CLINICAL SUPERVISION AS A METHOD OF PROVIDING BEHAVIORAL FEEDBACK TO SIGN LANGUAGE INTERPRETERS AND STUDENTS OF INTERPRETING

Alan A. Atwood
Gallaudet University

Abstract

Sign language interpreters and students of interpreting need close supervision to improve their interpreting skills. Clinical supervision is a process of monitoring and responding to interpreting behaviors more disciplined than many other supervisory techniques, and can lead to improved message transmission. Its use gives control over the process to the interpreter (or the student); this differentiates clinical supervision from various forms of evaluation and grading. Clinical supervision encourages changed behavior through introspection, it allows for input from all people involved, can be used to identify specific behaviors for observation, and separates collection of data from analysis of behaviors. Clinical supervision is not a traditional evaluation, but a method of providing information to the interpreter educator, sign language interpreter and student of interpretation.

Clinical supervision is a process of providing behavioral feedback based on a model developed by Cogan and his colleagues at the Harvard-Newton Summer Program in 1962 and was expanded upon by Goldhammer to be used in the training of school administrators and teachers (Anderson in Goldhammer, 1969). Its inception grew out of a need to provide feedback to teachers about their effectiveness when traditional evaluations did not seem to improve teaching behaviors. Clinical supervision is based on the premise that supervisors can do a better job of assessing employee's professional skills without using formal evaluations. Teachers may see evaluations as a tool for grading and for promoting particular behaviors over others on the basis of a supervisor's opinion, and not as an objective tool to encourage the use of effective skills. In order for evaluations to effect a change of behavior, the teacher (here, the interpreter) must be willing to reflect on present behaviors, recognize areas that can be changed, follow through with action, and experience the targeted behavior through modeling and practice. Traditional evaluations based upon supervisor-supervisee relationships generally do not provide enough time and effort to carry out such a change of behavior.

Change is more likely to occur where a trusting relationship is the basis for supervision. Goldhammer's (1969) premise is that peers, not supervisors, may serve as better agents to encourage positive changes. This is because of mutual trust, the amount of contact, and a functional and realistic knowledge of the working environment based on present experience. On the other hand, Cogan (1973), one of the original creators of clinical supervision, places responsibility on the supervisor to work with the teacher in developing the appropriate relationship and trust to use this model effectively.

Although the concept of clinical supervision has been promoted from two different perspectives on who should be responsible for clinical supervision, an important concept in both is that a trusting and comfortable relationship is necessary in order to use the process effectively. It is possible that a supervisor using clinical supervision is not viable for some people, because a supervisor-supervisee or educator-student relationship exists. For others it may not be an issue, especially when the supervisee or student feels that the superior has competence in the professional skills being assessed (Hunter 1984, in Brandt 1985, p. 65) and when the process is followed to completion.

Following Goldhammer's view, I believe it is possible that first-year interpreting students may be supervised by knowledgeable second-year students, second-year by third-, or second-year students by other second-year students. Another possibility is for the teacher to make the first clinical observation, and then to allow peers the opportunity later. Alternately, participants could make the choice between a peer or the teacher. I have not investigated all these suggestions, but in my opinion, peer support has been lacking in the field, and clinical supervision could be used to encourage peer support, as well as for assessing effective interpreting behaviors.

The burden is on the observer to build trust and rapport and to separate clinical supervision from evaluation and grading of students. Second, the observer must be sure that, if peers use the clinical supervision process, they are knowledgeable of observable interpreting behaviors. Clinical supervision does allow for the differing needs of those using the process.

In the field of interpreter education, clinical supervision can be useful in that it provides information rather than grades or evaluation. Interpreters and students need feedback about their interpreting behavior so that they can monitor and work on change more independently. Clinical supervision creates independence by promoting reflection on present behaviors, provides the knowledge necessary to recognize areas for change, encourages action to follow through, and provides opportunities for discussion and modeling of goal behaviors. It gives people the power to control what happens to them.

I should mention at this point that the use of the term "clinical" does not imply pathology, but rather emphasizes the use of observation of the interpreters or students. By now it should be obvious that the term "supervision" is not to be equated with traditional evaluations. I prefer to think of clinical supervision as "disciplined subjectivity" which comes from a description of a clinical approach from Erickson:

> The argument, therefore, is that rather than striving for a state of "objectivity" (and hence of a false sense of security from scientism), the clinician works instead towards "disciplined subjectivity": that is to say, a circumstance in which he "maintain(s) a constant inner traffic between his often dramatic observations and his conceptual models, however crude they may be" (Smyth 1985, p. 4, on Erickson 1969).

Although clinical supervision was developed for use in the field of education, sign language interpretation has many similarities to that of classroom teaching. Both are fields where the primary service-providers — usually women — serve the needs of a varied group of consumers, act with little supervision but make hundreds of important decisions in their work. Teachers (and interpreters "have to accommodate to the need for rules and regulations, in the knowledge that these stifle individualization and innovation", ". . .are self-confessed pragmatists whose work styles are characterized by concerns for practicality and immediacy, teachers [and interpreters] have to contend daily with community expectations and demands that take no account of the ambiguity and uncertainty surrounding much of what transpires in life in classrooms [and interpreting situations]" (Smyth 1984, p. 25, on Lieberman 1982). In both cases, "outsiders fail to appreciate the highly personalized artistic nature of [the task], the endemic uncertainty of the linkage between teaching and learning [or interpreting and communication] in the absence of an established knowledge base and the absence of goal specificity. There is also an insensitivity to the fact that. . .[both groups] work in a context characterized by isolation and in the absence of a strong professional culture based on shared experiences" (Smyth 1984, p. 26).

Finally, both groups have few means to get feedback about their performance other than traditional evaluations. These similarities lead me to believe that clinical supervision can be used in the field of interpreter education to enhance the skills of working interpreters and students of interpretation alike, as it has been used in education.

My direct experience with clinical supervision is limited. I was knowledgeable about the process, and because of that I was asked to visit an interpreter education program and work with students and the staff interpretersin the program. The initial success, in my opinion, seems to warrant sharing it within the field at large. As a result of the opinions of the first group of participants and the information gathered about their interpreting behaviors, the director of the program went on to use the process in other situations and with other groups of interpreters. The entire process required approximately three hours from beginning to end for each participant. This may seem like a great amount of time, but it was spread over five stages which involved three separate meetings with the participant and two sessions where I worked alone, analyzing data and reflecting on my behaviors. The time may vary for others. I am certain the use of clinical supervision

with working interpreters and students should be studied more. My personal experiences have been very positive and the responses of the participants were encouraging.

Clinical supervision has five basic stages:
1. pre-conference with the participant where the trust-building relationship is first developed, and where a contract or plan is developed;
2. observation of the person performing interpreting behaviors where behavioral data are collected;
3. analysis of the data and strategy for presentation of the data;
4. supervisory conference where discussion of impressions, behaviors, data, and suggestions occur; and
5. post-conference analysis of the educator's behaviors.

Clinical supervision defines specific behaviors for the person performing the supervision and for the participants. I briefly list the steps involved with the process and define them below:

Process of Clinical Supervision

I. The educator's responsibilities
- A. identify interpreting behaviors
- B. identify observable criteria (characteristics) of interpreting behaviors
- C. develop easy-to-use scoring forms to collect data about the interpreting behaviors
- D. meet with the participants to establish the working relationship and to explain the process of clinical supervision
- E. meet with each individual for a pre-observation conference to develop rapport and a contract or plan
- F. observe the participants in a setting where interpreting behaviors will be exhibited
- G. make an anecdotal record of the behaviors observed without judging effectiveness
- H. analyze the data in a different setting:
  - a. identify the patterns of interpreting behaviors and determine which patterns are effective and non-effective, based on research where possible and on current practices in the field of sign language interpretation
  - b. identify behaviors that will improve and reinforce effective interpreting behaviors
- I. meet with the participants on another date to discuss:
  - a. participants' observations and comments about the process and situation
  - b. data
  - c. analysis of the data
  - d. behaviors to improve or reinforce the interpreting skills
  - e. effective interpreting behaviors and model them

II. The participants should:
- A. have the opportunity to use the process as a matter of choice rather than as a requirement
- B. identify specific interpreting behaviors that are to be observed
- C. be available to:
  1. learn about the process
  2. discuss the identified interpreting behaviors for observation
  3. be observed while interpreting
  4. discuss personal observations, the process and data
  5. work on improving and reinforcing specific interpreting behaviors

Responsibilities of the Interpreter Educator

Interpreter educators must be prepared with certain information when using the clinical supervision process. This includes a detailed knowledge of the behaviors required in sign language interpretation, and a knowledge of observable criteria for each of those behaviors. It takes some effort to learn this information and to develop the criteria, but it is worth knowing exactly what behaviors are being observed. This knowledge can be used for a host of tasks and is not limited to this process. Resources such as Baker and Cokely (1980) can be used to understand ASL better; also McIntire (1986) can provide insight into the task of interpretation. Although we in the field of interpreter education have only recently undertaken a formal effort to identify what constitutes interpretation, it is important that individual educators and interpreters continue to develop their insights into the process. As one educator has pointed out,

> Since professional uncertainties seem likely to persist for a long time, the professional supervisor must learn to live with them productively. The key in that sentence is productively. We cannot merely go on working, we must work productively. This signifies that we do not make do with what we have, we make the best of it. If our store of useful data is small, we exhaust its resources before we draw inference, propose hypotheses, or form judgments. Supervisors need to be prepared to live with partial knowledge (Cogan 1973, p. 52).

It is also important to have observable criteria for behaviors that constitute interpretation. This means being able to identify how one behavior is different from another. The educator must be

able to identify exactly what the person has exhibited so that the behavior can be documented, analyzed, and discussed. If it is not observable, then it is very difficult to model or to tell a person exactly what they have done. Let us look, for example, at the observable criteria for a sign: they are the sign parameters, handshape, location, orientation, movement, as well as non-manual markers. Each of these criteria are observable, are a characteristic of every sign, and can be used to distinguish one sign from another. When developing or using criteria for behaviors, the observer should avoid terms like "movement appropriate for," "should look like," and "correct production of." These describe behaviors that must already be known to be understood. The observer must remember that the criteria must be clear and observable, especially to others. The use of clinical supervision requires this feature:

> When clearly defined goals are lacking, it is impossible to evaluate a course or program efficiently. . . .There is no sound basis for selecting appropriate materials, content, or instructional methods. . .an instructor will function in a fog of his own making until he knows just what he wants his students to be able to do at the end of instruction. . . .Unless goals are clearly and firmly fixed. . .tests are at best misleading; at worst, they are irrelevant, unfair, or useless. To be useful they must measure performance in terms of the goals. Unless the [instructor] himself has a clear picture of his instructional intent, he will be unable to select test items that clearly reflect the student's ability to perform the desired skills, or that will reflect how well the student can demonstrate his acquisition of desired information. . . .The student is provided the means to evaluate his own progress at any place along the route of instruction and is able to organize his efforts into relevant activities (Cogan 1973, on Mager 1962, pp. 3 - 4).

Invaluable to the clinical supervision task are forms for collecting data. We must be able to note specific behaviors quickly and in a way that we can understand later. It is helpful to make use of forms where criteria for behaviors can be checked off or indicated with a word or two or with a short phrase. Abbreviations and symbols can be used, but it can be confusing for co-workers or future employees to decipher. These forms must be few in number, but capable of including in-depth and specific information about the behaviors being observed. It is distracting to the participant when the observer continuously flips through numerous forms to find the behavior or characteristic to be documented. A general rule is to use no more than three pieces of paper or whatever can fit on top of a student desk with minimum overlay.

The Process of Clinical Supervision

It is crucial that the entire process of clinical supervision be described to the participants. It is important to remember that this process is not an evaluation, but a way to gather information and share it in as non-threatening a fashion as possible. Clinical supervision is both person-oriented and task-oriented and is a partnership between the educator/observer and the participant that is ". . .not achieved until the. . .[participant]. . .(1) knows why he is changing his behavior, (2) wants to change it, and (3) derives professional satisfaction from doing so" (Cogan 1973, p. 58). The participants who want to learn more about their own skills ". . .are asking in short to become participants in supervision rather than the objects of it" (Wilson 1969, in Cogan 1973, p. 69). Knowing how the process works and each person's responsibilities will help everything go smoothly and more productively. (Refer to the outline labeled "Process of Clinical Supervision" [page 89] for an overview.)

First, participants meet with the observer and get an overview of the philosophy of clinical supervision. The observer explains to all that the process is to identify interpreting behaviors and can focus upon as few behaviors as wanted or can take a "shotgun" approach, assessing a range of behaviors. For example, some behaviors might be conceptual accuracy in sign choices, fingerspelling, and non-interpreting behavior. The choice of interpreting behaviors should be agreed upon by the observer and the participant. The participant should have the first choice of areas for observation, and the observer should be allowed to make suggestions of other behaviors to be considered.

Inform participants that each individual is to arrange for a "pre-conference" where they will discuss individually with the observer their choices of interpreting behaviors for observation. Do not require participants to make their minds up immediately. Both parties should have time to decide what areas will be of most benefit. In the pre-conference time you can develop the working relationship further, inform each other of the areas for observation, clarify each behavior, so that both parties know what the other expects, and define criteria for each behavior. In this initial meeting, agree upon the time and place of the pre-conference, observation, and supervisory conference.

Overall, the pre-conference is the time to clarify the behaviors for observation, to answer questions about the process, and to build a rapport and trust with the participant. The next stage is the observation. The educator will observe the participant interpreting and will stay for the entire contracted time. This is where well-developed data collection forms are crucial. Remember to use as few forms as possible and to place the forms in a way that several behaviors can be documented without flipping pages. The observer should make it clear that notes will be made throughout the session. No interjections are to be made while the observation is occurring. This stage is for data collection only, and not for suggestions or critique.

When observing the specific areas of interpretation that were contracted for, the observer should be careful to document behaviors and not opinions or judgments. For example, write a phrase that was spoken or signed and the interpretation for it verbatim. Remember, this is an anecdotal record of observable acts. This is not the time for analysis. Some may think that videotape should be used with clinical supervision to document interpreting behaviors. Again, Cogan and Goldhammer have different ideas about this topic. Goldhammer, on the use of videotaping, is persuasive:

> If it were possible to videotape a lesson and to record every sight and sound in a manner that overrode the cameraman's selective biases, then the resulting record would probably be as complete and as undistorted as possible.... Even if it were generally feasible to produce such a record, however, it seems likely that its very completeness would make it unmanageable for supervisory purposes; data processing would take too long. It takes as long to air a tape as it does to film it, even longer to edit our selections for supervision, and longer still to air selections from the tape a second time in the conference. Moreover, since teachers [and probably interpreters] can generally reconstruct episodes...very quickly in their imaginations with the aid of written, verbatim, observation notes, it would consequently be wasteful to recapitulate taped episodes that take as long to see as they did originally — unless, perhaps, <u>pacing</u> represented a focal supervisory problem (Goldhammer 1969, p. 83).

Cogan's opinion is more neutral. He feels that the educator is able to focus selectively on behaviors which are important to the participant, whereas recording equipment is able to document nearly everything that occurs during the situation. "Perhaps the best answer to the man versus camera-and-microphone question is that each can perform certain important functions in observation far better than the other. Both are necessary if we are to capture the important events of the classroom, and each is incomplete without the other" (Cogan 1973, p. 139).

The most important concept to keep in mind during the observation is to document what you <u>see</u> and not to document your <u>opinions</u>. Secondly, observe the behaviors contracted for. Some of the problems related to observations and recording are discussed by Cogan (1973) and are taken from Kounin (1970). Deficiencies in observations include: "(1) an inability to obtain complete records of what happened. . .(2) A tendency to selectively notice and record events that were impressive, contrasting, in line with some pre-existing hypotheses or concerns, intense, or otherwise perceptually outstanding to the point of exclusion of other mundane and less noticeable events. . .[and] (3) A propensity to include labels, evaluations, judgments, pseudo-interpretations, summaries, and other types of nonobjective and nondescriptive entries" (Cogan 1973, pp. 136 -137, on Kounin 1970).

After the observation session has concluded, it is time to begin the analysis of the data. This is where the observer's judgment about effective and non-effective interpreting behaviors comes into play. Although this involves subjectivity and opinion, as much of the analysis should be grounded in research as possible. Educators should be well-versed in current research related to interpretation.

A participant's change of behavior should not be based on feelings of good or bad, but rather on documented successful behaviors. Again, behaviors must be observable, distinguishable from other behaviors, and available for modeling. Feelings or impressions are difficult concepts upon which to base reflection and change. Analysis should detect patterns of behaviors such as a large number of movement errors in signs, consistently missing time markers, lack of classifiers and the like. Document the pattern and determine whether it is production or conceptual. A handshape error in a sign is production, whereas signing FIRE for firing an employee is a conceptual error. The analysis should conclude with a summary of findings and be put in a form that is understandable to both parties.

Determine carefully the strategy to use in the supervisory conference. Consider the type of feedback the participant best responds to. Some prefer direct rather than indirect statements; some

prefer "sandwiching" of effective and non-effective behaviors; and others prefer visual over auditory. Be prepared for personal preferences and use whatever the person is comfortable with. This is a process which uses trust and rapport as a basis for change; it involves the participant and is not done to the participant.

The supervisory conference is the meeting where the observer/educator presents the data to the participant. This is a time for discussion and conversation between the two. The educator is obliged to probe for the feelings, opinions and observations of the participant about the performance, goals, or problems while interpreting. It is a mistake for any educator to present objective data or behavioral observations in a cold and sterile environment. As no act is without some human purpose, this type of information needs to be embedded in the human perspective and intention. After a discussion of how the situation went, the educator can begin to point out patterns of behaviors and show the information that was collected. Model any suggestions for the participant and then the participant should practice them. This will help in the goal of changed behavior. Be sure to ask for and then include ideas from the participant about ways to improve.

The supervisory conference is the most important stage for interaction with the participant. The educator should seek input from the participant, provide insights as an educator and as an interpreter, present the data and analysis in a personal way. Be sure that the participant understands, and practices any suggestions. Make arrangements to meet again to follow up on the suggestions. Again, clinical supervision is done with, not to the participant.

The final stage of the clinical supervision process is the post-conference analysis. In any process, there should be a time for reflection by those providing the service. In clinical supervision, this is related to the educator's behaviors. Some information from the participants can help to identify areas where the educator can improve. The educator should also do a self-review. Questions to be considered can include:

- Did I clearly describe the process of clinical supervision to the participants so they can fully appreciate its philosophy and benefit from it?
- Did I pay attention to what the participants want from the process and fully understand their needs?
- Did I observe and document the behaviors of interest to the participants or did I document my feelings and opinions?
- Did I analyze the data for patterns of behaviors or did I look for behaviors that I would exhibit when interpreting?
- Did I seek out and listen to the comments of the participant during the supervisory conference?
- Did I present the data and their analysis in an understandable manner, while considering the human aspect of the interpreting performance?
- Did I offer suggestions that will lead to improved interpreting skills and are those suggestions reasonable and obtainable?
- Did I use clinical supervision, including and working with the participant, or did I make the participant the object of the process?
- What can I do as the educator to do a better job of using clinical supervision?

As educators, we should do what we can to improve our use of clinical supervision, tailoring it to the needs of the participant, and working with the participant toward some meaningful closure of the process.

Conclusion

Clinical supervision is a means of providing information to people. It is a process that may take some getting used to, but which can lead to a better understanding of one's interpreting behaviors and provide opportunities to change some of them. We can also it to provide peer support, which is a major issue in the field of sign language interpretation. Overall, clinical supervision allows interpreters and students of interpretation to control and be involved with their assessments, instead of having just another evaluation of their skills.

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