcox (1982) confirmed the need for this internal support as it related to clinical
supervision. This study further affirms internal support as a necessary component of educational change and, in particular, a change concerning the institutionalization of clinical supervision in the public schools of North Carolina.

The amount of training a principal receives was defined in this study as the number of clock hours of training in clinical supervision a principal receives multiplied by the span of time, in months, between the first and last training sessions. Training is a part of the clarification process of an educational change that is necessary for the effective institutionalization of the change (Berman, 1981). Snyder, Johnson, and MacPhail-Wilcox (1982) contended that more complete institutionalization of clinical supervision is a result of the additional training a principal receives in clinical supervision. The results of this study do not support the hypothesis that the amount of training a principal receives in clinical supervision leads to a greater degree of institutionalization. This leads to the speculation that the variable was not measured appropriately. Although doubtful, it may be true that the amount of training a principal receives is not a predictor of institutionalization.

A principal’s belief in the effectiveness of an innovation would seem to be necessary to achieve a high
degree of institutionalization (Berman, 1981). Synder, Johnson, and MacPhail-Wilcox (1982), Reavis (1978b), and Garman (1982) concur that the belief of a principal in an educational change is related to its institutionalization. The results of this study do not support the hypothesis that a principal's belief in the effectiveness of clinical supervision is related to the institutionalization of that innovation. This implies that the measure of the principal's belief was inaccurate or that the variable is not a predictor of institutionalization. It is also possible that many principals believe in the effectiveness of clinical supervision but do not use it when supervising personnel.

The literature contains many authors who report that clinical supervision requires more time and places an increased burden on principals than more traditional forms of supervision (Ryan, 1971; Sullivan, 1980; Reavis, 1978a; Howell, 1981). The principal's perception of this time was defined in this study as the number of hours that a principal perceives it takes to perform one clinical supervision cycle. This perception of time, if excessive, would result in less institutionalization of clinical supervision. This contention was not supported by the results of the study. A number of implications result from this lack of support. Principals may not accurately estimate the number of hours a clinical
supervision cycle takes, or they have different definitions of what components are contained in a clinical supervision cycle. Additionally, the variable may have been measured inappropriately or the principal's perception of time is not a predictor of institutionalization of clinical supervision.

Berman and Pauly (cited in Berman, 1981) found that effectiveness of the implementation of an educational change varied between elementary schools and secondary schools. The notion existed that the majority of educational change takes place at the elementary school level. Results of this study determined that level of school produced no significant, systematic variation in the institutionalization of clinical supervision. This implies that differences in clinical supervision that developed during implementation due to type of school could homogenize because of the time span between the implementation and institutionalization stages. Therefore, less variation would occur during the institutionalization of an educational change, in this instance clinical supervision.

Age was added as an exploratory variable to the multiple regression analysis and proved statistically significant. This implies that future research should consider age as a possible predictor of institutionalization.
Four of the five predictor variables did not support the present theory and literature from which they were derived. This implies that either the measures used to assess each of the predictor variables and the criterion variable were not developed to allow for the greatest reliability or that the four predictor variables actually do not predict institutionalization.

Recommendations

Recommendations will be made for school districts in North Carolina wishing to institutionalize clinical supervision and also for further study on clinical supervision and institutionalization of change. These recommendations will be drawn from the conclusions and implications of the study.

Since internal support was found to be a significant predictor of institutionalization, it is recommended that any district implementing an educational change or any North Carolina school district implementing clinical supervision carefully develop their internal support system during the mobilization, implementation, and institutionalization stages. This internal support system should consider planning, monitoring, and mandating the use of the educational change. Districts should also concentrate change efforts with the older principals since the results indicated that younger
principals institutionalized the educational change to a greater degree.

It was noted that the measurement of all variables could have been inappropriate and should be measured differently to increase the reliability. This could be accomplished by revising items that are ambiguously stated, such as, the measurement of the amount of training. This variable needs to eliminate the confusion that appeared in the survey responses. A number of respondents noted that the hours reported included college courses on evaluation and supervision. In this author’s opinion most college evaluation and supervision courses only briefly mention clinical supervision and do not deal entirely with it. Therefore, an inaccurate measure of training resulted. Future research should measure this variable using checklists specifying the different types and numbers of hours of training for each clinical supervisory activity. Also, reliability could be increased by developing additional items (Kerlinger, 1973) that are unambiguous and similar in nature to the items on the Principals’ Survey.

Future researchers should consider eliminating the estimated number of hours it takes to perform one clinical supervision cycle from the measurement of the variable of the principal’s perception of time. This is because some principals may not spend many clock hours
performing clinical supervision, even though they perceive the time as being excessive. Therefore, these principals would be reporting a small number of clock hours as being excessive for performing a clinical supervision cycle. Additionally, principals who actually use every component of clinical supervision could be reporting a high number of hours as not being excessive for performing a clinical supervision cycle.

Future researchers of the institutionalization of clinical supervision might also consider measuring the criterion variable differently. For this study, complete institutionalization totaled 25 on the set of Likert items. A mean of 22.33 with a standard deviation of 2.93 was realized from the survey sample. This indicated that a very high average degree of institutionalization was reported by principals. A possible explanation for this is what Rossi, Wright, and Anderson (1983) refer to as deliberate additions of information to make a good impression. This response inflation by principals could be avoided by sampling teachers and having them specify the extent their principals use clinical supervision. In addition, each component of clinical supervision, such as the preconference, could be measured using a checklist of its specific parts. Both recommendations should lead to a more accurate assessment and greater reliability in the measurement of institutionalization of clinical super-
vision.

Many questions were left unanswered considering the small amount of variance accounted for in institution-alization of clinical supervision. The questions should be addressed soon since the use of clinical supervision in the public schools of North Carolina is receiving strong emphasis by the State Department of Public Instruction.
References


Appendix A

Principal's Survey

Please fill in a response for each question.

4-5. Age_____ 6. Sex_____

7. Check the type of school you administer.
   _____Elementary or Primary
   _____Middle School or Junior High School
   _____Senior High School
   _____Other. Specify type and list grades__________

8-10. Approximately how many clock hours of training have you had in clinical supervision? _____

11-13. Estimate the number of hours per teacher, on the average, that it takes to perform one clinical supervision cycle._____  

14-16. If you have received more than one training session or workshop in clinical supervision, what was the span of time, in months, between the first and last training session or workshop? ____months?

For each statement below, decide which of the following answers best applies to you. Place the number of the answer in the space at the left of the statement:

1. Never  4. Often
2. Seldom  5. Always
3. Sometimes

17. _____ I schedule a preconference with each teacher for each formal observation to discuss and clarify the upcoming observation.

18. _____ I discuss with each teacher every item on a preconference form and then fill it in prior to each formal observation.

19. _____ I collect data during each in-class observation pertaining to objectives and activities that were discussed at the preconference.

20. _____ I schedule a postobservation conference with each teacher for each formal observation to discuss the teacher’s strengths and weaknesses and to make specific job performance recommendations.
21. _____ I fill in and discuss with each teacher every item on a postobservation conference form after each formal observation.

22. _____ I spend a minimum of 30 minutes during each formal observation.

For each statement below, decide which of the following answers best applies to you or your district:

1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

23. _____ Clinical supervision takes too much time to justify its use.

24. _____ I am required to use clinical supervision as a part of the performance appraisal process.

25. _____ Use of clinical supervision increases student learning.

26. _____ The time that it takes to perform clinical supervision is not excessive.

27. _____ My central office administrators check to be sure that principals use clinical supervision.

28. _____ Clinical supervision helps teachers become more effective.

29. _____ Clinical supervision would be used more if it were not so time consuming.

30. _____ The training I received in clinical supervision was sufficient for me to implement all of the procedures.

31. _____ My district helps principals become more competent in using clinical supervision.

32. _____ Teachers who are not clinically supervised will be less effective than those teachers who are clinically supervised.

33. _____ Clinical supervision does not take that much extra time when compared to the benefits derived from it.
34. _____ My central office staff provides no help to me in using clinical supervision.

35. _____ Use of clinical supervision results in better teaching.

36. _____ I am evaluated on how well I perform clinical supervision.

37. _____ Teachers who are coached improve to a greater extent than teachers who are not coached.

Please return to: William L. Dobney, PO Box 416, Moyock, NC 27958.
Thank you.
Appendix B

Letter to Sample of Principals

Virginia Tech Letterhead

College of Education

October 10, 1985

Dear Principal,

We are presently involved in studying the extent to which North Carolina principals have used clinical supervision.

We hope that you will be willing to help in this study by responding to the enclosed survey and returning it within ten (10) days. Approximately ten (10) minutes of your time is needed to complete this survey.

Surveys are numbered to permit follow up; however, all responses will be kept confidential. We will be glad to share the results of the study with you if you indicate an interest. The successful completion of this study depends on your participation. Thank you for your help.

Sincerely,

William L. Dobney,
Director of Personnel Services

David J. Parks,
Associate Professor of Education
Appendix C

Follow-up Letter to Principals

October 31, 1985

Dear Principal,

I am in the final stages of data collection for my study on the use of clinical supervision by principals in North Carolina. As yet, I have not received your survey so would you please take a few minutes and fill out the extra copy I have enclosed. Your participation is needed for the successful completion of this study as all the different points of view on clinical supervision are needed.

Thank you for your help. Please return the completed survey to:

William L. Dobney

Sincerely,

William L. Dobney
Director of Personnel Services
Currituck County Schools
The vita has been removed from the scanned document.