**Chapter 11**

**Co-Teaching in Teacher Preparation Clinical Practice**

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**with**

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Topics Included in This Chapter:

 Why is co-teaching in clinical practice needed?

 What is co-teaching in clinical practice and how is it different from traditional clinical practice?

 How can teacher candidates and cooperating teachers be prepared for co-teaching clinical practice?

 What are changes in the roles of teacher candidates, cooperating teachers, and clinical supervisor when using co-teaching in clinical practice?

 What are the research outcomes of co-teaching in clinical practice?

 What do cooperating teachers, candidates, and supervisors say about co-teaching in clinical practice?

As has been emphasized throughout this book that all educators who are employed to work with students in today’s schools are expected to teach with one another, and collaboratively plan and problem solve with colleagues to differentiate instruction for their increasingly diverse student populations (Villa and Thousand 2011). In what ways might we prepare our new teacher candidates to have both the disposition and the background knowledge and skill to engage in quality co-teaching partnerships? Why is a new approach to clinical practice needed?

**WHY CO-TEACHING IN CLINICAL PRACTICE?**

Many teachers are reluctant to mentor a student teacher because of this era of high stakes testing especially given the requirement to leave the classroom during the student teacher’s solo teaching time (Ellis and Bogle 2008). In addition, many teachers are now participating in schools that have adopted a Response-to-Intervention approach (see Chapter 2) where the core instructional program is enhanced to accelerate student learning. They are required to differentiate instruction to meet diverse needs of learners.

Co-teaching has been shown to be an effective strategy to increasing student achievement (see Chapter 2) by partnering teachers with different expertise (e.g., special educator and general educator). Bacharach, Washut-Heck, and Dahlberg (2010) of St. Cloud University in Minnesota showed that co-teaching during clinical practice helped to close the achievement gap for English language learners, students with disabilities, and the general student population overall. Nevertheless, as Bacharach et al. point out, teacher preparation programs continue to structure the clinical practice experience *after* completing all coursework and featuring one to two weeks of *solo teaching*. This practice has been recognized as an undesirable and unsuccessful induction approach (Darling-Hammond and Bransford, 2005) and has prompted a national push to enhance school and teacher preparation program collaborative partnerships for teacher induction that are “fully grounded in clinical practice” (National Council for Accreditation of Teacher Education. 2010, p. 2). Given this reform initiate in combination with the documented academic and other benefits of the St. Cloud University’s co-teaching model of clinical practice on student performance, schools and colleges of education across the nation are piloting transformations of their clinical practice paradigms through the application of co-teaching practice and principles (e.g., McGrath 2012).

**WHAT IS CO-TEACHING IN CLINICAL PRACTICE?**

**HOW IS IT DIFFERENT FROM TRADITIONAL CLINICAL PRACTICE?**

Clinical practice or student teaching is an expected and essential dimension of any teacher preparation program, with the overarching objective of providing teacher candidates with the modeling and guided practice to demonstrate their abilities to translate educational theory into actual practice with real students in real classroom settings. A co-teaching clinical practice approach departs from the traditional approach where after some period of observation, the candidate took over all classroom duties with little guidance or intervention from the cooperating teacher. Bacharach and colleagues (2010) aptly characterize this *solo teaching* experience in which the cooperating teacher steps aside as a “‘sink or swim’ approach [in which] a teacher candidate either survived or failed on his or her own” (p. 4).

As a reader of this text, you already know that co-teaching involves two or more people sharing responsibility for all of the students assigned to them for instruction. In the case of clinical practice or student teaching, the co-teachers are the teacher candidate and the cooperating teacher. As co-teachers, they have an ongoing and evolving relationship throughout the duration of the clinical partnership, which might be several weeks, a semester, or an entire year. In co-teaching clinical practice, the cooperating teacher gradually releases classroom responsibilities to the teacher candidate. As partners, they engage in ongoing planning for and practice of co-teaching variations in which both collaboratively teach and assess all students throughout the clinical experience.

The co-teaching clinical practice approach described in this chapter relies upon the four co-teaching approaches (i.e., supportive, parallel, complementary, and team) and the collaboration and planning structures and tools described in previous chapters of this book. This co-teaching clinical approach and tools have been piloted by a large clinical practice team of faculty, teacher candidates, and local teachers affiliated with the School of Education in the College of Education, Health, and Human Services at California State University San Marcos (CSUSM). They are under ongoing revision and refinement. We offer them as suggested processes and tools for your own efforts to induct new educators into the field and welcome hearing from you about your own innovations or variations on the use of these processes and instruments. Teacher induction through co-teaching is in its infancy; so borrow and modify liberally as we jointly make our baby steps forward!

**Preparation and Introduction of the Co-Teaching Clinical Practice Players**

To what extent are teacher candidates, cooperating teachers, university supervisors, teacher preparation program faculty, school site administrators, school district induction program coordinators, and/or students prepared to know what to expect in clinical practice? In many cases, there is little to no preparation for some or all of these stakeholders. In contrast, in a co-teaching clinical practice approach, it is essential that, at a minimum, the required and essential players in clinical teams – the candidate, the cooperating teacher and the evaluating supervisor – receive a baseline of information and training. For the CSUSM pilot initiative, not only were these triads provided instruction and coaching, but the school site principals, program course instructors, onsite liaisons (i.e., site teachers who provide daily and weekly “touch in” support to the credential candidates) are invited to and, in fact have routinely attended professional development that provides direct instruction in, modeling (via DVD demonstrations of co-teachers in action), and guided practice in at least the following topics that are described throughout this text:

1. The research-base for co-teaching (see Chapter 2 for the history and research base for co-teaching)

2. The four approaches to co-teaching - supportive, complementary, parallel, and team (see Chapter 3 for the basic definitions of each approach)

3. What each of the approaches looks and sounds like in action (see Chapters 4 – 7)

4. Cautions for the use of each approach (see Chapters 4 – 7 for detailed descriptions of each co-teaching approach and cautions in using on the approaches)

5. Issues all new co-teaching teams must address, including identification of planning time, establishing norms or ground rules for communication, and clarifying discipline and classroom management procedures (see Table 3.3 of Chapter 3 for Co-Teaching Issues for Discussion and Planning)

It is ideal if the candidate-cooperating teacher-supervisor triad receives training in the above content simultaneously as a team to facilitate conversations as a team Topics should include “getting to know you” and logistical issues such as when to schedule regular planning meetings, when will the university supervisors observe planning and teaching, how and when will lessons be debriefed,. We acknowledge that this is not possible for many triads due to conflicting work schedules, training opportunity conflicts, or structure of the training program delivery. What we have learned is that as long as all parties can (a) acquire and share the common co-teaching concepts and language with which to speak about their co-teaching experiences, (b) get to know each other and decide on logistical issues, and (c) access support materials (e.g., the training materials, supervision forms, clinical community resource website), these key stakeholders have the basic essential information to converse about and describe their actions and relationships. For example, the authors recently overheard a teacher candidate effectively communicate about co-teaching with his cooperating teacher with whom he had not had simultaneous training: “So, when you take the lead in whole class direct instruction, I could take the supportive co-teacher role and collecting data on student engagement through a “management by walking around” check-in with table groups to see that individual students are attending and taking notes.”

**Communication and Planning**

Often in clinical practice arrangements that do not follow a co-teaching approach, little time or focus is directed toward relationship building or collaborative planning of instruction. In contrast, in co-teaching clinical practice, conversation and planning is deliberate, frequent, and initiated from the start of the relationship. Part of the initial training is expressly designed to prompt critical conversations about everything from time for planning to logistics such as how the teacher candidate will be introduced to and addressed by the students. Table 3.3 of Chapter 3 offers a comprehensive list of issues co-teachers discuss and resolve. One role of the university supervisor in co-teaching clinical practice is to support both the teacher candidate and the cooperating teacher through these conversations, especially when it is the first time that the cooperating teacher as well as the candidate have had to negotiate agreements about certain topics such as joint planning time (see Table 12.1 in Chapter 12 for suggested strategies for expanding time for planning) and the role of the cooperating teacher when the teacher candidate is in the lead in *supportive* or *complementary* co-teaching lesson arrangement.

In the authors’ view, whenever two or more people are in a classroom interacting with students, co-teaching is occurring, whether it is planned or not. To optimize the effectiveness of teacher-student interacting, teacher candidates and cooperating teachers plan in advance by deciding “if one of us is doing this” then “the other person could be doing this” (Murawski and Dieker 2004). This requires joint time for planning lessons and the flow of the day and strategies for efficiently using that time. To support this planning, we offer two tools Table 11.1, lists concrete suggestions for how co-teachers can differentiate and coordinate their actions during a supportive, parallel, complementary, or team co-teaching lesson. This table provides space for co-teachers to brainstorm ways in which “If one of us is doing this… the other could be doing this…” This format allows co-teachers to discuss and agree upon how they will work out their division of labor during instruction and also practice labeling their co-teaching arrangement as supportive, parallel, complementary, or team co-teaching.

The second tool that clinical practice co-teachers have found useful is the Co-Teaching Differentiation Lesson Planning Matrix show in Table 11.2 and as Resource Q and illustrated in Tables 11.3 and 11.4. Clinical supervisors of credential candidates in co-teaching clinical placements have noticed that co-teachers tend to plan their collaboration for a school day by first thinking about each time block of the day and the content and curriculum objectives that typically are addressed in that block, then discussing how they will coordinate their actions through co-teaching. The Co-Teaching Differentiation Lesson Planning Matrix planning tool acknowledges this planning process and offers a structure for guiding conversations about what the cooperating teacher and the teacher candidate will be doing in each time block, which co-teaching approach(es) their actions represent, and, perhaps most importantly, how the co-teaching arrangement(s) they select support the differentiated instructional needs of the students in the classroom. The matrix explicitly includes a discussion on differentiating instruction, with the column titled, **“**What are differentiated instructional needs of our students?” This question allows co-teachers to consider and discuss the needs of students as the basis for decisions about their co-teaching arrangements. Tables 11.3 shows how a fourth grade co-teaching team used the matrix to organize their morning co-teaching blocks and structure supportive, parallel and complementary co-teaching approaches to address student needs. Table 11.4 shows an example of how the cooperating teacher and teacher candidate in a first and second grade combination bilingual classroom used the matrix to structure their co-teaching with their bilingual and struggling first and second graders in mind.

**Gradual and Systematic Release of Responsibility in Co-Teaching Clinical Practice**

The goal of clinical practice is to support each teacher candidate to demonstrate competent, independent teaching performance that meets professional and state teaching performance expectations and standards. A unique feature of co-teaching clinical practice is the ongoing collaborative planning, teaching and reflection that occurs between the teacher candidate and the cooperating teacher, with coaching support from the clinical supervisor. This is in contrast to a non-co-teaching model in which the cooperating teacher often has only his or her own past clinical practice experience to guide them in determining their role as a coach or collaborator with the teacher candidate. And that past experience often is the *sink or swim* experience of *solo* teaching, with the cooperating teacher leaving classroom responsibilities fully to the teacher candidate to negotiate on his or her own.

Co-teaching clinical practice, then, provides a teacher candidate the opportunity to demonstrate increasing instructional competence and independence through a gradual release or shift of responsibility from the cooperating teacher to the teacher candidate. Within a co-teaching clinical practice approach, it is this shift of responsibility of *who takes the lead* *in the collaborative work* (i.e., from cooperating teacher to teacher candidate)that best describes the trajectory toward competent independent teacher candidate performance.

The Table 11.5 Suggested Timeline for the Systematic Release of Responsibility in Co-Teaching Clinical Practice suggests a progression or shift in the roles of a teacher candidate and his or her cooperating teacher in (a) planning and reflection and (b) instruction from the beginning to the end of a co-teaching clinical practice experience. Note the complementary role of the cooperating teacher in the process of gradually releasing planning, teaching, and reflection leadership responsibilities to the teacher candidate. The *beginning* of clinical practice is characterized by the *cooperating teacher* taking a lead in the collaborative planning, teaching, and reflection processes across four phases – beginning, early, middle, and end - of clinical practice. The *end* of clinical practice is characterized by the *teacher candidate* taking the lead in each of the dimensions (i.e., planning, instruction, reflection) of the recursive instructional cycle. It is recommended that not only the teacher candidate, the cooperating teachers, and clinical supervisor become familiar with and discuss how they plan to execute the timeline suggested in Table 11.5, but all of those involved with the teacher candidate (e.g., the site administrators and formal or informal onsite clinical practice liaisons, grade level or department chairs) become familiar with this suggested timeline so they too may prompt and support the teacher candidate’s movement toward independently demonstrating competence in teaching performance.

A major debate particularly among cooperating teachers and clinical supervisors is whether, in a co-teaching clinical practice approach, teacher candidates should be held accountable for planning and delivering instruction alone. The argument for solo teaching goes like this: “Most teachers today still have to plan and teach by themselves, so we have to make sure that this candidate can do this without the cooperating teacher’s ‘wind beneath his/her wings’ during planning or teaching.” Clearly, all teacher candidates must have opportunities to demonstrate that they can individually plan for and instruct and manage a classroom of students. However, in co-teaching clinical practice, when a teacher candidate is expected to lead both the planning and the instruction with minimal input from the cooperating teacher, that candidate will have had a well-supported, well-modeled, and well-guided set of previous collaborative planning and teaching experiences to draw upon. Further, during the time that the teacher candidate takes the full lead in planning and instruction, the cooperating teacher is free to remain in the classroom. The cooperating teacher might take on a role similar to that of a clinical supervisor. Using the *supportive* co-teaching approach, the cooperating teacher may observe and script the teacher candidate’s performance for discussion in a follow-up meeting in which they reflect collaboratively on the lesson. The cooperating teacher also can engage in other supportive, parallel or complementary roles under the direction of the teacher candidate.

**Changes in the Role of the Clinical Supervisor**

In a co-teaching clinical practice paradigm, the clinical supervisor becomes much more of a coach than an evaluator of teacher candidate performance. Teacher candidates and cooperating teachers are more likely to move forward in their conversations about execution of the four co-teaching approaches if the teacher candidate is both prompted and held accountable through supervisory observations, regular face-to-face or online conversations about their co-teaching experiences, and weekly tracking of the co-teaching approaches that are being used over time.

One essential teaching performance expectation is that of instructional planning which, in the words of the California Commission on Teacher Credentialing (2008), encompasses “understand [of] the purposes, strengths and limitations of a variety of instructional strategies, …” and the ability to “select or adapt instructional strategies, grouping strategies, and instructional material to meet student learning goals and needs…” and “improve … successive uses of … strategies based upon experience and reflection” (p. A-14). If instructional planning and reflection on instruction to inform future planning are expected performances to earn a teaching credential, then both are worthy of observation and coaching. In co-teaching clinical practice, clinical supervisors observe not only the delivery of lessons - the execution phase of the instructional cycle, but also the planning and reflective debriefing conversations between the teacher candidate and the cooperating teacher. As Table 11.5 highlights, the person taking the lead in these conversations is expected to shift over the course of a clinical practice experience, with the teacher candidate increasingly taking the initiative to lead instruction. One of the roles of the clinical supervisor, then, is to observe and offer comment on these planning and debriefing sessions. Table 11.6 offers a Co-Teaching Observation of Planning and Debriefing Reflection observation form that the clinical supervisor can use to provide feedback and coaching to the teacher candidate about their planning and reflective conversations. This tool is designed to assist the teacher candidate in setting goals for being proactive in the *planning* portion of the co-teaching partnership.

To further prompt and support teacher candidates to plan and reflect upon the co-teaching aspect of their clinical practice, clinical supervisors can request candidates to complete the Co-Teaching Clinical Practice Weekly Reflection form presented in Table 11.7. This form asks candidates to note their use of any of the four co-teaching approaches and indicate requests for an observation of their planning or delivery of a co-taught lesson. Clinical supervisors request candidates to complete this form at the end of the week and e-mail or otherwise deliver it to them. This weekly monitoring form allows a supervisor to both track a candidate’s overall perceived progress in the clinical experience and hold the candidate accountable for transitioning to the lead role in planning and delivery of co-taught lessons. Teacher candidates might also be asked to complete the Co-Teaching Tracking Form initially presented in Chapter 3 in Table 3.2. Table 11.8 shows a completed form for a teacher candidate in the early weeks of clinical practice in a middle –level sixth grade classroom.

To facilitate positive reflective conversations, clinical supervisors sometimes request teacher candidates to use something like the “Report Card” Conversation Starter for Reflection and Debriefing shown in Table 11.9 in order to prompt teacher candidates to (a) provide their cooperating teachers with praise and positive feedback about what was learned from observing and co-teaching with the cooperating teacher and (b) question their cooperating teachers about the rationale for their observed instructional or classroom management decisions. The report card can create an opening for a teacher candidate to take the lead in suggesting ways in which to improve his or her own or the partnership’s instruction in the future.

**RESEARCH PROMISE OUTCOMES AND TESTIMONIALS**

**What Does the Research Say?**

The research on clinical co-teaching models is limited to a handful of studies such as Bacharach et al. 2010; Larson and Goebel 2008; Nevin, Cohen, and Marshall 2007; Swain, Nordness, and Leader-Janssen 2012). Research findings are summarized in terms of academic benefits and changes in perceptions of efficacy in use of instructional strategies.

***Academic Benefits.*** Increased student achievement on standardized math and literacy achievement tests were reported for teacher candidates who were in a co-teaching clinical practice in contrast to student achievement with teacher candidates prepared in the traditional way (Bacharach et al. 2010). For example, in co-taught classrooms, 65% of students eligible for free and reduced lunch and 74% of students eligible for special education achieved proficiency in reading as compared to 53% in classrooms with no student teacher or ones without co-teaching being practiced in clinical practice. For English learners, nearly 45% achieved proficiency vs. 26 – 31% in comparison classrooms without co-teaching. An advantage they noted is that co-teaching in student teaching provides two professionally prepared teachers in the classroom for longer periods of time, leading to increased achievement gains. Students in co-taught classrooms also identified benefits including getting help and feedback more quickly, fewer disruptions due to routine task such as passing out papers or student behavior.

***Changes in Perceptions of Efficacy in Use of Instructional Strategies Due to Direct Instruction on Strategies.*** Changes in classroom strategies were identified by Nevin et al. (2007) in a comprehensive study of 271 teacher candidates who were assigned to classrooms in a multi-culturally diverse urban school system where teachers were using co-teaching strategies to include students with disabilities. To prepare them for co-teaching, student teachers were required to participate in a one-day hands-on seminar on inclusive instructional strategies such as peer tutoring, cooperative group learning, and quick cooperative structures such as th*ink-pair-share*. Evaluation results showed candidates highly rating the following two statements: “I can use different classroom routines to help meet diverse needs of my learners, and “I know how to use flexible grouping when I teach my lessons.” Similar changes in teacher efficacy also were reported when teacher candidates completed a co-teaching clinical experience as part of a professional development school-university partnership (Larson and Goebel 2008).

**What do Candidates and Cooperating Teachers Say About Co-Teaching Clinical Practice?**

During and after implementing a pilot program to assess the feasibility of a co-teaching clinical practice approach (Stall, Thousand and Garza, 2012; Stall, Thousand, Garza, Robledo, and Rich 2013; Thousand, 2012) collated and analyzed feedback on the experiences of cooperating teachers, teacher candidates, supervisors, school site administrators, and teacher education faculty. From their reflections, three strong themes emerged.

*Theme 1: Shared Language About Co-Teaching*

Teacher candidates, cooperating teachers, and clinical supervisors overwhelmingly indicated their appreciation of having a new, shared language and schema about collaborative planning and teaching and methods for high quality co-teaching. Candidates, cooperating teachers and supervisor had all participated in common professional development in which this language was introduced and they also had tools such as the Co-Teaching Differentiation Lesson Planning Matrix (shown in Tables 11.2, 11.3 and 11.4 and as Resource Q) to assist them in having conversations about their co-teaching role.

This shared language allows co-teachers to *talk* about their partnerships and plan for their roles and relationships in their lessons. As one teacher candidate noted, “One thing that co-teaching taught me is talking about what I am doing. Writing it down is one thing, but talking and getting another perspective was very helpful.” Having a shared language allows co-teachers to jointly *think* and encode this thinking into a shared *understanding* of what they want to do with their students. This shared understanding not only allows the co-teachers to co-teach the lesson, but prepares them to be *flexible* to adjust their instruction “in the moment,” based upon observations of student performance.

Example. Consider the case of the clinical co-teaching partners who, in their planning, decided to use the complementary co-teaching approach to introduce a new math concept. As they delivered the lesson, they observed that several students did not seem to *get it*. Because they had a shared understanding of the purpose of the lesson (i.e., establishing all students’ understanding of a new math procedure), it was natural for them to confer to make a quick, on-the-spot decision to shift from a complementary to a parallel co-teaching structure for a brief block of time. The split-class and supplementary co-teaching approach allowed one co-teacher (e.g., the cooperating teacher) to provide immediate supplemental instruction to the identified students while the other co-teacher (e.g., the teacher candidate) guided the remaining students through practice applications of the newly introduced procedure.

*Theme 2: Efficacy in Overall Instruction and Differentiating Instruction*

Teacher candidates and cooperating teachers overwhelmingly expressed that the overall quality of instruction in co-teaching was superior to either of them teaching alone. They emphasized the importance of increased opportunities to differentiate instruction. This allowed the co-teachers to increase student access to and performance in the core curriculum in their mixed-ability classrooms that included large numbers of English learners and students eligible for special education or other learning support services (e.g., Title 1 reading and mathematics). The increased ability to differentiate is due, in part, to the increased number of instructors in the classroom. However, to an even greater extent, it is likely due to the exchange of ideas, knowledge, and skills that resulted from co-teachers’ regularly and deliberately planning not only for their co-teaching roles, but the differentiation needs of their students, prompted by such aids as the Teaching Differentiation Lesson Planning Matrix and the clinical supervisor’s observations of planning using theCo-Teaching Observation of Planning and Debriefing Reflection (in Table 11.6).Stated another way, the perceived increased capacity to differentiate instruction likely was due to the co-teachers *acting* on the identified differentiation needs through the co-teaching arrangements they decided to use throughout the day.

Examples. Participants described their increased efficacy to various ways. One co-teaching partnership described how they were able to provide language models for their English learners through their regular ongoing *think alouds.* A cooperating teacher noted how it became natural to jump in to clarify or explain in different ways, proudly describing how her teacher candidate would “enter in and rephrase, giving a suggestion so that students really connected with the concept.” Another cooperating teacher noted that “when there are two teachers it keeps the students’ attention longer. We could role-play adult conversations and step in when one teacher seemed stuck.” Others described increased use of differentiated supports such as visual supports. Acknowledging the *time for planning* demand of co-teaching, another cooperating teacher commented on the positive synergistic outcome of having a partner with whom to reflect and brainstorm, stating “We reflected and planned extensively based on what we were seeing, combining our ideas. It took a lot longer, but it was meaningful time.”

In a clinical co-teaching partnership, the cooperating teacher is, in most cases, more of the content expert. However, in some instances a teacher candidate has expertise that allows for enhanced instruction and learning.

Example, For example, one elementary cooperating teacher acknowledging that the teacher candidate, with her current training in differentiation, had more knowledge than herself about strategies for working with different levels of English learners, turned the lead for differentiation of instruction for those students to the candidate. In a high school setting, one cooperating teacher described teaching a unit on marine biology. The teacher candidate had actually been a marine biologist and was more of the content expert. The teacher candidate naturally took the lead while the cooperating teacher took more of the supportive or complementary co-teaching roles. In both cases, the co-teaching allowed for the cooperating teachers to expand and deepen their own content knowledge while simultaneously benefitting their students by giving them access to the knowledge of a content expert.

*Theme 3*. *Confidence and Competence Building Through Planful Gradual Release of Responsibility*

Participants appreciated the planful way that responsibility for planning and teaching was gradually released from the cooperating teacher to the teacher candidate as a consequence of their ongoing planning conversations prompted by the suggested timeline for systematic release of responsibility offered in Table 11.5. This is in contrast to being thrown into solo teaching without the support of planned transitions in leadership roles in instruction and planning.

In conversations that reflect this theme, numerous teacher candidates expressed the anxiety of pressure associated with planning on their own in a non-co-teaching situation. In one case, the teacher candidate described being “paralyzed by fear” and almost dropping out of his preparation program. Albeit, the situation may have been as much situational as related to non-co-teaching. Nevertheless, the *gradual release* nature of a co-teaching approach to clinical practice seems to allow for better planning and delivery of lessons.

Example. This gradual release phenomenon is illustrated by a teacher candidate in his comparison of co-teaching and non-co-teaching clinical experiences. “Last semester [in non-co-teaching], I would plan for the whole week. I had really long lesson plans. I thought in theory they were cool, but in execution it didn’t work as well. You had to adjust. Co-teaching allows for us to discuss and see what we need to do before and even during the lesson.” Another teacher candidate noted, “I was shown the ropes more with co-teaching. I don’t like to get thrown into things. I had more confidence through the support of my cooperating teacher and the smooth transition to my own teaching.” Yet another candidate described the co-teaching transfer of responsibility as “like having a safety net.”

**FREQUENTLY ASKED QUESTION**

Aside from the question about “solo” teaching already addressed in the chapter text, the question people ask about the most when they are considering the use of co-teaching in clinical practice has to do with time.

1. **Won’t potential cooperating teachers decline having a teacher candidate in the classroom, once they realize how much more time it will take to plan and debrief instruction with a candidate in a co-teaching clinical practice approach?**

We know that the one resource that teachers have the least of is time for planning and that planning for co-teaching with a teacher candidate requires even more of that precious commodity. In fact, the number one identified challenge for any co-teaching team, whether it be grade-level co-teachers, general and special education co-teaching partners, teachers supported by paraprofessional co-teachers, classroom teachers co-teaching with high school students, or teacher candidates and cooperating teacher partners is finding enough time to plan. As with any co-teaching team, candidates and their cooperating teachers have had to be creative and flexible in using the time allotted for planning and finding or expanding new time to plan. In addition to the suggested ideas for expanding time for planning ideas offered in Table 12.1 of Chapter 12, co-teachers in clinical practice have utilized shared interests, existing collaborative structures in the school day and week, and technology to get their planning (and reflection) accomplished. For example, many of the schools in which co-teaching clinical practice is occurring also have teacher and student support structures such as Professional Learning Community blocks each week in which teachers talk about individual students, groups of students (English learners, students performing “below basic” performance levels in reading and/or mathematics). Many schools already have built into their school day Tier II intervention blocks in which interventions are already structured and require less planning, because the research-based instructional strategies are already planned and organized.

One of the first things that co-teaching clinical practice partners are asked to do in their initial training is to share with one another their personal strengths, interests, and something the other might find surprising. Sometimes, in these conversations clinical practice partners discover shared interests that also accommodate time for planning.

Examples. One co-teaching partnership discovered that they both walked 45 minutes every morning prior to school and decided that they would walk together two or three days a week while they simultaneously talked about and planned their lessons. This idea to talk while walking came from their shared knowledge of the “Talk Walk” quick cooperative learning structure that suggests that the physical movement involved in the problem solving conversation “increases free thinking, creativity, and expression” (Villa, Thousand, and Nevin 2010, p. 31). Another shared running as a passion and used their daily jogs for the same purpose. Others have car pooled and used that time for planning. Many use technology to supplement their face-to-face time by (a) sending daily e-mail messages with lesson plans, PowerPoint presentations and adapted materials attached; (b) video conferencing via Skype (see www.skype.com) or FaceTime on their iPads or iPhones; or (c) creating and sharing their work online at sites such as Google Docs (see https://docsgoogle.com/).

1. **It makes sense that, over time, credentialed teachers (e.g., same-grade, same-content, complementary-expertise teachers such as general and special educators) can evolve in their partnerships to truly being team co-teachers in planning and instruction. However, given the short time a teacher candidate and cooperating teacher have together, is it possible for a teacher candidate and a cooperating teacher to actually go beyond the supportive, parallel, and complementary co-teaching approaches and become team co-teachers?**

This question, in part, is about having the time to develop a deep partnership, as is suggested in the answer to the question posed in Chapter 7: “How long will it take for co-teaching teams to evolve to the team co-teaching?” We acknowledge that it does take time to build trust, communication, and collaborative problem solving relationships for a clinical partnership to be truly equal in the shared responsibility for planning and instruction. This question also is very much about recognizing the reality that, in most cases, there will be a content knowledge and instructional authority discrepancy between the seasoned and experienced cooperating teachers and the novice teacher candidates, particularly when they first come together. This same authority discrepancy usually does not exist between co-teachers who hold valid credentials who have an ongoing professional relationship as colleagues at a school site. By virtue of the fact that a teacher candidate has a *learner* rather than a *collegial* relationship with his or her cooperating teacher and clinical supervisor, it is difficult to imagine a teacher candidate developing the level of content and pedagogical expertise and authority to be on equal footing in planning and teaching with the credentialed cooperating teacher. That said, we have observed co-teaching clinical practice partners get to the place of being able to dance the tango of team co-teaching, anticipating and one another’s moves, sharing the instructional stage, and being flexible in adjusting their lessons and roles as co-teachers as they diagnose student progress in the moment. What helps to make this happen? The answer is, “Likely, a combination of factors!”

One factor involves setting the expectations and coaching the teacher candidate to be proactive, observant, and inquisitive. The clinical supervisor and cooperating teacher can prime these dispositions and behaviors in several ways. For example, if you look back at the Report Card conversation starters offered in Table 11.9, you will see that the sentence starters prompt teacher candidates to observe and note exemplary practices of their cooperating teachers and to be inquisitive by asking questions of their cooperating teachers about *what* the instruction practices they are observing represent in terms of effective pedagogy, *how* these practices are planned and structured, and *why* these practices are selected for use with the class or particular students. Ground rules can be established to clarify that it is the teacher candidate’s responsibility to take action from day one to proactively study the curriculum and classroom management demands of the placement (e.g. take home and study the grade-level curriculum guides) and solicit suggests for improving their own teaching. It is important for teacher candidates to remind themselves that becoming a competent and confident educator is not a destination but an ongoing journey that requires the dispositions and the practice of inquiry and wonder.

Another factor that likely contributes to co-teaching teams achieving the equitable collaborative team teaching instructional arrangement in a clinical practice situation has to do with *role release* or *role exchange,* the release of planning and instructional tasks and methods usually performed by the cooperating teacher to the teacher candidate. As recommended in Chapter 6, role release is more likely to occur smoothly and naturally when it is systematically planned (see Table 11.5 for a suggested timeline for systematic release of responsibility). This, of course, requires that the cooperating teacher has both the disposition and a strategic plan (as suggested in Table 11.5) to *let go* and gradually increase the teacher candidate’s roles and responsibilities so as to become an equal and equitable team co-teacher in planning and instruction. As suggested earlier, cooperating teachers can be supported through this *letting go* process, if site administrators, clinical supervisors, grade level or department chairs communicate their understanding of and agreement with this letting go process to achieve a team teaching partnership at least for certain lessons or portions of the day.

Does a clinical practice co-teaching team need to have had at a team co-teaching experience by the end of a clinical practice experience? We would say that the answer to this question is “No.” Can a clinical practice co-teaching team become genuine team co-teachers? Certainly! We have seen it happen time and time again, particularly when both partners have had previous experience with co-teaching (e.g., at least one previous co-teaching partnership) and when both perceive that they have permission and encouragement to take the risk and attempt to dance this tango.

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