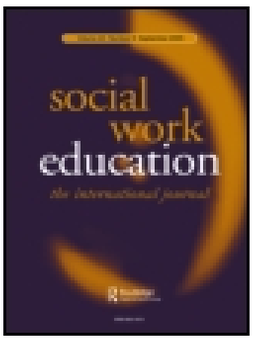

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'Just what is there now, that is what there is'—the effects of theater improvisation training on clinical social workers' perceptions and interventions

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ABSTRACT

Flexibility, Therapeutic Presence (TP), and collaborative tendency are core capacities in clinical social work as well as in theater improvisation. This mixed-methods pilot study studied the effects of theater improvisation training on 35 graduate-level social work students, who participated in an experiential, semester-long 'theater improvisation skills for clinicians' course, compared to a control group of a similar cohort. These variables were measured before, after, and at a three-month follow-up to the course. Additionally, Follow-up semi-structured interviews were conducted with 17 course graduates. Quantitative results showed a significant increase in flexibility and TP immediately following the course compared to the controls, which was not maintained at the three-month follow-up. The qualitative findings indicated an increase in flexibility, open-mindedness, TP, and self-awareness following the training. Triangulation of both sets of data suggests that improvisation training contributed to changes in participants' general attitudes and perceptions regarding their clinical work. However, longer training is needed in order for these skills to effectively impact their clinical work. The findings suggest that improvisation skills can help clinical social workers increase their flexibility and TP, as well as other important alliance abilities. Implications for teaching and research are discussed.

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Improvisation; therapeutic presence; training; therapeutic alliance; relationship skills

Social work has been described as art (Gray & Webb, 2008) or as an 'improvised performance' (Walter, 2006), with social workers constantly tailoring their approach to the idiosyncratic strengths and needs of the clients (Blom, 2009; Frost, 2015). As such, improvisation is an important relationship skill for social workers (Graybeal, 2014; Steitzer, 2011; Walter, 2003). Researchers have found that regardless of theoretical orientation, clinicians that exhibit flexibility, honesty, openness, interest in client, and exploration were found to contribute positively to the therapeutic alliance (Ackerman & Hilsenroth, 2001; Horvath, Del Re, Flückiger, & Symonds, 2011). Advocates for an improvisational stance in clinical work describe additional benefits which include: expanding professional repertoires (Ringstrom, 2011), generating a sense of excitement, and expanding possibilities for interpreting and enactments (Frost, 2015), as well as

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increased flexibility and activeness in clinical work (Todd, 2012). Therefore, an improvisational stance is especially beneficial for clinical social workers engaged in ongoing relationships with their clients. Clinical social workers focus on bringing about the healthy bio–psycho–social functioning of people—individuals, couples, families, and groups—of all ages and backgrounds (American Clinical Social Work Association), be it through psychotherapy, consultation, or providing ongoing bio–psycho–social support.

Theater improvisation and relationship skills

Most of the literature on theater improvisation describes the need for guidelines or 'rules' for improvisers in order to help incorporate and channel their limitless imaginations (Madson, 2005). This set of principles and guidelines can be useful for social workers to expand and refine their clinical relationship skills (see Table 1 and also Johnstone, 1999).

Training in improvisational skills not only requires an ability of theory of mind, but also demands high levels of attunement to the other, in order to co-create the moment, which helps develop empathy (Bayne & Jangha, 2016).

Training in relationship skills is important for social workers (Howe, 1998). This training traditionally included didactic theoretical components, role playing, mindfulness training, reading of manuals, audio and/or videotapes of demonstrations, or treatments as well as one-on-one and group supervision (Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Safran & Kraus, 2014). Therefore, this article continues the call for theater improvisation skills training for social workers as an additional skill that can help develop relationship skills (Todd, 2012) in a new and innovative way.

This study explores whether teaching clinical social work graduate students theater improvisation skills will improve their perception of their relationship skills with their clients, a key factor in the clinical process and outcome (Norcross, 2011). More specifically, the study examines three variables: flexibility, therapeutic presence (TP), and collaborative tendency. All three variables, which are detailed below, are related to enhancing the therapeutic relationship, and are also core skills of theater improvisation.

Flexibility, collaborative tendency, and therapeutic presence

Flexibility, the ability to adapt mentally and emotionally to the present situation in therapy, is an important trait for clinicians (Ackerman & Hilsenroth, 2001) as well as for improvisers (Johnstone, 1999).

Table 1. Theater improvisation guidelines relevant for social workers.

Guideline
Stay curious and enjoy the interaction through humor and spontaneity, among other things.
Listen and watch intently, not only for content but also for what spontaneously emerges in you.
Act now—don't be afraid to introduce now what emerges spontaneously in you.
Try not to block (negate) the other's version of reality (also called offer/bid).
Accept and build off the other's reality. Try to co-create the reality of the moment, which is called the 'Yes and' rule.
Make clear offers that move the action and co-creation forward.
Reincorporate information that was previously improvised.
Let yourself fail and make 'mistakes' because there are no mistakes.
Make your partner look good.

Flexibility can be as important as knowledge of well-rehearsed techniques in social work (Frost, 2015; Grady & Keenan, 2014). Clinicians who showed higher levels of flexibility were more positively rated by their clients (Ackerman & Hilsenroth, 2001). Flexibility could also be seen as open-mindedness, a person's capacity to look at situations from multiple perspectives and see the different sides of the encounter; adaptability in thinking and ideas; and willingness to try new things (Lough, McBride, & Sherraden, 2012).

Collaborative tendency has been rated by clients as effective in regard to treatment outcome (Ackerman & Hilsenroth, 2001; Norcross & Wampold, 2011). Collaboration in therapy can be seen as a process of shared decision-making in which the clients are actively involved in the session through discussing feelings and concerns, as well as working together with the therapist to achieve treatment goals (Tryon & Winograd, 2011). This collaborative 'working together' relationship has been correlated to positive therapeutic outcomes (Cooper & McLeod, 2007).

Theater improvisation is essentially a collaborative endeavor. It is the act of co-creating without pre-planning and requires two or more people cooperating in a moment-to-moment emotional engagement in order to keep playing and be creative (Ringstrom, 2010). Therefore, we carefully hypothesize that training in theatrical improvisation could aid in increasing the collaborative tendency of the therapist.

TP is defined as the process and experience of bringing oneself completely to the encounter with the client on an emotional, physical, cognitive, and spiritual level (Geller, Greenberg, & Watson, 2010; Geller, Pos, & Colosimo, 2012). It describes a process that includes both being inwardly attentive as well as actively extending that experience with the client (Geller & Greenberg, 2002; Greenberg & Geller, 2001), while experiencing greater creativity and spontaneity (Geller & Greenberg, 2012).

Elsewhere (Romanelli, Tishby, & Moran, 2017) we have presented a qualitative study showing an initial correlation between training in theater improvisation skills and subsequent higher levels of TP.

Study aims and hypotheses

In this study, we examined the effects of participating in theater improvisation skills course on clinical social workers' perceptions and interventions in their work. Our hypotheses were:

(1) Training in improvisational skills will increase subjects' levels of flexibility, TP, and collaborative tendency in comparison to a similar control group who did not participate in the training.
(2) These changes will be maintained at a three-month follow-up.

Our qualitative research question was: How do subjects describe their experience and learning gains from the theater improvisation course three months after the completion?

Method

Research design

This study is a mixed quantitative/qualitative longitudinal study (Creswell, Plano Clark, Gutmann, & Hanson, 2003; Green et al., 2015). Quantitative data were collected before and immediately after the courses with a follow-up three months later. Qualitative data were collected in semi-structured interviews to better understand the subjective experience as well as other processes in the learning and application of improvisation skills. The institutional ethics committee approved this research.

Participants

All participants in the study and control groups were graduate social work students actively working as clinicians in individual or family settings. A preliminary power analysis based on medium effect size and significant level of $p = 0.002$ yielded a suggested sample size of 30 in the study and control group. The study group consisted of 35 students (9 male and 26 female), aged from 25 to 44 (M = 32.2, SD = 4.66) who participated in the theater improvisation skills course for clinicians. The control group consisted of 46 graduate students (11 male and 35 female), aged from 24 to 49 (M = 33.46, SD = 6.46) from the same cohorts who did not partake in the improvisation course. Students in the two groups had an average of 4.8 years of clinical experience (SD = 3.6).

For the qualitative arm of the study, 13 females and 4 males were interviewed, ages ranging from 26 to 42 (M = 32.47, SD = 4.01). Their clinical experience varied from 3 to 17 years (M = 6.41, SD = 4.12).

Theater improvisational skills for clinicians' course

The semester-long course was developed especially for this study and taught by the first author, who is a social worker and family therapist as well as a seasoned theater improvisation trainer. The course was an elective, credited course with participation limited to 16-students per course to ensure an intimate, safe group that will encourage participation and experimentation in the improvisation games. Allocation to the course was done by the computerized system of the university. The course incorporates clinical and improvisational literature and was built on the principles of experiential learning theory (ELT) (Kolb, 2015), which emphasizes four stages of the learning cycle: *concrete experience, reflective observation, abstract conceptualization, and active experimentation*. Each class had a different focus on specific theater improvisation skills, such as 'accepting and blocking offers,' 'making your partner look good,' 'accepting and enjoying mistakes,' and other skills described in Table 1. Course syllabus and manual can be obtained from the first author.

Measures

Development of psychotherapist common core questionnaire (DPCCQ) (Orlinsky et al., 1999)

Several aspects of flexibility were measured by relevant items from the DPCCQ, a 370-item self-report questionnaire designed as a cooperative enterprise by the Society for

Psychotherapy Research Collaborative Research Network (SPR CRN) in 1989–1990 as the basis for a comprehensive survey of the formative experiences and practices of psychotherapists (Orlinsky et al., 2005). This study used 34 items from the DPCCQ in consultation with David Orlinsky. These items focused mostly on flexibility with regard to theoretical frameworks and perception of professional growth.

Questions regarding open-mindedness and satisfaction during clinical work

Flexibility in the choice and delivery of clinical interventions, which lies within the construct of open-mindedness (Lough et al., 2012) was measured by five original questions referring specifically to social workers' feeling of having different choices available to them during their sessions, the freedom to choose between them, and the freedom to change their original session plan according to the reality unfolding during the clinical hour. Items are rated on a 6-point Likert scale ranging from 0 (not at all) to 5 (very much). The research team formulated all the questions with high agreement regarding content validity. These questions were analyzed separately from the other questionnaires.

Working alliance inventory—short form revised scale (WAI-SR) (Hatcher & Gillaspy, 2006)

This 12-item measure consists of three subscales (Goals, Bond, and Task) based on Bordin's (1979) tripartite conceptualization of the alliance: agreement on the tasks of therapy, agreement on the goals of therapy, and development of an affective bond. This short form is based on the original 36-item WAI (Horvath & Greenberg, 1989). The WAI-SR has been found to have good reliability (Perdrix, de Roten, Kolly, & Rossier, 2010). Coefficient alphas were found for total score (alpha = 0.90) (Patterson, Uhlin, & Anderson, 2008). A Hebrew version of the scale yielded high Alpha coefficients (Ben Ami, 2012).

The therapist presence inventory (Geller et al., 2010)

TP was measured by a validated Hebrew translation of the TPI-T scale (Ben Ami, 2012). The Therapist Presence Inventory (Geller et al., 2010) includes two forms, the therapist (TPI-T) and the client (TPI-C). Both are self-report questionnaires with 7-point Likert-style scaled responses. The TPI-T consists of 21 items on which the therapist rates his or her own level of presence in the preceding session. The TPI-T has been found to have Cronbach's alpha of 0.94 and internal consistency ranging from 0.88 to 0.94 (Dunn, Callahan, Swift, & Ivanovic, 2013).

Semi-structured interview

Semi-structured face-to-face interviews were conducted with course graduates three months after course completion. The interview guide was developed by the two authors, who are clinicians and psychotherapy researchers, and was audited by a third researcher from a different university. The interviewer was a female graduate student, who did not participate in the course, and was blind to the research questions. All questions were pretested on two pilot interviews, following which the interview guide was revised for clarity.

The interview focused on two main domains. First, the Students' experience during the course including significant moments and reflection of their learning process. The

second domain focused on students' perceptions of changes in their clinical work that they attributed to the course. They were asked to describe whether or not they were using any of the tools and skills learned in the course and provide examples.

The interviews were conducted at locations based the interviewee's preference and ranged between 1 and 2.5 h each. Interviewees were not offered pay or any benefits. In total, 17 alumni were chosen based on convenience of time and location. Thus nine graduates from the first course, five from the second, and three from the third ($N = 17$) were interviewed.

Anonymity was ensured by changing the names and identifying features of the participants in the verbatim before given to the research team. All interviewees signed an informed consent form and could end the interview at any time. All interviews were recorded and fully transcribed independently by the interviewer.

Procedure

The course was taught three times consecutively (Fall 2013, Spring 2014, and Fall 2014) to groups of 14–16 social workers in the clinical MSW program. The pre-course questionnaires were delivered electronically to the entire cohort of first- and second-year MSW student from the second researcher's lab and covered much larger themes of therapist training. This was done in order to mask the focus on the research. The main researcher, who was also the teacher of the course, was blind to whether class participants filled out the research questionnaires and their data.

The second round of questionnaires was administered electronically after the completion of the semester to all participants in both groups who had completed the first questionnaire. The final questionnaire was also administered electronically, three months after the end of the semester, to both groups. In this paper, only subjects who completed all three questionnaires were included in the quantitative analysis, hence the larger number of controls than study group.

Results

Quantitative results

Changes in flexibility, collaborative tendency, and TP along the three time points were assessed using ANOVA with repeated measures. Pearson correlations and linear regressions were used to explore relationships between the variables.

Changes in flexibility and open-mindedness

To test differences in levels of flexibility between course participants and the control group, a two-factor, repeated measure ANOVA (time by group) was conducted. Results showed that differences between groups and across three time points was not significant (p = ns) in the DPCCQ questions. Factor analysis of the additional questions written for the study found the three questions regarding open-mindedness as a separate factor. Therefore, in order to examine the effects on open-mindedness of the course immediately after its completion, an ANOVA was conducted for Time 1 and Time 2 only. In Time 1, the study group's scores were not significantly higher than controls. A

significant difference was found between the mean flexibility of the two groups in Time 2 [$F(1,79) = 7.08$, $p < 0.01$]. Course participants had significantly higher open-mindedness scores than the controls. Figure 1 shows that general pattern of difference persisted through Time 3, although at that point the differences were no longer significant.

Changes in collaborative tendency

To test the effects of the training on collaborative tendency, a repeated-measures ANOVA was computed on general as well as sub-scales of the WAI-SR. No significant differences were found in levels of WAI-SR scores between groups or across times (Table 2). An examination of the data showed that WAI-SR ratings were consistently high in both groups.

Changes in therapeutic presence

To test the effects of the training on TP, a repeated-measures ANOVA was computed on the two groups at all three time points. No main or interaction effects were found. However, when we conducted a repeated-measures ANOVA for Time 1 and Time 2 only, we found an interaction effect [$F(1,1) = 3.69$, $p < 0.05$], which shows that the TP level of the study group improved significantly between Time 1 and 2, whereas no such improvement was found in the control group. Once again, the study group scores continued higher in Time 3, although the difference was not found to be significant (see Figure 2).

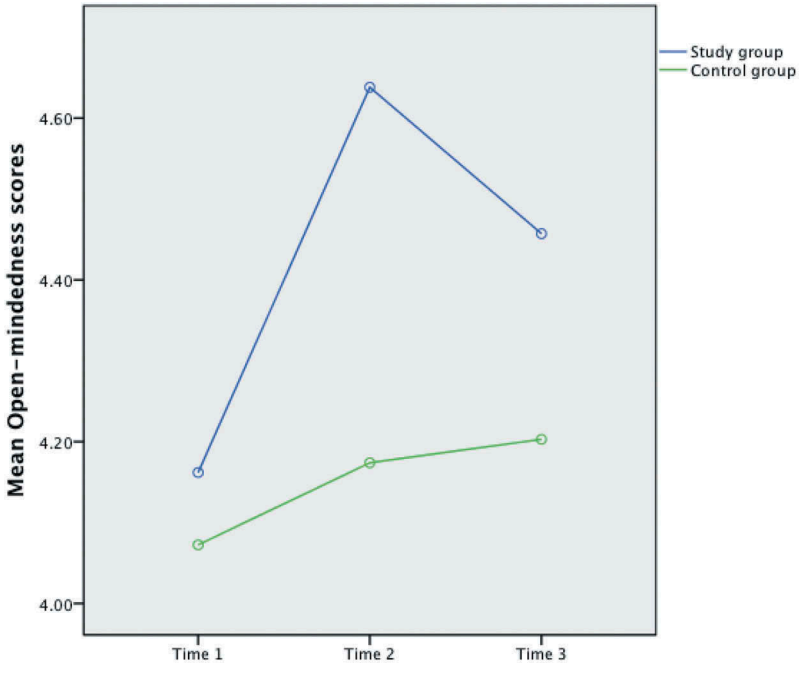

Figure 1. Means in Open-mindedness scores in study and control group at three time points.

Table 2. WAI-SR scores in study and control groups at three time points.

	V2	*N*	Mean (divide by 12)	*SD*
WAI-SR Time1	Study	35	4.507	8.772
	Control	46	4.623	7.182
WAI-SR Time 2	Study	35	4.638	7.722
	Control	46	4.663	7.004
WAI-SR Time 3	Study	35	4.647	7.348
	Control	46	4.581	8.546

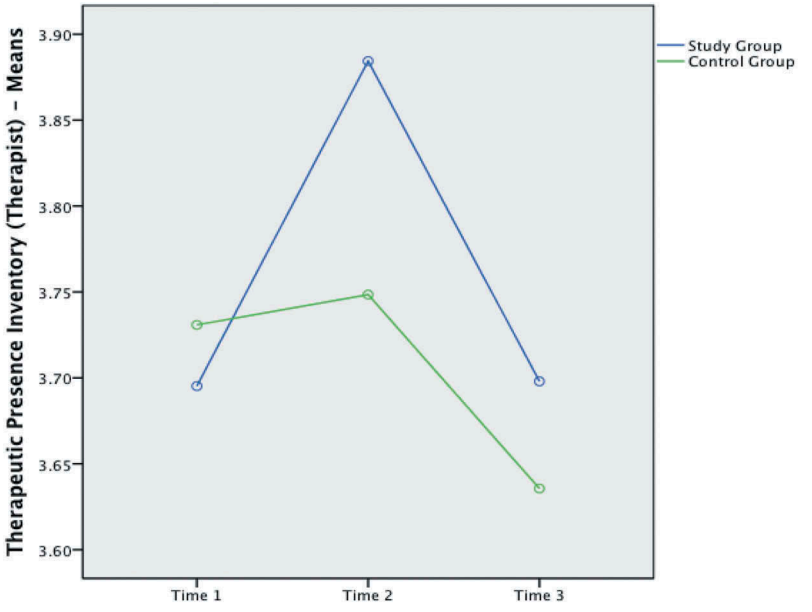

Figure 2. Means in TPI-T scores in study and control group at three time points.

Summary of quantitative results

Participating in the course was related to significant improvement in self-reported flexibility and TP immediately following the course. Collaborative tendency did not change following the course and remained high throughout the study. Results show similar overall patterns in the measures of flexibility and TP. In Time 2, the study group generally showed greater improvement and scored higher than the control. Study group maintained higher scores at Time 3 but the difference between groups was no longer significant.

University course evaluations

To check the reliability of these results, and to ensure that social desirability was minimal, these results were compared with the data from the anonymous university course evaluation scores, administered by the university computer system to all courses given every semester. All three improvisation courses got very high satisfaction rates by course graduates (9.4–9.58 points from a possible 10), ranking these courses fourth best

of 91 courses given that year. More detailed remarks included reports of increased vitality, interest, practical skills, and increased congruence, as well as constructive feedback that the course was too short and requests for a year-long training. These remarks were of similar nature to the interviewees' reports.

Qualitative results

The qualitative analysis focused on shared terms, concepts, and descriptions (Moustakas, 1994), which were generated by the interviewees to depict their experience of improvisation and spontaneity during the course and in their clinical work. Categories of information were created through open coding and discussion within the research team. These categories were given names based on the interviewees' phrases (Creswell, 2003). This information was then developed into an initial coding paradigm portraying the interrelationship of the categories of information (Strauss & Corbin, 1990), which enabled an initial charting of the process of learning and implementing improvisation in therapy.

As an additional precaution against possible preconceived biases of the first author, the second author also coded independently the interviews, with an additional researcher serving as an auditor of the meaning codes and categories.

The results of the qualitative analysis focus on three domains: changes in flexibility, changes in TP, and challenges in mastering skills.

Categories

Consensual Qualitative Research (CQR) guidelines were used for establishing category frequency levels (Hill et al., 2005): General pertaining to all or all but one cases (16/17), typical pertaining to more than half and up to the cutoff for general (9–15), variant pertaining to between three-and-half of the cases (4–8), and rare pertaining to two to four cases (see Table 3).

Changes in flexibility

Fourteen participants reported changes that can be conceptualized as higher levels of flexibility due to the course.

Higher levels of mental and emotional flexibility—'I'm examining this together with her'. Nine participants reported being more adaptable to their clients' positions and needs in the session. Participant 12 enhanced this description by saying:

> I'm more aware and understanding of what my client is going through and what he needs from me about this specific thing. I also try to ask myself at this point what he needs from me and how this moment now will lead to a place of growth.

Flexibility was increased due to lessening the tendency to block their client's relational moves (Stern, 2004) or offers, as Participant 15 demonstrates:

> I'm more accepting and less blocking… I'm even thinking to myself: here I blocked my friend, here I blocked my client.

Table 3. Domains 1, 2, and 3, categories and category frequencies.

Domain	Category	Frequency
Changes in flexibility	Higher mental and emotional flexibility	Typical (9)
	Open-mindedness	Typical (12)
	Willingness to try new things	Variant (8)
Changes in therapeutic presence	More presence	Typical (11)
	Improved awareness of feelings	Typical (15)
Challenges in mastering improvisation skills after the course	Training too short	Typical (9)
	Challenges of integrating improvisational skills into clinical work	Variant (4)
	Socialization challenges	Variant (6)

Open-mindedness to seeing situations from multiple perspectives—'I can hear voices and feelings that are not being said'. Twelve participants reported being more open-minded to what is happening in the session, being aware of different perspectives in themselves and the clients: 'I can hear voices and feelings that are not being said … That I can go along with' (Participant 1). Participant 9 complements this theme: 'I'm noticing more how I react, as well as noticing what I'm enabling or not enabling. This is supposed to happen anyway, but the course helps you be more aware … of reactions, blocks, words.'

Willingness to try new things and change views—'I'm taming myself less'. Seven participants reported an increased willingness to try new things due to the course:

> It allowed me to dare a little, to speak about things I used to be scared to.… It gave me the confidence that nothing will happen if I do something now, you can always go back and open it again. (Participant 7)

Changes in therapeutic presence

In total, 16 participants reported changes in relation to their perception of self and behavior in the sessions that relate to the construct of TP—namely the themes of presence and mindfulness during the clinical hour.

More presence in therapy—'Just what is there now, that is what there is'. Eleven participants reported feeling more present in the clinical encounter, connecting to themselves and the client.

> Really, the increased connection to yourself and the other together in the here and now, and to be wherever you are. And then you are connected, and connected to everything—intuition, spontaneity, you are bare, and like, it's all built in. (Participant 4)

Others expanded on the feelings of being in the 'here and now' during the therapy sessions: 'Something about being in the here and now. Truthfully, that is something that has changed a lot in my work … Just what is there now, that is what there is' (Participant 3).

Improved awareness of their emotions—'If I do work from my brain, I get stuck'. Fifteen participants reported being more mindful of their feelings and associations during therapeutic sessions with their clients. Participant 6 articulated this experience:

> I am more aware of my feelings. . . . So there is something in improvisation itself, in the games and exercises that I work from my emotion and not from here [points to his head]. I can't. Because if I do work from my brain, I get stuck.

Challenges in mastering improvisation skills after the course

Eleven participants reported that even though their perception and practice changed due to the course, there were challenges in deepening their implementation of the skills and tools after course completion.

Training is too short—'It's all really new, so first I tried it on myself'. Nine participants said that they felt the training was not long enough for them to internalize the skills sufficiently. Participant 1 reported that 'The course was really short, we felt were weren't succeeding. I felt it wasn't enough and that I need more and more practice.' Participant 9 added:

> It took time until I took the course into the therapy room, and a semester-long course is not a lot of time. . .. But there were moments when I saw it influencing the relationship, something more relaxed in the room.

Challenges of integrating improvisational skills into clinical work: 'It was a taster.' Most of these participants spoke about the difficulty of integrating and executing the improvisational stance and skillset. Participant 10 reported:

> Since the course ended, all these things fade away. You go back to your old ways really fast. . . I try to improvise, but I'm not improvising. I'm doing it superficially and not from the inside, so it's not what it should be.

Participant 2 adds to this theme: 'When I don't have the framework, things disappear…. If there is something I wish would remain [from the course] it's the courage and the experience, so that I can keep experiencing that in my work.'

Socialization challenges 'I would rather be quiet than make a mistake'. Six interviewees recognized that the difficulty in implementing these skills was due to earlier socialization from the academy and/or supervision. Participant 3 reports: 'I'm a student, and my supervisor would write on my reports "you should've said this" or "I would've said that." … So there was fear, and I would rather be quiet than make a mistake.'

Discussion

The goal of this study was to examine possible effects of training clinical social workers in theater improvisational skills, in relation to flexibility, TP, and collaborative tendency. As shown above, the quantitative results show a general pattern of higher scores for the study group in Time 2, but these differences were not maintained in Time 3. These results convene with the interviews to show an increase in flexibility and TP immediately after the course. Therefore, we can carefully assume that the hypothesis that the course will increase the sense of flexibility and TP was confirmed for the immediate post-course period. The hypothesis of an increase in collaborative tendency was not supported.

Flexibility

The results showing significantly higher levels of open-mindedness immediately following the course can be triangulated with qualitative reports of feeling more flexible, open-minded, and willing to try new things. These qualitative domains resonate with the definition of flexibility in previous research (Ackerman & Hilsenroth, 2001; Lough et al., 2012). In the interviews, flexibility was experienced as less blocking of the client's offers. Blocking (Johnstone, 1989) refers to the act of negating your partner's perception of reality when improvising (for example 'you are not my mother, you are my brother'). Instead, interviewees reported saying 'yes' to the client, and feeling more open in the session due to reduced fear of making mistakes. The quantitative results at Time 3 show a decrease in flexibility, which can be understood through the qualitative domain 'challenges in mastering skills'. In that domain, interviewees reported not only socialization challenges, but also articulated the difficulties of mastering improvisation skills in a short period of time.

Collaborative tendency

Collaborative tendency did not increase following the course. It is possible that most of the participants in both the study and control groups were social workers with adequate experience in alliance-building skills. Thus, alliance scores in both groups may indicate a 'ceiling effect' (Austin & Brunner, 2003). Perhaps the main contributions of the course are not in basic alliance skills but rather in the more complex relational dimensions. These advanced dimensions are usually necessary and appear later in the therapeutic relationship, as clinicians and clients deal with more painful issues and ruptures in the alliance (Safran, Muran, & Eubanks-Carter, 2011).

Therapeutic presence

Increased scores of TP in Time 2 convened with the qualitative reports of an increased sense of mindfulness and presence (Greenberg & Geller, 2001), which are core aspects of TP (Geller & Greenberg, 2012). The drop in the quantitative measure of TP in Time 3 was in contrast to the positive reports regarding increased presence and awareness of emotions in the interviews.

Integration of results using the theory of planned behavior

As shown, the quantitative results at Time 3 did not completely convene with interview results in relation to flexibility and TP. These discrepancies are important in integration (Green et al., 2015) and could be a result of the different foci of each of the research arms: The quantitative data focused on conscious behaviors and interventions, while the qualitative data focused on perceptions and values. It is possible that the course had lasting effects with regard to ideas and concepts regarding improvisational skills in therapy, but that additional training was needed for improvisational skills to be experienced on the *practical* level of interventions. The relationship between impact

on concepts and behaviors within a learning process can be understood through the framework of the theory of planned behavior (Ajzen, 1991).

The Theory of Planned Behavior (Ajzen, 1991; Ajzen, 2002) states that human behavior is dependent on behavioral intentions, which are influenced by three categories of beliefs (see Figure 3).

Attitudes toward behavior are beliefs about the likely consequences of a newly learned behavior. For example, the belief that use of theater improvisational skills can help therapy outcomes. The second category, subjective norm, refers to beliefs about the normative expectation of society or others to this behavior. In our study, this was reflected in interviewees' anxiety that improvisational skills might be perceived as 'unprofessional'. Lastly, perceived behavioral control refers to beliefs about one's ability to successfully perform a behavior. In the current study, this category was expressed to be interviewees' beliefs regarding their ability to use their improvisational skills efficiently following the course. These three categories together formulate the behavioral intention, which when given the opportunity, will lead to perform the new behavior: the use of improvisational skills in therapy.

Through this prism, we could interpret the quantitative increase in flexibility and TP in Time 2 as an indication of increased behavioral intention toward improvisational behavior in therapy. This increase could be explained through changes in the belief categories influenced by the course experience. Qualitative data indicate that during the

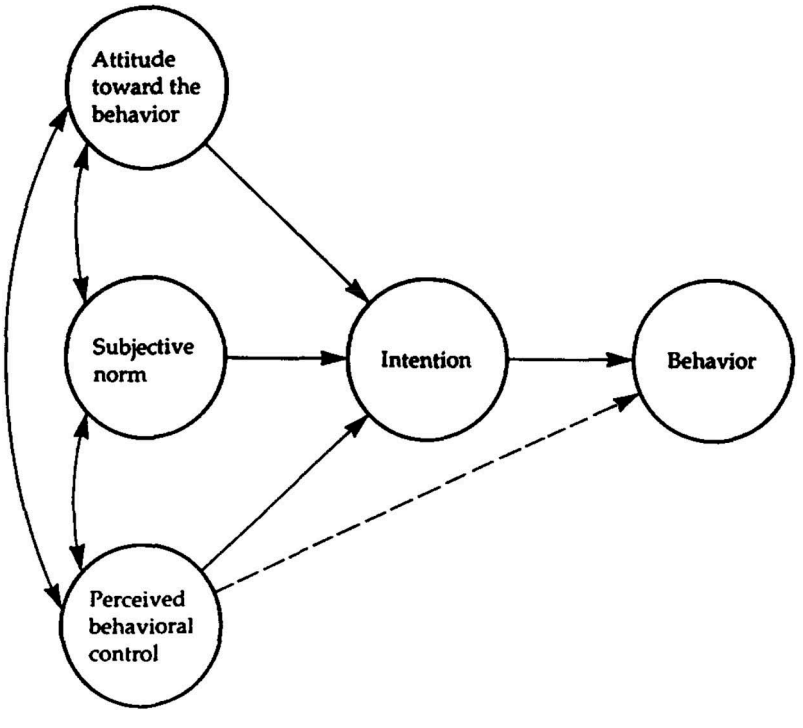

Figure 3. Theory of Planned Behavior. Reprinted from 'The Theory of Planned Behavior' by I. Ajzen (1991), *Organizational Behavior and Human Decision Processes, 50*, 182. Copyright by Elsevier. Reprinted with permission.

course, interviewees developed positive attitudes toward improvisational skills in therapy (attitudes toward behavior), while being immersed in an environment instilling a belief that improvisation was important to clinical work (Subjective norm), thereby perhaps increasing behavioral intention in their clinical work.

This model can also explain the weakening in the behavioral intention at Time 3. Following the course, some interviewees continued to question whether improvisational skills were legitimate in clinical practice. It is possible that this weakening of the subjective norm developed due to their continuing work in agencies that hold to a traditional view of psychosocial clinical work, where improvisation is neither valued nor encouraged.

Evidence for a lowered perceived behavioral control in Time 3 can be found in qualitative reports of feeling inadequate and not skilled enough to successfully use improvisational skills in the clinical session. This data were also expressed in the lower quantitative open-mindedness scores at Time 3.

Implications for training

There is a call for more experiential, arts-based training (McKinney, O'Connor, & Pruitt, 2016) and specifically theater improvisation skills training (Todd, 2012) of social workers. While clinical improvisation training may sound unorthodox, it important to note that the exercises used to practice the improvisational skills are not meant to be implemented in the clinical encounter. That said, improvisation skills can help social workers understand and practice their un-knowing (Blom, 2009): the use of intuition, openness to unpredictability, and co-created change process. Moreover, these skills can also improve their responsiveness to clients' changing needs (Stiles, 2009, 2013), which current research has shown to be an important factor in therapy outcome (Constantino, Boswell, Bernecker, & Castonguay, 2013; Stiles & Horvath, 2017).

We therefore recommend combining experiential theater improvisation training together with traditional supervision to help solidify clinical social workers' newly acquired skills by strengthening the belief categories of perceived behavioral control and subjective norm. This type of experiential learning could help clinical social workers develop a deeper, more accessible, and lasting mastery of these skills, thereby finding a balance between the 'science' and 'art' of social work (Grady & Keenan, 2014). Our data, together with university evaluation reports, suggest that this type of training should be longer in order to increase participants' perceived behavioral control as well as to allow for a longer improvisation-friendly subjective norm. Longer improvisational training can help clinical social workers widen the prism through which they observe and asses their clients, thus leading to more possibilities in their interventions.

It is worthwhile noting that this type of training may not less suitable for the novice social worker, who is still developing basic mastery of social work practice. Once these social workers have mastered the core skills, they can start being flexible in their practice, based on careful deep attunement to the unique need of every client. These improvisation skills are not intended to replace evidence-based interventions and models, but rather facilitate alliance building and maintenance, including rupture resolution. Social workers should therefore find a balance between structure and spontaneity depending on the specific needs, symptoms, and characteristics of their clients.

Limitations and further research

As an exploratory research, the first author also taught the improvisation course, and therefore there is a threat of priming. This was done due to the first author's expertise both in psychotherapy and improvisation. Moreover, it was necessary to conduct this preliminary research before training others to teach this course. In order to avoid the researcher's priming, multiple strategies were employed (see methodology), and we believe they were quite effective. Still, future studies will benefit from replicating the course with different teachers that can be trained using the same protocol, in order to minimize possible priming effects.

Second, allocation to study and control groups was not completely random, due to the structure of the academic setting. Future research could randomly allocate participants to either control or study group, with two controls groups: those who wanted to partake in the course but ultimately did not, and those who are not interested in the course.

Lastly, this study focused only on clinicians and did not investigate the experience of their clients. In this research, it was not possible to collect data from clients due to logistical and ethical factors. Future research could pair social workers' and clients' post-session reports to better establish the effectiveness of this training (for example, using matching WAI-SR and TPI-C client questionnaires). Incorporating videotape analysis by independent coders would help to further assess and even quantify any changes in the intersubjective field following such training. Such steps could help advance the theoretical and procedural understanding of the role of improvisation within the change process in therapy.

Disclosure statement

No potential conflict of interest was reported by the author.

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