Clinical record-keeping and client tracking practices within the arts therapies

Jodi Batty

u14012368

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Supervisors: Dr Carol Lotter and Dr Andeline Dos Santos

Abstract

The arts therapies are recognised healthcare professions regulated by the Health Professions Council of South Africa (HPCSA). Among other responsibilities the HPCSA provides guidelines and procedures to enable practitioners to adhere to ethical practices during their work. Such practices include clinical record-keeping and client tracking (CRCT). Each arts therapy modality practices CRCT according to its specialised clinical training. Despite working primarily in the modality of their specialisation, arts therapists might include other creative mediums, such as music, art, drama, dance, etc. during the therapy process. For this reason, it is necessary for arts therapists to familiarise themselves with CRCT processes that apply in other arts therapies. As there has not been a review of literature that provides an understanding of CRCT practices across all four arts therapies modalities, this qualitative study aims to (i) adopt a narrative approach in reviewing the literature to explore CRCT practices in arts therapies across the world and (ii) through questionnaires explore the experiences and insights of arts therapists in South Africa regarding the application of CRCT in their specific modality. This study is therefore guided by two research questions, namely (i) What knowledge does the published literature in the arts therapies convey regarding CRCT practices? and (ii) What CRCT practices are used by South African arts therapists? A rigorous, four-step screening process of available literature was followed, and 22 data sources were selected to be part of the narrative literature review of the study. During the screening phase, the data sources were analysed for literature pertaining to the research question. A total of ten themes were identified to guide the study. An invitation to participate in this study was sent to all arts therapists in South Africa who were listed on the database of the South African National Arts Therapies Association (SANATA). A total of nine participants agreed to participate and completed the questionnaires. Questionnaire data was analysed using the six steps of thematic analysis and a total of 42 higher-level codes emerged. This study concludes with ten themes from the narrative literature review, supported by higher-level codes that speak to the practices of CRCT and how these might be useful and implemented in practice in the work of arts therapists. The findings of the study explored both the themes of the narrative literature review, as well as the responses from the participants in the questionnaire and concluded that CRCT is a valuable practice in the arts therapies and should include aspects such as clinical note-taking, assessments completed by the therapist, client-centred approach to work, emphasis on training in CRCT, reflexivity in practice, focus on and adherence to ethical

work, manual or digital methods of practice in CRCT, the use of multimedia in work with clients and becoming familiar with CRCT practices used within other arts therapy modalities.

Keywords

Arts therapies

Music therapy

Drama therapy

Art therapy

Dance/movement therapy

Clinical records

Client tracking

Record-keeping

Administration

Practice standards

Reflective practices

Declaration form

UNIVERSITY OF PRETORIA

DECLARATION OF ORIGINALITY

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Full names of student: Jodi Sarah Batty

Student number: U14012368

Declaration

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4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

SIGNATURE OF STUDENT: 

SIGNATURE OF SUPERVISOR: CBhotter

Dedication

This study is wholeheartedly dedicated to my beloved family, who never failed to support me, even in difficult moments. To my darling husband, Justin, you have been a pillar of strength, an inspiration, and my biggest cheerleader, thank you. You helped me to stay strong when things felt too big to conquer. To my mother, you always believed in me throughout the years of studies and sacrificed so much to watch me achieve my dreams, you are so appreciated. Then to my in-laws and siblings, thank you for always rooting for me.

This study also would never have been possible without my supervisors, my mentors, and my fellow music therapy classmates, who shared their words of encouragement and offered so much advice to help me finish the study. You are all my inspiration!

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The completion of this study would not have been possible without the guidance and expertise of Dr Carol Lotter and Dr Andeline dos Santos, my wonderful supervisors. I owe a debt of gratitude to you both for the time, dedication and support you both gave in helping me to finish this study.

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Finally, to my editor, Rose, for your kindness in helping me to refine, edit and finish the study.

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Chapter One: Introduction

1.1 Background and Context

"Arts therapies" is an umbrella term for a group of therapies that use creative and expressive processes to meet health-related clinical goals with clients. A key focus is the therapeutic relationship between the client and therapist. Within this therapeutic relationship, the client may experience growth, change, and improved psychological and social well-being (Shafir et al., 2020). Arts therapies in South Africa include music therapy, art therapy, drama therapy, and dance movement therapy.

The arts therapies are recognised healthcare professions regulated by the Health Professions Council of South Africa (HPCSA). Under this council's guidelines, professionals are ethically obligated to create, keep, and safeguard documents and other materials related to the therapeutic process with clients. According to the HPCSA (2016), record-keeping is vital in guiding further sessions and clinical goals with a client, encouraging their ongoing well-being, and promoting research and good clinical practice within arts therapies. The HPCSA suggests that arts therapists keep clinical records stating the personal details of the client and their medical history, the time and date of every session, any assessment of the client's wellbeing, clinical goals, the client's engagement with and responses to the therapeutic process, times the client may have missed therapy sessions and reasons for missing sessions, as well as signed consent forms. The arts therapist should sign all clinical records with their name and signature and, where applicable, the client should also sign.

1.2 Definitions

The following section explains the key terms used within the study.

1.2.1 Clinical Record-Keeping

Alexander Mathioudakis et al. (2016) describes clinical record-keeping as an important aspect of professional practice in healthcare. Clinical records are valuable documents compiled by healthcare professionals and include clinical notes that document any relevant clinical information about the client, such as medical history, therapeutic processes, goals for the client's care, ongoing assessment of the client's goals and needs, and the healthcare practitioner's reflexive notes on the care provided to the client.

1.2.2 Client Tracking

Client tracking can be defined as a way of routinely monitoring a client's progress by a healthcare professional (Jensen-Doss et al., 2016). This would involve collecting data from sessions using available tools, such as standardised assessments and rating scales, and evaluating this data to reflect on clinical practice to provide feedback for clinical decision-making. Client tracking is usually ongoing.

1.2.3 Music Therapy

Music therapy is a formalised health profession using music-centred therapeutic techniques. Clinical goals are formulated through assessment and are implemented in a treatment program. Music Therapy is a healing tool for diverse clients with a wide range of challenges (Hagan, 2018).

1.2.4 Art Therapy

Art therapy entails the therapeutic use of artmaking to achieve clinical goals such as coping, relieving stress, increasing self-awareness, or enhancing cognitive abilities. This is achieved within the therapeutic relationship between the client, therapist, and the art form. Art therapy can be offered to a variety of clients who suffer from different illnesses, trauma, life challenges, or who seek personal growth (Edwards, 2014).

1.2.5 Drama Therapy

The therapeutic relationship is central in drama therapy. Clients engage in drama-based therapeutic processes as they explore life experiences to achieve greater insight and growth. Drama therapists use techniques such as storytelling, role play, mask work, improvisation, and puppet work in sessions with clients to achieve clinical goals. Drama therapists work with clients experiencing various emotional, cognitive, physical, and social challenges (Landy, 2006).

1.2.6 Dance Movement Therapy

Dance movement therapy is the psychotherapeutic use of dance or body movement to explore and understand emotional, social, cognitive, and physical processes. Dance movement therapy provides individuals with a multisensory experience to help them better understand, explore, acknowledge, and grow in relation to their therapeutic goals (Kiepe et al., 2012).

1.3 Research Problem

According to the HPCSA, the regulating body of arts therapies in South Africa, clinical record-keeping is vital to being an ethical and effective arts therapist. Each arts therapy modality—music therapy, art therapy, dance movement therapy, and drama therapy—practices record-keeping and client tracking according to their specialised clinical practice training. While arts therapists work primarily with the modality of their specialisation, other art forms can also be included in a therapy process, for example, a music therapist may include movement or work with images within a music therapy session. A music therapist, however, may be familiar with music therapy record-keeping practices but not necessarily with other arts therapies' record-keeping practices. There has not been a review of the literature that provides a comprehensive understanding of record-keeping and client tracking across the four modalities. To this end, I considered it a valuable exercise to review the literature and structure a questionnaire to establish the status of CRCT practices among arts therapists in South Africa.

1.4 Research Aims

In this study, I have drawn on a narrative literature review and data from questionnaires completed by arts therapists to address the research question. These two arms of the study address complementary facets of the study's aims.

Through the narrative literature review, I aimed to explore published literature on clinical CRCT practices in arts therapies across the world. I wanted to find out how arts therapists adhere to the ethical practices of CRCT.

Through the questionnaires, I aimed to explore the experiences and insights of arts therapists in South Africa regarding the application of CRCT practices in their specific modality to understand how arts therapists in South Africa are adhering to the guidelines of CRCT set out by the HPCSA. Questionnaires were sent to South African arts therapists only due to feasibility and this being a master's mini-dissertation.

1.5 Research Questions

The study was guided by the following questions:

> Question One: What knowledge does the published literature in the arts therapies convey regarding clinical record-keeping and client tracking practices?

Two sub-questions were in focus for this part of the inquiry:

> 1.1 What current practices of clinical record-keeping are used in the arts therapies?
>
> 1.2 What current practices of client tracking are used in the arts therapies?

> Question Two: What clinical record-keeping and client tracking practices are used by South African arts therapists?

1.6 Chapter Overview

This chapter aimed to introduce the topic of this study as well as provide the reader with clear definitions and descriptions of relevant information relating to the topic. Furthermore, the research aims and questions were stated for the study. Chapter two will provide the methodology of the study. I chose to make use of a narrative literature review with questionnaires. The methodology precedes the narrative review, as the narrative review and questionnaires within the study inform each other. The narrative literature review is also part of the methodology of the study, making this more understandable. Chapter three provides an overview of the data collection process for the narrative review, data analysis and the findings of the narrative review. Chapter four presents the findings of the questionnaire data. Finally, Chapter five discusses the findings from the narrative review and questionnaires and provides reflections and conclusions for the study.

Chapter Two: Research Methodology

This chapter provides the motivation for using a narrative literature review and questionnaires to explore the relevant research questions in this study. Due to the narrative literature review being part of the methodology of the study, this chapter on research methodology precedes the following chapter, which presents the narrative literature review.

2.1 Phase One: Narrative literature review

This study focuses on CRCT within the arts therapies both globally and in South Africa. Due to the broad nature of this topic, the limited scope of a mini-dissertation, and the fact that questionnaires were also used for data collection, a narrative literature review was selected (as opposed to a more extensive systematic literature review). A narrative review offers a comprehensive narrative synthesis of previously published information on the topic of interest. This overview of information was useful for the current study, as it offered a means of synthesising multiple sources of information concisely (Green et al., 2006). Furthermore, narrative reviews aim to identify and summarise information that has been previously published and seek new study areas (Ferrari, 2015). A limitation of narrative reviews is their lack of rigorous and systematic data gathering (as one would find in a systematic literature review). For this reason, a detailed search strategy was intentionally employed. Due to the topic being expansive and explorative, a narrative review enabled the gathering of broad information instead of being limited by narrow inclusion criteria.

2.1.1 Search Strategy

The following databases were used to identify relevant literature for review:

- Google Scholar
- SAGE
- EBSCO Host

- Science Direct

Data sources were included if they met the following criteria:

- A peer-reviewed journal article
- Book chapters
- The text was in English.
- The text was published between 1990 and 2023.
- Full access was available through the University of Pretoria's library website.

Keywords were used to search within these databases. Dixon-Woods et al. (2007) suggest expanding certain search words, which involves identifying words that may be used with a similar meaning or in the same context, to identify additional relevant literature. Table 1 provides the list of keywords and expanded keywords that were used when searching the databases. The table can be found on the next page.

Table 1

Search Words for the study: Clinical Record-Keeping and Client Tracking Practices within Arts Therapies.

THERAPY MODALITY	BROAD TERMS RELATING TO THERAPY MODALITY	EXPANSION OF TERMS RELATING TO BROAD TERMS
"Arts therapies" Or "Creative arts therapies" Or "Creative Therapies"	"Documentation" Or "Client Tracking" Or "Clinical record-keeping" Or "Assessment in" Or "Evaluation" Or "Administration"	"Keeping records" Or "Client progress" Or "Assessment tools" Or "Standardised assessment tools" Or "Safekeeping records" Or "Note writing" Or "Reflection practices" Or "Practice standards"

"Music therapy"	"Documentation"	"Keeping records"
	Or	Or
	"Client Tracking"	"Client progress"
	Or	Or
	"Clinical record-keeping"	"Assessment tools"
	Or	Or
	"Assessment in"	"Standardised assessment tools"
	Or	Or
	"Evaluation"	"Safekeeping records"
	Or	Or
	"Administration"	"Note writing"
		Or
		"Reflection practices"
		Or
		"Practice standards"

"Dance Therapy"	"Documentation"	"Keeping records"
Or	Or	Or
"Dance movement therapy"	"Client Tracking"	"Client progress"
	Or	Or
	"Clinical record-keeping"	"Assessment tools"
	Or	Or
	"Assessment in"	"Standardised assessment tools"
	Or	Or
	"Evaluation"	"Safekeeping records"
	Or	Or
	"Administration"	"Note writing"
		Or
		"Reflection practices"
		Or
		"Practice standards"

"Drama therapy"	"Documentation"	"Keeping records"
	Or	Or
	"Client Tracking"	"Client progress"
	Or	Or
	"Clinical record-keeping"	"Assessment tools"
	Or	Or
	"Assessment in"	"Standardised assessment tools"
	Or	Or
	"Evaluation"	"Safekeeping records"
	Or	Or
	"Administration"	"Note writing"
		Or
		"Reflection practices"
		Or
		"Practice standards"

"Art therapy"	"Documentation"	"Keeping records"
Or	Or	Or
"Fine art therapy"	"Client Tracking"	"Client progress"
	Or	Or
	"Clinical record-keeping"	"Assessment tools"
	Or	Or
	"Assessment in"	"Standardised assessment tools"
	Or	Or
	"Evaluation"	"Safekeeping records"
	Or	Or
	"Administration"	"Note writing"
		Or
		"Reflection practices"
		Or
		"Practice standards"

The following steps were followed to screen the texts that were identified:

- The first screening was of the titles and abstracts. If the titles and abstracts seemed to support the research questions or aims of the study, they were included in the next screening step.
- The second screening was to ensure there were no duplicates.
- The third screening was of the full articles or chapters. As a significant number of texts were found, only the most relevant ones, texts that spanned all the arts therapies, and

those that gave the richest information on the topic were chosen to give a spectrum of insights to draw from in the narrative review.

2.1.2 Synthesising the Literature for the Narrative Literature Review

I extracted relevant information from each text that addressed my research question. This information was captured in a table, which will be included in Chapter three. This also helped in creating links between the literature and the questionnaires during the discussion and reflective sections of this study.

2.2 Phase Two: Questionnaires

In addition to the narrative review, three HPCSA registered therapists from each modality (music, art, drama, and dance movement) were invited to complete a questionnaire about the CRCT practices in their specific arts modality. The aim of the questionnaire was to invite the arts therapists in South Africa to think about their own CRCT practices and that their answers would help me understand CRCT of arts therapies in South Africa. As Eckerdal and Hagstrom (2016) explain, questionnaires in research can be a useful tool for gathering insightful information through open-ended questions about the experiences of the participant. The questions were informed by the findings and themes of the literature review. This link was to enable a comparison between global views and South African views on CRCT within the arts therapies. It was also to provide a clear and concise understanding of CRCT in South Africa, which may be useful in providing arts therapy practitioners in South Africa with insight into current views and practices in the country on the subject.

2.2.1 Participants

I aimed to recruit a total of 12 HPCSA registered participants. In their study named, *How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability,* Guest et al. (2006) found that data saturation was reached in interviews with twelve participants and that themes were already emerging within the data as early as with six participants. Three HPCSA registered participants from each arts therapy modality (music, art, drama, and dance movement) in South Africa were asked to participate in the study and to complete a Google form questionnaire if they consented to participate. Participants were invited through their emails,

which were available publicly on the SANATA website and the first 12 who were interested received information forms and were asked to sign consent forms. In the case that more than twelve participants (or more than three per arts therapy modality) were interested in participating, I planned to select only the first 12 who showed interest and notify the other interested participants of this. If a participant chose to discontinue their participation at any point, a previously interested participant was contacted and offered the chance to participate.

2.2.2 Data Collection

Questionnaires were designed in accordance with the advice of Eckerdal and Hagstrom (2016) who suggest designing questions that help the researcher gather rich information that aid in answering the research question. In this study, the important themes included: (i) clinical record-keeping and (ii) client tracking practices of South African arts therapies and (iii) the themes from the narrative review findings. Therefore, the questions centred around these three focal points. The questions were open-ended, clear, and concise. The questionnaire consisted of ten questions and were designed to address themes from the literature as well as identify gaps in the literature from the narrative review. This allowed for an interesting comparison between the literature and the responses from South African arts therapists.

Data from questionnaires was captured on Google Forms using pseudonyms.

2.2.3 Analysis of the Questionnaire Data

Responses to the questionnaire were analysed using reflexive thematic analysis (Braun & Clarke, 2019). Using thematic analysis allowed me to create high-level codes for the answers to the questions that could be compared under the themes that were created from the narrative review. Thematic analysis involved searching across the data from the questionnaires with the intention of identifying, analysing and reporting on repeated themes and patterns in the data through coding. In Braun and Clarkes' paper, they describe coding qualitative data as a robust and systematic process, which can be used to identify existing patterns across a data set to answer the research question. Kiger and Varpio (2020) describe Thematic analysis as one of the most highly employed forms of data analysis that involves using data to understand experiences, thoughts, and behaviours of participants in research and aims to identify, analyse and report on repeated patterns within the data. Whilst TA is a method of describing data, it is also a method of interpreting data, as it involves creating codes and themes. Themes and codes provide a clear and

concise way of reading and understanding data from multiple participants (Kiger & Varpio, 2020). In this study, the findings from the narrative review became the themes, and Braun and Clarke's (2006) six step analysis was used to find higher-level codes that could be linked to the themes from the narrative review.

The process of reflexive TA involved the following six steps:

- Familiarisation of data: reading and familiarising oneself with the data.
- Initial coding: creating codes/labels for parts of the data that might help one answer the research questions.
- Generating potential higher-level codes: examining the initial codes to identify potential, existing patterns, and generating possible higher-level codes from this.
- Reviewing higher-level codes: refining the higher-level codes and making sure they relate clearly to the collected data from questionnaires. This also involved me sorting the initial higher-level codes by applying them to broader patterns of meaning and providing subheadings where necessary.
- Defining and naming the higher-level codes: creating names and meanings for each higher-level code. For this study, this step will be creating high level codes under the existing themes from the literature. This will be linked to each question in the questionnaire, as the questions were designed around the findings from the narrative review.
- Writing up the higher-level codes: discussing and reflecting on the higher-level codes and linking them to the themes from the narrative review.

2.3 Phase Three: Reflecting on the Narrative Literature Review and the Questionnaire Responses

The themes from the narrative literature review were then explored in relation to the higher-level codes that were developed from the questionnaires. This helped to show the links in CRCT practices from across the world and those of South African arts therapists. These subjects form part of the discussion in chapter five.

2.4 Ethical Considerations

Participants were informed of the nature of this study and its objectives. (See Appendix A for the information form and Appendix B for the consent form.) Participants gave consent for their questionnaire answers to be used as research data in the study. Confidentiality was maintained by not using participants' names but rather calling them Participant A, B, C, etc.

Questionnaires are kept electronically in a secure password-protected folder on Google Drive. As per the University of Pretoria regulations, the data in this study will be archived in FigShare for ten years. Other researchers may use the archived data if they wish.

Ethical approval was received from the University of Pretoria's Humanities Research Ethics Committee. The approval number is HUM030/0922.

2.5 Research Quality

Flick (2009) describes trustworthiness, credibility, transferability, and confirmability as important considerations when conducting qualitative research. This statement is supported by Mays and Pope (2000), who argue that there is no easy solution when it comes to research quality in qualitative research, but that aspects such as trustworthiness, triangulation, clear exposition of methods, reflexivity and relevance are valuable.

The data collection process for the narrative review required a vigorous and clear screening of data sources to ensure they met the inclusion criteria. The analysis of the data from questionnaires included the six clear and academically recognised steps of Braun and Clarke's (2006) thematic analysis. Trustworthiness was enhanced through triangulation, wherein more than one perspective was gathered and analysed in both the narrative review and the questionnaires. The views of respondents in all four arts therapy modalities were also included. All included data sources for the narrative review were peer-reviewed and all participants were qualified arts therapists with HPCSA registration in South Africa. Furthermore, I reflexively examined my role in the creation of the themes through keeping a reflexivity journal and engaging in supervision. At all times during data collection, data analysis, interpretation, and the representation and discussion of findings, I held the topic and research questions at the forefront

of my mind to maintain relevance. Finally, the extent to which the findings impact both working arts therapists and training arts therapists is explored. Limitations of the study are also acknowledged.

Chapter Three: Narrative Literature Review

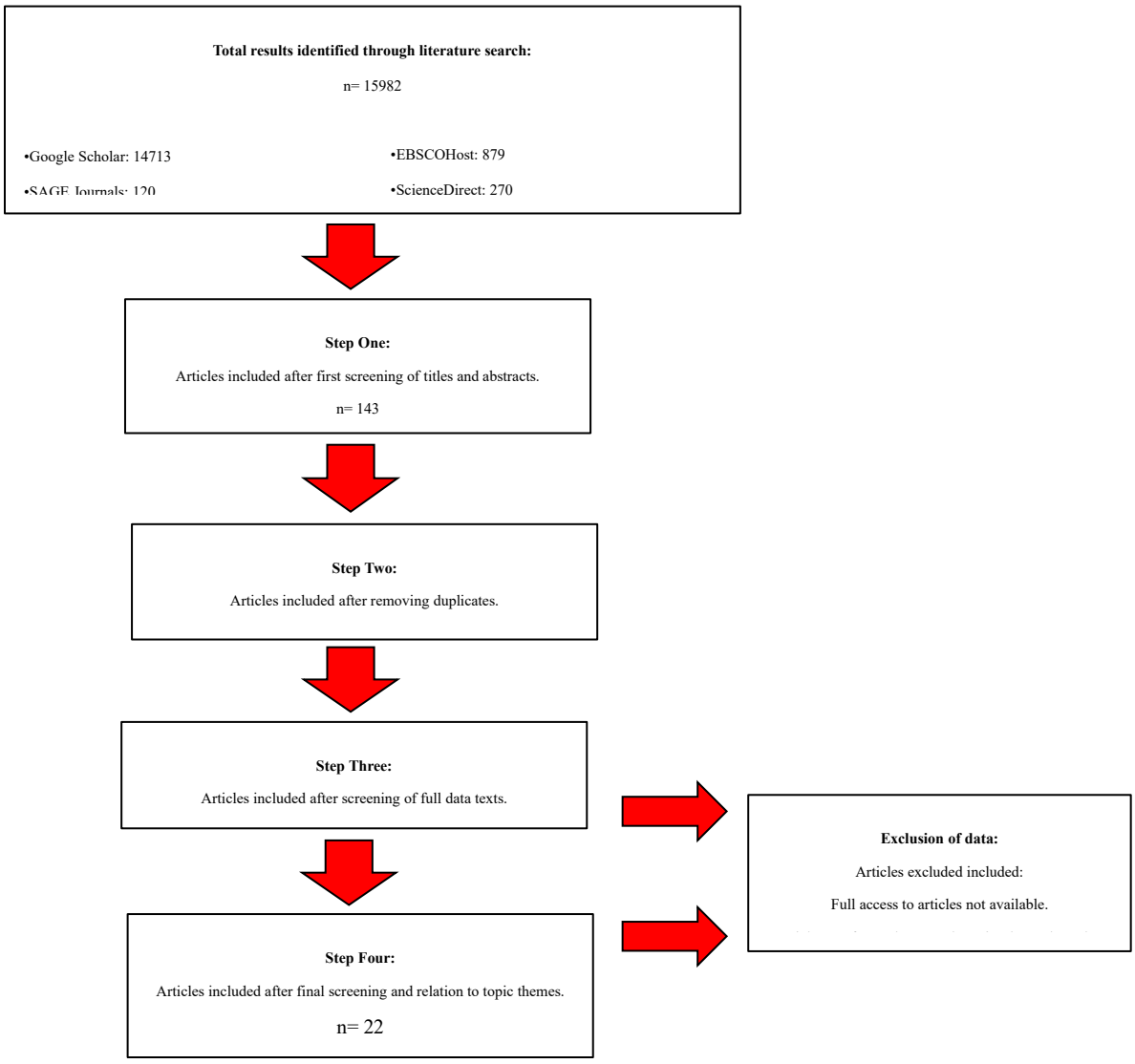
This chapter begins with a description of the process of identifying relevant literature and developing key themes based on these texts. The themes are then discussed.

3.1 Data Collection for the Narrative Literature Review

Due to some databases containing a high volume of studies related to the keywords, and due to the feasibility constraints of this mini-dissertation, only the first 100 articles were perused for possible inclusion in the narrative review. The following page displays the flowchart of the data collection process that was followed.

Figure 1

Flowchart of the Screening Process for the Narrative Review



3.1.1 Overview of the studies included in the narrative review.

A total of 22 studies were identified for inclusion in the narrative review. Seven of these were journal articles from books, three were mixed-methods studies, 11 were qualitative studies and one was a quantitative study.

Table 2 provides a summary of the content that was extracted from the studies that was relevant to answering the research questions. Each study was summarised, and the table includes the following information:

- Author/authors
- Publication Year
- The article type
- The participants in the study
- The focus area/theme within CRCT in my study

Table 2

Summary of data included in narrative review.

Study no.	**Author**	**Data source**		**Participants**	**Clinical record-keeping and client tracking practices**
		Year	**Type**	**n**	**Focus area in review**
1	Wigram	2007	Journal article from book	0	Importance in practice Assessment in practice Clinical note-taking in practice

2	Wheeler	2015	Journal article from book	0	Clinical note-taking in practice Assessment in practice
3	Gussak & Rosal	2015	Journal article from book	0	Importance in practice Assessment in practice
4	Dunphy & Hens	2018	Mixed-methods study	35	Importance in practice Clinical note-taking in practice Assessment in practice Training in modality for practice Ethical practice Multimedia usage in practice
5	McGann	2012	Qualitative case study	0	Clinical note-taking in practice Assessment in practice Reflexivity in practice
6	Penzes, Dokter & Hutschemaekers	2018	Qualitative study	8	Clinical note-taking in practice
7	Penzes, et al.	2014	Qualitative study	7	Clinical note-taking in practice Client specific practice in practice
8	Rafieyan & Ries	2007	Journal article from book	0	Assessment in practice

9	Schuldt & Silverman	2020	Qualitative study	4	Assessment in practice Training in modality for practice
10	Ritnour, et al.	2014	Quantitative study	120	Assessment in practice Training in modality for practice Ethical practice
11	Valente & Fontana	1994	Qualitative study	250	Assessment in practice Client specific practice
12	Jones	2008	Qualitative narrative study	25	Clinical note-taking in practice Assessment in practice Training in modality for practice
13	Powell	2008	Qualitative study	62	Assessment in practice
14	Karkou & Sanderson	2001	Qualitative study	155	Assessment in practice Client specific practice Training in modality for practice Reflexivity in practice
15	Thompson	2020	Qualitative study	45	Client specific practice
16	Jennings & Mitchell	1994	Journal article from book	0	Client specific practice

17	Jennings & Meldrum	1994	Journal article from book	0	Assessment in practice Client specific practice Reflexivity in practice
18	Pendzik	2008	Journal article from book	0	Client specific practice
19	Dunphy, Lauffenburger & Denning	2021	Mixed-methods study	3	Training in modality for practice Ethical practice
20	Wong	2021	Qualitative autoethnographic study	0	Reflexivity in practice
21	Peterson & Gussak	2006	Mixed-methods study	1000	Use of technology in practice
22	Dunphy, Mullane & Allen	2016	Qualitative study	10	Use of technology in practice

3.1.2 Focus areas/themes found within included data

In order to identify focal areas or themes within the literature and for the purposes of this study, the following queries guided my examination during the literature screening process:

- What does the title of the article indicate in terms of focus?
- Are there any evident focus areas emerging from the introduction or abstract of the article?
- What does the author of the article aim to tell the reader?
- What information is present in the texts that relate to the keywords provided in Table 1?
- What does the article say about clinical record-keeping practices?
- What does the article say about client tracking practices?

By carefully reviewing the literature and considering these questions, I organised the information in the texts into the following themes, which will guide both the narrative review and discussion chapter of this study. I chose to do this, as the themes from the narrative review were found from a broad pool of literature and were not only focused on one country. This also helped me to compare the responses from participants in the questionnaires to these broader themes from across the world. The themes included are:

- The importance of clinical record-keeping and client tracking as standard practice in the arts therapies
- Clinical notes as a practice in record-keeping and client tracking in the arts therapies
- Assessment as a practice in clinical record-keeping and client tracking in the arts therapies
- Client-centred clinical record-keeping and client tracking practice in the arts therapies
- Training within clinical record-keeping and client tracking practices in the arts therapies
- Reflexive practice in clinical record-keeping and client tracking in the arts therapies
- Ethical practice in clinical record-keeping and client tracking in the arts therapies
- Practicing clinical record-keeping and client tracking manually or digitally in the arts therapies
- Inclusion of multimedia in clinical record-keeping and client tracking practice in the arts therapies

3.2 Narrative Review Findings

3.2.1 Importance of clinical record-keeping and client tracking as standard practice in the arts therapies

Three articles were found that made mention of the important role that CRCT practices have in ensuring good practice within the arts therapies. In music therapy, Tony Wigram (2007) highlights the significance of keeping records and tracking clients in many different settings, whilst Gussak and Rosal (2015) reinforce this by mentioning that clinical record-keeping, client tracking, and assessment are crucial in art therapy work. Gussak and Rosal explain that, much

like other modalities within the creative arts therapies, art therapists' client tracking and clinical record-keeping are centred on non-arts-based interactions (talking, facial expressions, hand gestures, etc.) and arts-based interactions (drawings, crafts, colours used, etc.). In their article, they emphasise the importance of this when practicing CRCT with clients. Dunphy and Hens (2018) also highlight the importance of CRCT practice, as many healthcare systems require evidence of therapeutic efficacy. As stated by Dunphy and Hens, dance movement therapists must follow record-keeping guidelines in most countries, which makes this practice a crucial part of arts therapists' work.

3.2.2 Clinical notes as a practice in record-keeping and client tracking in the arts therapies

Seven of the 22 included studies found that part of record-keeping and client tracking involves the practice of making and keeping clinical notes or records (session notes, progress notes and assessment reports), which are written or digital notes describing the interactions between the therapist and the client. It is within these records that the therapist will document the client's long- and short-term clinical goals, reflect on therapy sessions that aim to enhance the client's experiences in the future, and include any assessment tools or notes on the client (Wigram, 2007).

Wheeler (2015) describes clinical record-keeping in music therapy as a process that does not include diagnosing clients (as this is not within our scope of practice) but making meaning of musical engagement and the process for the client. Documenting interactions is important in music therapeutic spaces where the therapist may begin to understand their client's thoughts, images, symbols, moods, preferences, coping strategies, and experiences. For clients who communicate without speech, this space may offer important communicative information, such as musical preference, quality of play, expression, and dynamics within the therapeutic relationship. In a qualitative case study by McGann (2012), she describes documentation within her therapy work to be a critical part of the music therapy process and also a resource for her work. Documentation becomes a data source that includes information such as what music was used, clinical notes on the session, reflexivity notes, and assessment. Other important aspects of documentation in her music therapy work included:

- Referral letters from the client's other health professionals
- Consent forms detailing confidentiality practices
- Contact details of the client and next of kin

- Completed assessments of the client from previous therapy sessions held by the music therapist
- Assessment reports
- List of clinical goals to guide music therapy sessions and to support the therapy process
- Clinical notes completed after each session
- A summary report of therapy and the progress of the client when halfway through the treatment program
- A discharge letter when the therapy ends.

Dunphy and Hens (2018) also mention clinical note-taking, but in digital form on the MARA application, which documents interactions and observations of clients in sessions. In their study, MARA would create reports that contain both graphical and written notes on a client, which could be made available to the therapist, the client, and any other consented parties.

Pénzes et al. (2018) discuss how art therapists explore formal elements (colour, brush strokes, lines, etc.) in their observations, reflections, and note-taking to gain insight into a client's mental, physical, emotional and spiritual health and for guiding further treatments. This forms part of the clinical note-taking process. Pénzes et al. (2014) discuss the importance of including session notes on a client after each session that highlight observations of the client's mood, behaviours, use of art materials, etc. as an important aspect in creating assessment notes and starting the evaluation process. Furthermore, Penzes et al. stated that an art therapist must emphasise the therapy process during CRCT, but also the art product (painting, drawing, sculpture, etc.), as they both provide useful information about their client.

Interestingly, Jones (2008) discusses clinical note-taking in the form of vignettes written by the therapist after each session as a useful way for a therapist to make a note of the interactions observed during sessions. Additionally, Jones entered into session note-taking with his clients via an internet platform aMSN. The session note-taking was collaborative in nature and formed part of his CRCT practice in the study. This collaborative style of clinical note-taking with clients was favoured by Jones for being highly reflective in nature.

3.2.3 Assessment as a practice in clinical record-keeping and client tracking in the arts therapies

A total of 13 studies focused on tracking the progress of a client and their therapy process through evaluation and assessment tools as a crucial part of CRCT practice within the arts therapies.

Wheeler (2015) discusses the importance of client tracking practices in music therapy and how following assessment standards during the record-keeping and client tracking process might direct and aid a therapist in sessions and the therapy process. These include recognising how the client may benefit from music therapy, being sensitive to diverse cultures of clients, selecting methods of client tracking that focus on the client's ability and strengths, interpreting session information about the client appropriately and accurately, being inclusive of music therapy assessment results, and finally, being aware of challenges faced by the client and how it may influence the client's life. Client tracking tools, such as those mentioned above, allow the therapist to notice patterns or trends in therapy regarding the client's mood, experiences, or emotions that may help the multidisciplinary team understand any changes in clients. For example, the music therapist may notice increased mood in their client, or the client may exhibit behavioural changes that could indicate increased resilience. This ongoing evaluation could assist a music therapist in responding appropriately and effectively to their client's needs and providing appropriate care (Rafieyan & Ries, 2007). In their study, Schuldt and Silverman (2020) go into detail about standards of practice when tracking a client's progress and describe assessment in music therapy as a complex process. Music therapists should recognise the individual nature of success when evaluating a client in a session, as non-verbal communication and interaction are an important part of assessment in music therapy.

Wigram (2007) mentions that the various assessment tools in music therapy include, but are not limited to, the Nordoff and Robbins Scales, Musical Interaction Rating Scale, Music in Dementia Assessment Scales, the Music Therapy Assessment Tool for Awareness in Disorders of Consciousness, and the Individualized Music Therapy Assessment Profile. McGann (2012) found it useful in her work as a music therapist to utilise existing music therapy assessment tools to track the progress of her clients in therapy and to guide her clinical record-keeping, but this author does not mention which tools she is referring to. However, she does refer to using SMART (specific, measurable, attainable, realistic, and timely) goals and SOAP (subjective,

objective, assessment, and plan) notes in her work as a music therapist, despite both of these being non-music therapy specific.

Pénzes et al. (2014) also describe their views on the standards of practice for CRCT, focusing on materials in art therapy assessment and how these might aid an art therapist in better assessing their client. They conducted their study in the Netherlands and recruited seven qualified and practicing arts therapists. They take note of how an art therapist observes and documents their client's interactions with the art materials, how the client experiences different art materials, how they behave in sessions with art materials, how the client applies different art materials in product, what emotions are experienced by the client whilst working with different art materials in the session, how a client rationalises their actions (control versus curiosity) in the session, how flexible the client is and the level of motivation shown by a client. Assessment also involves reflecting on and understanding the product of the creative process, for example, a drawing, painting, sculpture, or collage and how it may be a symbol for the client's life.

Gussak and Rosal (2015) discuss how art therapists assess formal elements of a client's art within a mental health setting during the client tracking process. They discuss how it is within the formal elements such as lines, contours, colours, shapes, etc., that an art therapist may become more aware of their client's needs. This awareness could be achieved by the therapist as the art product and art process reflect emotions, ideas, thoughts, symbols, stories, and experiences of a client, thus allowing them to document and evaluate clients' strengths, challenges, and functioning for improved treatment. Gussak and Rosal found that through formal elements of clients' artworks, art therapists could gain a sense of the adaptability and balance (flexibility, openness, self-management, creativity, resources, and strengths) of their clients. Assessment, such as the Diagnostic Drawing Series (Ritnour et al., 2015), is seen as a useful tool for client tracking practice after sessions within the clinical record-keeping process. This tool should include aspects such as evaluation of colour, space usage on the paper, objects found in the art, symbolism, lines, shapes, the quality of the lines, abstractions, how the overall image presents itself, the orientation of the paper, how objects are placed in the art and the angles found within the art.

Valente and Fontana (1994) examine good practice and outcomes in drama therapy through questionnaires with 250 qualified drama therapists. They conclude that client tracking is one of the more difficult areas of work within the field and that client self-reports after sessions are

good indicators for gathering experiences and perceptions, but therapists' professional judgement is also important. Drama therapists in this older study suggested that because drama therapy is a space that offers expression and embodied experiences for clients, many aspects of the self (self-awareness, self-confidence, self-esteem, self-awareness) emerge. In this sense, drama therapy may become a space where a client may engage with or explore aspects of themselves, and the drama therapist witnesses and supports the client through various clinical techniques.

Jones (2008) discusses the role of core processes (role play, dramatic projection, drama therapeutic empathy, witnessing, embodiment, playing, the life-drama connection and transformation) as an integral role in helping to evaluate clients in a clinical setting, as it is within these processes that change can be explored, witnessed, reflected upon and then assessed by a therapist. In his narrative study, where he looked at the core processes through sessions and vignettes with 25 drama therapists and their clients, he found that drama therapists should be observing these core processes in such a way that they are able to document what the client has experienced through observing behaviours, communication, movement, symbolism. This should be done after each session during the CRCT process. In *The Handbook of Dramatherapy*, Jennings and Meldrum (1994) explain that it is within the health systems of various settings that assessment within CRCT is a regulation for therapists. It is within these regulations that continuous assessment of a client allows a therapist to make the most effective choices for therapy in the future and to come to the best clinical decisions. Meldrum acknowledges these regulations within the field of drama therapy, however she mentions that it is very difficult to follow assessment and evaluation practices within CRCT due to the nature of assessment being that of judgement of a client, whereas therapy focuses on positive regard towards a client. This author has found that this leads to the therapy process becoming about assessment and the client experiencing pressure from the feeling of being assessed in sessions, even though the client consents to assessment. This is why Meldrum discusses the importance of collaboration within the practice of assessment in drama therapy, arguing that the client may feel empowered through their own choices and creating the landscape for their progress in therapy. The therapist's aim, whilst practicing assessment, would be to help the clients achieve their goals through their own problem-solving.

In a study by Powell (2008), 62 participants were surveyed about their views on client tracking and clinical record-keeping in their practice. The dance therapists in this study were working in many clinical settings, with different client groups and were at different stages of their work

experience. The findings suggest that client tracking is not a consistent practice within the field of dance therapy and that dance therapists choose to use unstandardised tools for CRCT. Dance therapists have access to a wide range of client tracking or assessment tools for different population groups, but these are not all regarded as practical in all clinical settings, resulting in inconsistent use of the tools. Dance therapists rely on a degree of intuition as they witness their client's movements and attempt to understand them, which has led to their use of individually created tools. Karkou and Sanderson (2001) discuss assessment within CRCT practices and found that when tracking a client, dance/movement therapists should be focusing on the body-mind relationship and how movement reflects the state of mind in a client, for example, their emotion, relationship to the world around them, and views on themselves.

3.2.4 Client-centred clinical record-keeping and client tracking practice in the arts therapies

Seven studies had a focus on CRCT in a way that is client specific, such as thinking of the context of the client, collaboration with the client and considering the client's needs and desires in therapy. Thompson (2020) writes about the core therapeutic processes found within the standards of practice of music therapy and she emphasises the importance of setting collaborative goals and aims so that a music therapist may feel a sense of mutual direction when planning sessions and tracking the client. In her study with 45 qualified music therapists, the researcher discusses the importance of continuously developing one's skill as a music therapist in setting goals, checking in on the client's needs, remaining knowledgeable in assessment practices, checking the feasibility of the sessions with clients, checking the feasibility of the interventions being used in music therapy sessions with the client and supporting a broader team when necessary. It is the professional responsibility of the music therapist to meet the needs of the client in their context, understand the values of the client, always remain ethical in one's practice, work within the theoretical frameworks of music therapy and advocate for the profession during all processes. This is important within the sessions and afterwards during CRCT. She describes all of these to be standards of practice in music therapy that uphold the therapeutic relationship and the profession itself.

A standard of practice mentioned by Pénzes et al. (2014) is the art therapy diagnosis. This is explained to be different to the work of other health professionals, who aim to diagnose their clients through the identification of an illness by evaluating symptoms but is rather focused on identifying a client's strengths and challenges when engaging in art making. Art therapists should follow deep observation, collaboration, and uphold the therapeutic relationship in order to

be ethical, efficient and successful in their documentation and client evaluations. Penzes et al. found CRCT practices to be helpful to the art therapist in planning long- and short-term goals, as well as tracking these goals in an ongoing way in therapy.

In the *Handbook of Drama Therapy*, Jennings and Meldrum (1994) discusses collaborative CRCT practices and makes use of Jennings and Mitchell's (1994) work as drama therapists. Mitchell further mentions the importance of creating a space where evaluation is a collaborative process between therapist, client, and the medical staff in the hospital where necessary. In his work, Mitchell creates maps with clients to document milestones in their life, and this becomes the basis for further formation of clinical goals, expectations of therapy, and topics for therapy. The life map becomes a creative representation of the client's life, and this informs how he continues therapy with the client. Much of his client tracking in sessions involves input from the client as they rate their feelings, expectations, ideas, and perceptions in therapy according to the goals they have set. Core processes in this study are described as the processes in therapy work that allow the work to have therapeutic benefit and allow the therapist to follow good practice standards.

Pendzik (2008) mentions that dramatic reality is a central therapeutic tool in drama therapy that involves creating a space where one's imagination might become tangible through play, character work, improvisations, stories, symbols, puppets, metaphors, or masks. Pendzik describes dramatic reality as a compass that guides the practice of drama therapy and this would, therefore, be a salient element for drama therapists to consider whilst tracking client progress and keeping records. Pendzik suggests the use of the Six-Key Model for drama therapists to achieve efficient client tracking, as this tool centers on dramatic reality. The drama therapists in Valente and Fontana's (1994) study mention the importance of self-reports and the client's input in documenting their own progression towards clinical goals. A client's communication, creativity, social interaction, spontaneity, initiative, self-disclosure, trust, mood, concentration, imagination, and courage, are other aspects the drama therapist may also observe and evaluate. Karkou and Sanderson (2001) mention that a dance/movement therapist should first be setting aims and goals of therapy with a client and these should be documented and evaluated after each session as part of the clinical record-keeping process. It is only then that the dance/movement therapist may start to use their knowledge of the fundamental dance/movement therapy-specific theories and assessment tools to observe and understand important aspects of the work, such as movement, the mind-body relationship, symbolism or metaphors displayed by clients in sessions, the

emotions displayed by clients in sessions, how the client may communicate (verbally and non-verbally), the therapeutic relationship, the engagement with movements by the client and the group dynamics when working with groups.

3.2.5 Training within clinical record-keeping and client tracking practices in the arts therapies

The theme of training appeared in six of the included studies. This focuses on the importance of receiving training in CRCT practices, but also training in skills and knowledge pertaining to the specific modality the therapist is working with, as this becomes the core of one's practice. Schuldt and Silverman (2020) mention the importance of theoretical training to ensure therapists can implement theories safely and in context within music therapy. They also state that this is an important aspect of adhering to the general standards of practice when facilitating music therapy work.

Ritnour et al. (2015) discuss standards of practice in CRCT practice within art therapy through an assessment tool called the Diagnostic Drawing Series. Their study involved 120 participants (both teenagers and adults). They found that it is important for an art therapist to be skilled and knowledgeable in their use of clinical assessment tools for client tracking and clinical record-keeping and that art therapists should engage in continuous research to further their knowledge of assessment tools and criteria in the profession.

Jones (2008) mentions the importance of educating drama therapists on what the core processes are in drama therapy and how they can be a useful tool in practice, as well as how these core processes might aid in becoming a useful tool for CRCT practices for drama therapists.

In Australia, dance/movement therapists need to provide outcome-focused reports and reflections to provide the best service delivery to clients (Dunphy & Hens, 2018). This poses a challenge to dance therapists who struggle with client tracking practices due to a lack of training or understanding of the practice. Karkou and Sanderson (2001) report on the important theories, practice standards and assessment procedures in dance/movement therapy within the United Kingdom based on the dance therapy work of registered therapists in the country. They found that the knowledge of fundamental dance/movement therapy-specific theories is essential when trying to understand the practice standards and assessment within the field. The use of psychoanalytic theory was emphasised here as being crucial to dance/movement therapists, as symbolism and metaphors in movement form an important aspect of how a dance/movement

therapist may understand their clients and track their process. Dunphy et al. (2021) focuses on competency and standards of practice in dance/movement therapists and their study highlights the important aspects that should be considered when it comes to this, based on the opinions through questionnaires with dance/movement therapists in Australia. Their study highlights the critical role that knowledge of the theoretical underpinnings in dance/movement therapy may have in helping with competency as a therapist in Australia. It also highlights that knowledge in the profession itself may play a role in becoming a more competent dance/movement therapist. They found that during the training in dance/movement therapy, dance and methods of clinical practice are important aspects of learning, so that dance/movement therapists know how to apply technical skills to their therapeutic practice. Dance/movement therapists should be trained during their studies in movement frameworks in dance/movement therapy, the use of safe movement in sessions, movement analysis, movement observation and assessment tools in order to remain safe in their practice with clients both in sessions and after sessions during the CRCT process.

3.2.6 Reflexive practice in clinical record-keeping and client tracking in the arts therapies

Reflexive practice, such as keeping reflection notes and attending supervision as a standard in CRCT, was mentioned within four studies. Reflexivity is described by McGann (2012) as a useful tool in music therapy after sessions and within documentation. This author describes reflexivity as something that should be a normalised practice standard and documentation practice. Wong (2021) describes reflexivity in art therapy, reflecting on the therapeutic relationship with a client, as a practice of wisdom that allows a therapist to promote attunement and positive transformation in the therapy space. In Wong's autoethnographic study, it is discussed how reflexivity practice during clinical record-keeping aided them in gaining a deeper understanding of their client and the nuanced contributions of the client and their art making to the therapy process. The author engaged in reflective practices by writing reflection notes after each session, recording emotions, thoughts, observations, responses and reflections from the session with the client, as well as reflecting on discussions with supervisors during supervision.

Karkou and Sanderson (2001) mention some general standards of practice when tracking clients in dance/movement therapy, such as creating a safe environment for clients to express themselves, engaging in self-reflection after sessions with a client for self-awareness, going to supervision for guidance, trusting one's abilities and intuition whilst being with a client and assessing them and using a video recorder in sessions to aid in reflection and assessment.

Supervision is further emphasised as a vital part of CRCT practice and something that arts therapists should follow for the duration of their professional lives (Jennings & Meldrum, 1994).

3.2.7 Ethical practice in clinical record-keeping and client tracking in the arts therapies

Three studies mention the importance of adhering to ethical guidelines and practicing ethically during the CRCT processes in arts therapies. Ethical practices, such as gathering a client's consent, safely storing clinical records and maintaining confidentiality are described by Ritnour et al. (2015) as important during the documentation stage of work with a client. Dunphy and Hens (2018) further emphasise the fact that many arts therapists are under an ethical obligation to meet the standards of practice set out by healthcare organisations and that arts therapists who are practicing ethically will provide evidence of their CRCT practices in work. Dunphy et al. (2021) mention the aspects that should be upheld by all registered dance/movement therapists when practicing ethically. These aspects are listed as:

- Promoting the therapeutic relationship
- Employing dance as the main therapeutic medium in sessions
- Ongoing assessment after sessions during documentation
- Setting goals and aims of therapy collaboratively with a client before therapy
- Using a therapy plan that is evidence-based and documented
- Client tracking through monitoring and reviewing the clients progress with assessment tools
- Practicing in self-reflection after sessions as part of documentation
- Developing skill in dance/movement therapy to remain well trained
- Keeping session notes that help evaluate and track a client after sessions
- Showing professionalism
- Managing information and records of clients effectively
- Remaining ethical in practice
- Practicing safely.

3.2.8 Practicing clinical record-keeping and client tracking manually or digitally in the arts therapies

Another emerging topic within the field of arts therapies is the use of written versus digital CRCT practices. Three studies within this review discuss the use of digital platforms to aid the

therapist in documenting the work more efficiently. Peterson and Gussak (2006) found that technology is a useful and effective way for art therapists to make, work on and keep clinical records of clients. He also found that client tracking processes using technology can be comprehensive, but that a therapist needs to be knowledgeable in their understanding of how to do this before it will be useful to the therapy process.

The inconsistency in CRCT within dance therapy spurred Dunphy et al. (2016) to create and develop the mobile application, MARA, which allows dance therapists to record information about their clients, as well as track their sessions and their client's progress digitally by filling in information on the screen. It makes use of cognitive, emotional, physical, cultural, social, and interactional domains and offers an overview of sessions for therapists. In their later study, Dunphy and Hens (2018) discuss the effectiveness and ease of having a mobile application that can help therapists make and keep notes during the CRCT process.

3.2.9 Inclusion of multimedia in clinical record-keeping and client tracking practice in the arts therapies

While Dunphy and Hens' (2018) study was mentioned in the previous section under digital and manual practice of CRCT, the study also highlights another topic, which is the inclusion and importance of multimedia, such as images, video recordings, and audio recordings whilst practicing CRCT. Their study highlights the usefulness of using mobile applications, such as MARA, to adhere to CRCT practice standards within the arts therapies with the increased access to and use of multimedia devices. In their study, Dunphy and Hens discuss the importance of including various forms of multimedia, such as videos, pictures, and audio recordings, to aid in the CRCT process within MARA. Multimedia was found to be useful to the therapists in this study, as it allowed a therapist to make more detailed notes of in-session interactions and for the client evaluation process to be more thorough.

3.3 Conclusion

Arts therapists acknowledge CRCT in all four modalities as being an important and ethical part of clinical practice. Other than its importance, CRCT is seen as beneficial to the therapy process and as practices that can serve as reflexive tools in the arts therapies.

The literature across all four modalities shows that clinical goals, both long- and short-term, should be recorded as part of the documentation process in therapy. These goals should be developed collaboratively with clients and should be client-centred, as a therapist should be looking at referral letters, diagnosis, culture, language, needs and desires of clients during this process. Another important aspect mentioned in the literature is that reflexive practice is important when engaging in CRCT. Some of the literature suggests that practicing reflexivity is a critical part of the therapy process, allowing a therapist to gain self-awareness, make ethical choices, gain valuable information about the client, and practice responsibility.

Clinical note-taking appears within the literature and is found to be an important part of the CRCT process. The literature refers to clinical notes as being notes on a client's basic information, session information, interventions used, observations, therapy process notes, client assessment notes and personal reflections, which form a valuable part of clinical record-keeping after sessions.

Assessment tools, which are modality specific, are available to therapists for client tracking and are deemed to be useful tools in helping a therapist track client progress and evaluate the therapy process. There is an emphasis on training in using these tools and the mention of this not being consistent within the field of dance/movement therapy specifically.

Across the four modalities, documentation processes, such as taking session notes, help the therapist to understand clients' thoughts, images, symbolism, moods, preferences, coping strategies, and experiences.

CRCT should keep the therapeutic relationship at the forefront, as it is within the therapeutic relationship that much valuable information can be observed by the therapist and this may aid them in guiding the therapy in the future.

CRCT practices should observe the holistic well-being of the client, encompassing evolving physical, emotional, spiritual, and cognitive aspects. This approach helps therapists understand the feasibility of therapy for clients and make informed choices about the way forward in the therapeutic process.

CRCT focusses on both the process of therapy in sessions with the client (for example, how a client explores lyrics in music therapy, or what colours a client chooses in art therapy), and the

product of therapy (for example, a song that is produced in music therapy, or the painting that is made in art therapy). Both the product and process of therapy become something that the therapist may document, and it becomes a critical part of the record-keeping and client tracking process.

Lastly, the literature refers to the importance of arts therapists across all four modalities making use of the theoretical frameworks available to them for their specific modalities as this helps guide the therapy process and the CRCT processes.

As mentioned, each modality has its own assessment tools with its own evaluation criteria and techniques. For example, music therapists might engage more with musical dimensions and meta-dimensions in their CRCT while a dance therapist may focus more on body movement, flow of movement or body expression. This is not to say that therapists may not be aware of or use practices from other arts therapy modalities. This is unknown from the literature.

Chapter Four: Analysis and Presentation of Findings from the Questionnaire Data

In this chapter, I will describe the thematic analysis of the questionnaire data. Each of the six steps will be discussed and the data analysed. The final, higher-level codes from the analysis are presented and described at the conclusion of this section. This is done for each question within the questionnaire.

4.1 Questionnaire Data

As mentioned in chapter two, this study also included questionnaires to explore the CRCT practices of arts therapists in South Africa. These questionnaires invited arts therapists in South Africa to think about their CRCT practices. Participants were contacted via an email and invited to participate in a Google Forms questionnaire for the study. Although the study sought to involve 12 participants in total, only nine participants expressed an interest in participating. This was due to time constraints for participants and because there are only two registered dance/movement therapists on the SANATA database. Participants included three drama therapists, one dance/movement therapist, three music therapists and two art therapists. All the participants in the study worked in both private and public health spaces in the country. All but one arts therapist lived in South Africa, and all of them practiced with South African clients. Only one participant in the study was male and the remaining participants female. All participants were HPCSA and SANATA registered.

4.1.1 Generating questions for the questionnaire

The questionnaire consisted of ten questions. The questions were designed to address themes from the literature as well as identify gaps in the literature from the narrative review. Themes from the narrative review guide this study~~,~~ as they focus on CRCT practices at a global level. The broad pool of literature that provided a picture of the global situation will serve as a basis for a comparison with the responses from South African arts therapists later in the study. The questionnaire consisted of the following questions:

- What do you think constitutes the primary components of clinical record-keeping and client tracking in your specific modality?

- How do you adhere to the HPCSA's clinical record-keeping and client tracking practices in your specific arts therapy modality?
- How do you include your modality in clinical record-keeping and client tracking, specific to your arts therapy modality in South Africa?
- Are your clinical record-keeping and client tracking practices done digitally, manually, or do you do both?
- Did you receive information in your training on clinical record-keeping and client tracking practices? (Yes or No). If yes, please provide details.
- What does reflexivity in practice mean to you?
- Do you include reflexivity in your clinical record-keeping and client tracking practices? (Yes or no). If yes, please explain.
- Are you familiar with clinical record-keeping and client tracking tools used in arts therapy modalities other than your specific modality (Yes or No)? If yes, please explain your understanding of these tools.
- Do you refer to clinical record-keeping and client tracking tools from other arts therapy modalities whilst engaging in modalities other than your primary modality? (Yes or No). If yes, please explain which tools and why.

4.1.2 Analysing the questionnaire data

Thematic analysis was used to sort through and create higher-level codes from the responses to the questionnaires. Braun and Clarke's (2006) six-step process were followed.

4.1.2.1 Step one: familiarising oneself with the data

I made use of a Google Form to gather the data. This platform automatically sorted the data in an organised and understandable way. This allowed me to see the responses of each participant clearly. The first step in the analysis process was to familiarise myself with the answers received from each completed questionnaire, which involved reading the collected questionnaire data multiple times to understand the responses before commencing with step two.

4.1.2.2 Step two: generating initial codes

Step two involved generating initial codes from the raw data. The answers from each participant's questionnaire sheet were entered into a table to generate the initial codes. Descriptive coding, which involves using words to summarise a chunk of raw data (participants' responses), was used during step two. I chose not to group the codes under each modality, as my study focused on themes within CRCT in the arts therapies. Table 3 shows an example of how the information was sorted and the initial codes that were generated for each question. Take note that participants were labelled using uppercase letters of the alphabet while the questions were labelled using lowercase letters. Table 3 only shows the process followed in step 2 for participant A, question "a". The full table of initial codes can be found in Appendix C.

Table 3

Example of Step Two Thematic Analysis: Generating Initial Codes from Raw Data

Participant	Question	Response of participant	Initial codes
A	a	I believe that most drama therapists keep clinical records to satisfy medical aid requirements, as well as keeping detailed process notes in order to capture where the client is at creatively and in their process. There are also NGO or organisational specific record-keeping practices that we must follow if we work in those spaces.	**Must follow the NGO or organisational specific record-keeping practices.** **Keeping detailed process notes to capture where client is at in process.** **Keep session notes to satisfy medical aid requirements.**

4.1.2.3 Step three: developing level 2 codes

Step three involved sorting the initial codes into potential level 2 codes. I grouped the initial codes from all participants under each question and worked at finding common initial codes, which could become the level 2 codes. For example, in Table 4 below, one can see that two initial codes were similarly focused on CRCT being guided by the organisation or site where the participant works. For this reason, these two initial codes were grouped together under the level 2 code *"NGO, organisational specific and site-specific clinical record-keeping practices"*. Table 4 only contains an example of the level 2 code drawn out from the initial codes for question "a"

in the questionnaires. Please note this is only a section of the level 2 codes for question “a”. The full table can be found in Appendix D.

Table 4

Example of Step Three Thematic Analysis: Level 2 Codes developed from the Initial Codes

Question	Initial codes	Level 2 Codes
a	Must follow the NGO or organisational specific record-keeping practices. Clinical record-keeping practices dependent on site.	**NGO, organisational specific and site-specific clinical record-keeping practices.**
	Keeping detailed process notes to capture where client is at in process. Process notes in clinical record-keeping and tracking.	**Detailed process notes in clinical record-keeping and client tracking, which track client’s process.**
	Keep session notes to satisfy medical aid requirements.	**Keep session notes to satisfy medical aid requirements.**
	Session notes made after each session. Written notes in clinical record-keeping. Session notes for reference between sessions in record-keeping. Thorough session notes made. Detail in note-taking for records.	**Session notes are made after each session, are thorough, detailed and for reference between sessions.**
	Written reports in clinical record-keeping. Quarterly reports made and kept.	**Reports are made and kept as part of clinical record-keeping and client tracking.**
	Taking photographs of artwork or projective work.	**Photographs of artwork or projective work are part of clinical record-keeping and client tracking practice.**

Consent of client needed before storing of artwork. A client's consent in clinical record-keeping.	**Client's consent needed for clinical record-keeping and client tracking practice.**

4.1.2.4 Step four: reviewing potential level 2 codes

Step four in thematic analysis involved reviewing the potential level 2 codes by once again grouping, collapsing, or expanding on their focus areas. I did this by writing the focus words from each potential code in Table 4 onto a digital word document and then using this to sort them into clearer codes. Creating a digital document that includes the focus words derived from the codes in Table 4 enabled me to delve deeper into the level 2 codes. This, in turn, facilitated additional grouping, collapsing, or expansion to generate more refined and reviewed level 3 codes along with potential subcodes. It was important for me during this step to review whether the level 3 codes made sense, were related to the questionnaire data collected and that the level 3 codes remained true to the responses of the participants. After thinking about and reviewing the data in the digital word document, a table was made with the reviewed level 3 codes and any related subcodes. Whilst the level 3 codes provide information on the primary or focused areas of the data, the subcodes include more secondary data and topics relating to the code. Table 5 below is an example of question "a" level 3 codes and subcodes. Please note this is only a section of the level 3 codes for question "a". The full table can be found in Appendix E.

Table 5

Example of Step Four Thematic Analysis: Level 3 Codes and Sub Codes

Question	Level 3 Codes	Subcodes
a	**Adherence to third party guidelines is a primary component of record-keeping and client tracking practices.**	Adherence to NGO, organisational, site specific and medical aid requirements as a consideration when practicing clinical record-keeping and client tracking.

Clinical notetaking/documentation is a primary component of clinical record-keeping and client tracking practice.	Taking and keeping session notes Keeping client reports Keeping progress notes Keeping assessment reports Choice of written notes or typed notes Including client observation notes Keeping notes on the client experiences
Art process and product included as primary component in clinical record-keeping and client tracking practice.	Use of photographs Use of audio recordings of client's therapy process Use of art product
Protection of the client as a primary standard of practice in clinical record-keeping and client tracking.	Gathering the client's consent Upholding confidentiality
Safe storage of data as a primary standard of practice in clinical record-keeping and client tracking.	Storage in compliance with laws Restricted access to documents
Clinical record-keeping and client tracking practiced in a collaborative manner with client as a primary component.	
Reflexivity as a primary standard of practice in clinical record-keeping and client tracking.	

4.1.2.5 Step five: refining and finalising level 4 codes

In step five, I refined and defined the level 3 codes to create higher-level codes (level 4 codes) based on the questionnaire data in my study. I completed this by reviewing the level 3 codes and subcodes, identifying focus points, and simplifying them where necessary. This also allowed me to provide very focused definitions when describing each finalised higher-level code. In this study, I generated 42 higher-level codes under step five. These codes were continuously grouped under their related questions in the questionnaire. I did this, as the questions in the questionnaire were related to and guided by the themes from the narrative review findings. The links between the higher-level codes and the broader themes from the narrative review will be discussed in chapter five of this study. To understand the meaning of each higher-level code, I created separate tables for them based on the questions in the questionnaire. My intention in doing this was to be able to easily relate the higher-level codes to the broader themes in the narrative review, as they are grouped under clear focus areas within each question. The data will be presented in tables for each question. Please note that the left column for each table in the following sections contains the number of the higher-level code (for example, code no. 1, 2, 3, etc.). This was done to tally up all of the higher-level codes and make it easier to refer to the codes within chapter five. Below, I will describe the higher-level codes for each question.

4.1.2.5.1 Which arts therapy modality do you represent in South Africa?

I aimed to include three therapists each from the four arts therapy modalities common in South Africa. Therefore, this question was more for administrative purposes. Out of a total of five drama therapists who completed the questionnaire, only the first three were selected for evaluation. Four music therapists responded to the questionnaire, but only the responses of the first three were considered. Only one participant represented dance/movement therapy in this study while two art therapists represented their modality in my study.

4.1.2.5.2 What do you think constitutes the primary components of clinical record-keeping and client tracking in your specific modality?

This question invited participants to think about the primary components of CRCT within their own practice. My aim with this question was to draw attention to the importance of CRCT practice, as well as what constitutes the practice. A total of eight higher-level codes were generated as primary components in CRCT. This question is represented by the lowercase letter “a" during the thematic analysis process. Table 6 below represents this.

Table 6

Primary Components in Clinical Record-Keeping and Client Tracking in the Arts Therapies in South Africa

Primary components of clinical record-keeping and client tracking practices			
Code no.	**Higher-level codes**	**Sub codes**	**Description**
1	**Adhering to third party guidelines.**	NGO guidelines. Organisational guidelines. Medical aid requirements.	Adherence to third party guidelines is a primary component of record-keeping and client tracking practices. This includes adhering to NGO, organisational, site specific and medical aid requirements when practicing.
2	**Clinical note-taking.**	Session notes. Client reports. Progress notes. Assessment reports. Written or typed notes. Client observation notes on the client experiences.	Clinical note-taking is a primary component of clinical record-keeping and client tracking practice. This includes taking and keeping session notes, keeping client reports, keeping progress notes, keeping assessment reports, keeping written notes or typed notes, including client observation notes, and keeping notes on the client's experiences.
3	**Inclusion of art process and art product.**	All multimedia.	Art process and product are included as primary components in clinical record-keeping and client tracking practice. This includes multimedia such as photographs, audio recordings or videos, as well as any art products.
4	**Client protection.**	Client consent. Confidentiality.	Protection of the client as a primary standard of practice in clinical record-keeping and client tracking. This includes gathering the client's consent and upholding confidentiality.
5	**Storage of data.**	Compliance to laws. Restricted access.	Safe storage of data as a primary standard of practice in clinical record-keeping and client tracking. This includes ensuring that storage practices follow laws and there is restricted access to documents.
6	**Collaborative.**		Clinical record-keeping and client tracking practiced in a collaborative manner with clients as a primary component.

7	**Reflexivity.**		Reflexivity as a primary standard of practice in clinical record-keeping and client tracking.
8	**Good quality documentation.**	Regular practice. Detailed documentation. Organised.	Quality and relevance of documents upheld in clinical record-keeping and client tracking as a primary standard of practice. This includes practicing regular documentation, having detailed documentation and remaining organised in documentation practices.

4.1.2.5.3 How do you adhere to the HPCSA's clinical record-keeping and client tracking practices in your specific arts therapy modality?

This question was focused on the extent to which the participants in the study adhere to the HPCSA guidelines within their work as arts therapists in South Africa. The broader aim of the question was to draw attention to the importance of CRCT practices in South Africa, as well as what constitutes this practice in the participant's work as arts therapists. A total of six higher-level codes were generated for this question. This question is represented by the lowercase letter "b" during the thematic analysis process. Table 7 below represents this.

Table 7

HPCSA Recommended Clinical Record-Keeping and Client Tracking Practices that are Adhered to by Arts Therapists in South Africa

HPCSA recommended clinical record-keeping and client tracking processes that are adhered to.

Code no.	Higher-level codes	Sub codes	Description
9	**Adherence to third party guidelines.**	HPCSA guidelines	Adherence to HPCSA guidelines in clinical record-keeping and client tracking practices.
10	**Client protection upheld.**	Client consent Confidentiality	Protection of the client adhered to in clinical record-keeping and client tracking practice. This includes gathering client's consent and upholding confidentiality.

11	**Safe storage of data.**	Adhering to laws. Long-term keeping of records. Restricted access. Hard copies of records.	Safe storage of data adhered to as a standard of practice in clinical record-keeping and client tracking. This includes adhering to laws about storage of documents, long-term. Keeping records, having restricted access to data and keeping hard copies of all data.
12	**Updated session documentation.**	Regular session notes. Photographs of sessions. Artwork from sessions.	Updated session documentation and information in clinical record-keeping and client tracking are adhered to. This includes keeping regular clinical session notes and including photographs of artwork.
13	**Client-centred documentation.**	Client feedback. Client's choice. Client's needs and wants included.	Adherence of client-centred and client-informed clinical record-keeping and client tracking practices. This includes giving client's feedback about their therapy process, giving the client the choice in clinical record-keeping and client tracking practices as to not follow oppressive nature of practice and remaining specific about client's needs and wants therapy.
14	**Supervision.**		Adhering to supervision requirements in clinical record- keeping and client tracking practice.

4.1.2.5.4 How do you include your modality in clinical record-keeping and client tracking, specific to your arts therapy modality in South Africa?

This question invited participants to think about how they include their modality (music, art, drama and dance) during the CRCT practice of their work. This was important to find out, as the literature explained how arts therapists sometimes make use of multimedia or art products within their CRCT practices. A total of six higher-level codes were generated for this question. This question is represented by the lowercase letter "c" during the thematic analysis process. Table 8 below represents this.

Table 8

Aspects in Arts Therapies Modalities that are Included in Clinical Record-Keeping and Client Tracking Practices in South Africa

Aspects in arts therapy modality that are included in clinical record-keeping and client tracking practice			
Code no.	**Higher-level codes**	**Sub codes**	**Description**
15	**Including multimedia.**	Photographs. Audio recordings. Video recordings.	Inclusion of multimedia in clinical record-keeping and client tracking to include modality. This includes photographs, audio recordings and video recordings.
16	**Including creative products.**		Inclusion of creative products in clinical record-keeping and client tracking to include modality.
17	**Inclusion of client's needs and wants.**		Client's needs and wants form part of clinical record-keeping and client tracking in modality. This includes the client choosing what to do with creative products after sessions.
18	**Modality specific practice.**		Use of modality specific tools and interventions as part of clinical record-keeping and client tracking practice.
19	**Use of language in practice.**	Clear. Understandable. Value to records.	Use of language in clinical record-keeping and client tracking promotes modality is clear, understandable, adds value to the therapy process and promotes the profession.
20	**Protection of documents.**	Safe storage. Compliant with laws. Backed-up documents.	Protection of documents in clinical record-keeping and client tracking. This is upheld through safe storage of documents, complying with laws such as POPIA and backing up documents.
21	**Clinical note-taking.**	Reflexive notes. Session notes. Process notes.	Clinical note-taking that is modality specific as part of clinical record-keeping and client tracking process. This includes keeping reflexive notes, keeping session notes, and naming the interventions used in sessions.

4.1.2.5.5 Are your clinical record-keeping and client tracking practices done digitally, manually, or do you do both?

From the literature mention was made of the use of digital technology within the practice of CRCT in arts therapies. This question aimed to establish whether arts therapists in South Africa make use of digital practices, or if they only use manual methods. Most respondents in the study use both digital and manual forms of CRCT. One participant only adheres to the manual practice and two only to the digital. This question is represented by the lowercase letter "d" during the thematic analysis process. Table 9 below represents this.

Table 9

Use of Digital or Manual Forms of Clinical Record-Keeping and Client Tracking in Arts Therapies in South Africa

Code no.	Higher-level code	Description
22	**Choice of digital or manual documentation**	Therapists' choice to use digital, manual or both forms of documentation when practicing clinical record-keeping and client tracking.

4.1.2.5.6 Did you receive information in your training on clinical record-keeping and client tracking practices? (Yes or No). If yes, please provide details.

Another theme which emerged from the literature was the importance of training in CRCT practices. It was clear from the literature that not enough training was being provided to practitioners. For this reason, I was curious to find out how arts therapists in South Africa feel about training on CRCT. This question is represented by the lowercase letter "e" during the thematic analysis process. Table 10 below shows the higher-level codes that were generated for this question.

Table 10

Training in Clinical Record-Keeping and Client Tracking Practices for Arts Therapists in South Africa

Training in clinical record-keeping and client tracking.

Code no.	Higher-level code	Sub code	Description
23	**Training provided in South Africa.**		Training provided to all participants in study on clinical record-keeping and client tracking.
24	**Quality of training.**	Inadequate training. Further training from external sources.	The quality of training in clinical record-keeping and client tracking is seen as inadequate by some participants. Other participants mention needing to seek knowledge from external sources to fill in gaps of knowledge.
25	**Training according to site-guidelines.**		Adherence to site-guidelines as part of training in clinical record-keeping and client tracking practices.
26	**Training in clinical note-taking.**	Session notes. Assessment scales. Transcriptions. Process notes. Clinical files. Keeping documents.	Training in clinical note-taking practices for clinical record-keeping and client tracking. This included training in keeping session notes, assessment scales, transcriptions, process notes, keeping clinical files and training in how long to keep documents.
27	**Resources provided during training.**		Training provided resources to therapists for clinical record-keeping and client tracking

4.1.2.5.7 What does reflexivity in practice mean to you?

From the narrative analysis of the literature, reflexive practice within the field of arts therapies is regarded as an important and valuable aspect element of CRCT practices. For this reason, I included two questions in the questionnaire about reflexivity. This first question aimed to gather higher-level codes under what reflexivity in practice means to arts therapists in South Africa.

This question is represented by the lowercase letter “f” during the thematic analysis process.Table 11 below displays the codes for this topic.

Table 11

Views on What Reflexivity is in Practice within the Arts Therapies Modalities in South Africa

Views on what reflexivity is in practice within arts therapy modalities

Code no.	Higher-level code	Sub code	Description
28	**Reflexivity is important.**		Reflection is an important practice in clinical record-keeping and client tracking.
29	**Self-awareness is reflexivity practice.**	Acknowledging one's own biases. Objectivity. Observing your own thoughts, feelings, and assumptions. Acknowledge own conduct.	Self-awareness is an important aspect in reflective practice in clinical-record-keeping and client tracking. Self-awareness includes reflexivity to acknowledge own biases, remaining objective, understanding own thoughts, feelings, and assumptions. Self-awareness allows a therapist to acknowledge how they are conducting themselves in their practice and that they are not the all-knowing therapist.
30	**Reflexivity in supervision.**		Supervision as a critical part of reflexive practice in clinical record-keeping and client tracking.
31	**Clinical details of clients in sessions in reflexivity.**	Reflection of session. Better understanding of clients in terms of their physical, mental, emotional, physical, and spiritual presentation.	Reflexive practice aids in understanding clinical details of the whole client in clinical record-keeping and client tracking. This involves reflexivity for gathering zoomed out view of sessions with a client, understanding client’s experience, to note client’s verbal statements in sessions, to understand physical expression of a client, in understanding client’s energy levels, understanding client’s vulnerabilities, becoming aware of client’s level of resilience, awareness of how client’s session might be an indicator for the wider context of their life and reflexivity for understanding emerging themes in sessions with clients.

32	**Reflexivity for making clinical choices.**		Reflexive practice as a tool for making clinical choices in clinical record-keeping and client tracking. This includes reflexivity helping a therapist to find missing pieces in session, helping the therapist to look at the client's process critically, finding the next steps in the therapeutic process and to help therapist make choices about use of arts materials and medium in sessions.
33	**Therapeutic relationship in reflexivity.**		Reflexive practice in clinical record-keeping and client tracking as a tool in understanding and improving the therapeutic relationship with clients.
34	**Reflexivity for client care.**	Making appropriate choices. Client at forefront of therapy.	Reflexive practice in clinical record-keeping and client tracking for optimal client care. This includes reflexivity helping a therapist to make appropriate choices, practicing reflexivity regularly and to help keep the client at the forefront of the therapy process.

4.1.2.5.8 Do you include reflexivity in your clinical record-keeping and client tracking practices? (Yes or no). If yes, please explain.

As a follow-up to the previous question, I thought it appropriate to ask the arts therapists if and how they apply reflexivity in their CRCT practices. This would enable me to understand how and to what extent reflexivity is a feature of their work. This question is represented by the lowercase letter "g" during the thematic analysis process.Table 12 below shows the higher-level codes associated with this.

Table 12

Inclusion of Reflexivity in Clinical Record-Keeping and Client Tracking Practice in Arts Therapies in South Africa

Whether reflexivity is included in practice and how reflexivity is included in practice			
Code no.	**Higher-level code**	**Sub code**	**Description**
35	**Choice of therapist to practice reflexivity.**		Choice of therapist to include reflexive practice in clinical record-keeping and client tracking process. Some participants include reflexivity in work and others do not.

36	**Reflexivity as aid to therapists.**		Reflexivity practiced is seen as an important aid to therapist in clinical record-keeping and client tracking practice, which is why it is used during this process.
37	**Reflexivity included in clinical notes.**		Reflexivity practiced as part of the clinical note-taking process in clinical record-keeping and client tracking practice. This includes reflexivity on therapists' ideas and interpretations within session notes or personal notes.
38	**Reflexivity as a hospital requirement.**		Reflexivity practiced as a hospital requirement in clinical record-keeping and client tracking. Reflections need to be on direct observations, themes in sessions and therapists' reflections for hospital notes. These reflections need to be accessible to external professionals.
39	**Reflexivity as aid to understand therapeutic processes.**	Transference and countertransference. Client's responses. Client imagery.	Reflexivity practiced in clinical record-keeping and client tracking as an aid in understanding therapeutic processes. Reflexivity aids a therapist to look at transference and countertransference. Client responses in sessions, client imagery and relevant content in sessions to aid the client's therapy process.
40	**Self-awareness in reflexivity.**	Therapeutic relationship.	Reflexivity practiced in clinical record-keeping and client tracking as means to remain self-aware as a therapist. Reflexivity aids in understanding impact of age, gender, race, etc. in sessions and aids in the therapeutic relationship.

4.1.2.5.9 Are you familiar with clinical record-keeping and client tracking tools used in arts therapy modalities other than your specific modality (Yes or No)? If yes, please explain your understanding of these tools

Although arts therapists often make use of various creative mediums (storytelling, drawing, dancing, singing, etc.) in their sessions, even if these are not integral to the modality they were trained in, the surveyed literature does not seem to cover this. This question aimed to explore whether arts therapists in South Africa are aware of CRCT tools from different modalities other than their own. This question is represented by the lowercase letter "h" during the thematic analysis process. Table 13 below includes the codes for this question.

Table 13

Awareness of Clinical Record-Keeping and Client Tracking Practices in other Arts Therapy Modalities in South Africa.

Awareness of clinical record-keeping and client tracking practices in other arts therapy modalities.			
Code no.	**Higher-level code**	**Sub code**	**Description**
41	**Limited to no awareness.**	Unless undergoing training in another modality.	Limited to no awareness of clinical record-keeping and client tracking practices used in other arts therapy modalities. One participant being aware of multimedia usage in clinical record-keeping and client tracking in music therapy.

4.1.2.5.10 Do you refer to clinical record-keeping and client tracking tools from other arts therapy modalities whilst engaging in modalities other than your primary modality? (Yes or No). If yes, please explain which tools and why.

This final question aimed to further elaborate on the previous question to understand how arts therapists in South Africa use CRCT tools in their practice and for what purpose. This question is represented by the lowercase letter "i" during the thematic analysis process.Table 14 below refers to this.

Table 14

Use of Clinical Record-Keeping and Client Tracking Practices from other Arts Therapy Modalities in own work.

Use of clinical record-keeping and client tracking practices from other arts therapy modalities in own work			
Code no.	**Higher-level code**	**Sub codes**	**Description**
42	**Limited to no use.**	Unless undergoing training in another modality.	Little to no use of clinical record-keeping and client tracking practices from other arts therapy modalities. Only one

participants reported on the use of multimedia clinical record-keeping and client tracking practices for GIM.

4.1.2.6 Step six: interpretation and reporting on codes

A total of 42 higher-level codes were developed from the responses of participants in the questionnaire. As the questions in the questionnaire were influenced by and tied to the themes uncovered in the narrative review, I sorted these 42 codes into their relevant questions. I did this during step five of the thematic analysis. The themes highlighted in chapter three of the narrative review serve as the guiding framework for this study, aiding in addressing the research questions. This is due to the extensive amount of data that was included, as well as the more global viewpoint of the literature, which would make for a good comparison when discussing the CRCT practices of South African arts therapists in chapter five. In order to understand how the higher-level codes might relate to the broader themes found in the narrative review, I discussed how each question drew on focus areas within the narrative review and how this guided me in creating an aim for each question. I discussed this under each question in step five of the analysis. Even though each question in the questionnaire was guided by the themes, many responses from participants could be applied across more than one theme from the narrative review during the interpretation and discussion phase of this study. I conducted my own journaling and reflexive practice before finalising the presentation and interpretation of findings in the following chapter, namely the discussion.

4.2 Conclusion

This study included a total of 9 participants who completed a ten-question questionnaire on Google Forms online. The six steps of thematic analysis by Braun and Clarke (2006) were followed to gather codes for each question. A total of 42 higher-level codes were generated from the question data.

The following chapter focuses on discussing and reflecting on the findings from the narrative review and questionnaire data. This will be done by relating the higher-level codes of the thematic analysis to the broader themes discussed in the narrative review.

Chapter Five: Discussion

This chapter seeks to address the following research questions, (i) What knowledge does the published literature in the arts therapies convey regarding clinical record-keeping and client tracking practices? and (ii) What clinical record-keeping and client tracking practices are used by South African arts therapists? This will be done through careful consideration of the findings presented in chapters three (the broader themes drawn from the literature) and four (the higher-level codes from the thematic analysis of the questionnaire data). Finally, the implications for training and practice will be discussed for each theme. This will be done as a paragraph under each theme to remain relevant and specific to each theme.

5.1 The importance of clinical record-keeping and client tracking as standard practice in the arts therapies

Three articles were included in the narrative literature review pertaining to the importance of CRCT practices in the arts therapies. These practices play a crucial role in ensuring good practice within different clinical settings (Wigram, 2007). Documenting the non-arts-based interactions (talking, facial expressions, gestures, etc.) and arts-based interactions (drawings, crafts, colours used, etc.) is an important facet of arts therapy work (Gussak & Rosal, 2015). Dunphy and Hens (2018) also highlight that CRCT is a practice that should be regarded as a crucial part of an arts therapist's work, due to this being a requirement of health councils in a country, health organisations, professional councils, etc.

All the participants made clear reference to what they view as the primary components in their practice of CRCT, as well as how they adhere to these practices. We could then propose that arts therapists in South Africa acknowledge the practice of CRCT as being an active part of their work with clients. Beyond this, participants also mentioned their responsibility and role in CRCT, such as within the higher-level codes, *Adhering to third party guidelines* (codes no. 1 and 9), *Safe storage of data* (code no. 11) and *Protection of documents* (code no. 20). These codes exemplify South African arts therapists' recognition of CRCT practices as integral to 'good practice,' as mentioned in the literature. The codes highlight some examples of aspects such as adhering to the Health Professions Council of South Africa (HPCSA) as being crucial in the work of an arts therapist, protecting client’s information through safe storage of data and confidentiality in order to adhere to good practice and ensuring that documents are always in good order, thorough and done regularly by therapists.

A practice mentioned in the thematic analysis of the questionnaire responses is that of *Adhering to third-party guidelines*, such as the CRCT guidelines set out by healthcare organisations or other organisations. As mentioned, arts therapists must follow the CRCT guidelines set out by the Health Professions Council of South Africa (HPCSA), Non-Government Organisations (NGO), their work organisations (hospitals, schools, clinics, etc.) and the medical aid of the client.

Working arts therapists should practice CRCT responsibly, underscoring its significance in the work of emerging arts therapists undergoing training in the field. It is crucial to not only make training arts therapists aware of the importance of CRCT but also to provide them with the necessary training. This ensures that arts therapists who are entering the workforce are cognisant of the value of CRCT processes, fostering the maintenance of good practice.

5.2 Clinical notes as a practice in record-keeping and client tracking in the arts therapies

In seven of the included studies, CRCT was mentioned as involving the practice of making and keeping clinical notes or records. This includes the making and keeping of session notes, progress notes and assessment reports, which are written or digital notes and describe the interactions between the therapist and their client.

The narrative review helps in answering question one of the study by emphasising the important aspects of clinical notes, such as documenting the interactions of the client in sessions, stating the client's clinical goals, reflecting on therapy sessions, keeping notes on the client and keeping assessment notes in the CRCT practice. Wheeler (2015) emphasises that an arts therapist should make meaning of the engagement and processes within sessions by looking at a client's thoughts, symbols, moods, preferences, coping strategies, experiences, and communication (both verbal and non-verbal). Beyond this, McGann (2012) states that clinical notes should also include items such as referral letters, contact details of the client, consent forms detailing the confidentiality practices and progress reports for the client, as these all become useful in keeping with ethical practice during CRCT. Pénzes et al. (2018) further the sentiment of clinical note-taking being an important tool in CRCT, as this practice helps an arts therapist gain valuable insight into the mental, physical, emotional and spiritual health of a client who is undergoing therapy. In their study, they also mention the usefulness of including art products (paintings, drawings, sculptures,

etc.) in the CRCT process, as the art product contains valuable information about the client and may become an aid to arts therapists. Another important aspect to consider for clinical note-taking is whether an arts therapist would prefer to make use of manual methods (written notes) or digital methods (typed notes, apps, etc.) when practicing CRCT (Dunphy & Hens, 2018). Whilst the use of manual or digital methods in CRCT features under this theme, it is discussed in more detail under its own theme in chapter 5. Finally, Jones (2008) highlights the positive nature of clinical note-taking that is collaboratively engaged in with the client. This would involve gathering the client's input about their goals for therapy, their experiences of therapy and reflecting on their own interactions within sessions.

To support the literature of the narrative review, higher-level code no. 2 highlights "process notes", "session notes", "client reports", "progress notes", "assessment reports", "written or typed notes" and "client observation notes on the client experiences" as elements within CRCT. Participant A describes clinical note-taking as "keeping detailed process notes in order to capture where the client is at creatively and in their process" and Participant F mentions "session notes for reference between sessions and progress recording over time."

Analysis of responses to question "d" in the questionnaire also contains *Clinical note-taking* (code no. 21), which is focused on keeping reflexive notes, keeping session notes that contain modality-specific information (for example, stating musical data in music therapy sessions), and naming the interventions used in sessions. The literature supports this idea by highlighting/mentioning specific aspects in music therapy, such as the inclusion of information like musical preference, quality of play, expression, and dynamics (as discussed in article 2). Additionally, it emphasises the documentation of formal elements in art therapy, such as the use of colour, quality of brushstrokes, and the use and directions of lines made by the client in art therapy (as discussed in article 6).

In support of (article 6) in the narrative review, *Inclusion of art process and art produc*t (code no. 3) and *Including creative products* (code no. 16) refers to drawings or paintings, photographs, audio recordings or video recordings as well as their creative work in CRCT. Participant A regards this as being crucial "so that the creative work that my client is working with can be kept as part of the client tracking process." Furthermore, keeping art products serves as a useful tool for therapists when writing assessment notes. Participant H states that "any images that I make in response to clients' work, is also considered a part of the tracking

process." With reference to research question two of this study, it can then be said that keeping the art product is not only a primary practice of CRCT practices, but also a way in which arts therapists in South Africa may include their modality within the practice.

Whilst the literature only mentions digital uses of this practice, such as typing out clinical notes in the MARA application within (article 12) or typing notes in aMSN chat within (article 4), the participants had mixed reactions to the use of manual or digital methods for CRCT in their own work. This will be further discussed under its own theme later in this chapter. It is important, however, to note that the practice of "written or typed notes" appears as a subcode for *Clinical note-taking*. This subcode highlights the choice that an arts therapist has in choosing whether they would prefer to make and keep their clinical notes written on paper or typed out and saved on their computers.

Finally, in support of (article 12) in the narrative review, the themes of *Collaboration* (code no. 6), *Reflexivity* (code no. 7) and *Supervision* (code no. 14) in clinical notes during the CRCT process are presented by participants as being both an important and primary component of their work. All three higher-level codes are further discussed later in this chapter, but it is important to note that participants in the study mention these aspects when describing clinical note-taking during their practice of CRCT.

Making and keeping clinical notes is a crucial and useful tool for arts therapists when engaging with CRCT in their work. This highlights the importance for arts therapists to be trained sufficiently in their studies on clinical note-taking, the forms it may take, how to think about clinical notes and the benefits it may have in their work with clients.

5.3 Assessment as a practice in clinical record-keeping and client tracking in the arts therapies

Thirteen articles in the narrative review were focused on tracking the progress of a client and their therapy process through evaluation and assessment tools in CRCT practice within the arts therapies. This literature discusses the use of assessment tools to allow the therapist to notice patterns or trends in therapy with a client. Client tracking through assessment or evaluation practices also involves a therapist reflecting on and understanding the product of the creative process, for example, a drawing, painting, sculpture, or collage, and how it may be a symbol of

the client's life. The use of assessment tools and the nature of evaluation in client tracking might involve aspects such as looking at client's strengths and abilities, noting interactions, noting both verbal and non-verbal communication, looking at how the client is presenting in therapy (emotionally, physically, behaviourally, etc.), observing the therapy process (for example, how the client is interacting with the creative material in a session) and looking at the creative product (for example, the finished song or the drawing of the client). Each art therapy modality would examine different aspects within their specific creative medium during the client tracking process. For example, in (article 12), Jones (2008) discusses how drama therapists might observe behaviours, communication, movement and symbolism in role play, dramatic projection, drama therapeutic empathy, witnessing, embodiment, playing, the life-drama connection and transformation with their clients in sessions. On the other hand, in (article 3), Gussak and Rosal (2015) discuss how art therapists will evaluate formal elements of their client artwork, such as lines, contours, colours and shapes when entering client tracking practices.

One cannot ignore the extensive information found within the literature on the benefits of evaluation of clients and the use of assessment tools within CRCT practices. All articles mentioned above argue for this practice being a direct aid to a therapist and the therapy process. Some benefits include aspects such as, (i) creating a culturally sensitive practice, (ii) understanding of a client's abilities and strengths, (iii) interpretation of session information, (iv) understanding of the client, (v) future planning of therapy with a client, (vi) responses with a client in therapy, (vii) client care and (viii) clinical decision making.

Evaluation and assessment in CRCT is highlighted in the literature as being a complex practice in the arts therapies, but also a practice that comes with many benefits to the process of therapy. Due to the complexity of evaluation and assessment in the arts therapies, many therapists choose to use their own methods of client tracking, which do not involve the use of standardised tools within their fields. For example, in (article 5), McGann (2012) explains her use of SOAP notes to help stay updated in her client tracking practices with clients. This has led to some degree of inconsistency within the client tracking in the arts therapies. Jennings and Meldrum (1994) support this statement and describes how difficult arts therapists find following assessment and evaluation practices. Meldrum not only emphasises that this may be due to the complexity of using assessment tools, but also due to the nature of assessment in therapy going against the values of an arts therapist who aims to not pass judgement on a client as they view them with positive regard. This is why Meldrum suggests that arts therapists follow more collaborative

styles of evaluation and assessment when practicing CRCT. By doing this, clients may feel more empowered and the client consents to the practice.

Despite assessment forming a primary element of evaluation in the articles mentioned above, the use of assessment tools in CRCT did not appear as a higher-level code within the thematic analysis of the questionnaires, but rather as a subcode for *Clinical note-taking* (code no. 2). It is here that participants explained the inclusion of assessment reports and notes within their clinical notes. Assessment scales are also described within higher-level code no. 26, *Training in clinical note-taking*, where participants mention receiving some training in the functions and use of assessment tools during their studies in the arts therapies. This aspect of assessment is not elaborated on and was not a common response from participants. I do think that this could be because there was no direct focus in any of the questions on assessment practices or tools within the questionnaire. I chose not to place focus on assessment tools or practices in the questionnaire (for example, asking direct questions about the use of assessment or assessment tools in CRCT), as I wanted to see what would emerge naturally from the responses of the participants regarding this. This would help me understand whether the use of assessment tools is a focal point in CRCT practices amongst South African arts therapists.

Client tracking practices also featured in some of the descriptions of the higher-level codes, as well as the responses from participants in the study. For example, higher-level code no. 18, *modality-specific practice*, describes how arts therapists make use of the resources, tools and interventions available to them in their modality in order to practice CRCT. Higher-level code no. 13, *Client-specific documentation*, may not make direct reference to assessment or evaluation, but Participant B mentions that they hold "regular feedback meetings with parents - summarising and tracking progress of client (if working with child)", which means that this participant does practice client tracking processes with their clients in a collaborative manner. Furthermore, in higher-level code no. 15, the inclusion of multimedia is described by Participant A as being an important aspect in clinical note-taking and client tracking, as the "creative work that my client is working with can be kept as part of the client tracking process." This emphasises how photographs, audio recordings or video recordings of a client's creative product might aid in helping an arts therapist track their clients. Finally, there is some mention of how reflexivity might aid an arts therapist during their client tracking practice. For example, Participant A mentioned that it is "important that in my client tracking specifically I am noting where my own ideas/thoughts/interpretations are coming in," when asked about how reflexivity

is included in their CRCT work as an arts therapist. Finally, there are higher-level codes such as *Inclusion of art process and art product* (code no. 3), *Collaborative* (code no. 6), *Including creative products* (code no 16), *Inclusion of client's needs and wants* (code no. 17) and *Modality specific practice* (code no. 18), which speak to the many aspects mentioned in the above-mentioned articles on what comprises evaluation in client tracking practices within the arts therapies. For example, code no. 17 speaks to how participants in the study always ensure that their practice in CRCT is one centred around the needs and wants of the client. This supports the information in (article 8), where Rafieyan and Ries (2007) explain how a client's needs should be met through ongoing evaluative practices within client tracking in the arts therapies.

Assessment and evaluation of a client in CRCT practices is a theme that is quite prominent in literature within the arts therapies. The literature argues for its importance and value in the work of arts therapists, yet this practice did not feature so prominently within the questionnaire data of this study. It is unclear whether the data reflected in the thematic analysis that was done can help in answering research question two of this study. Perhaps rewording "assessment in clinical record-keeping and client tracking" to "client evaluation practice in clinical record-keeping and client tracking" would have elicited more relevant responses in this regard. There is data from responses by participants that supports some of the different ways of tracking a client in practice. Despite this, due to the prominence of assessment in the literature on global practices, it might be useful to build into the training of South African arts therapists, assessment practices that might aid in CRCT practices.

5.4 Client-centred clinical record-keeping and client tracking practice in arts therapies

Seven articles in the narrative review had a focus on CRCT that is client-centred. This involves aspects such as thinking of the context of the client, collaborating with the client, and considering the client's needs and desires whilst engaging in the practice of CRCT.

In the articles emphasis is laid on the importance of setting collaborative goals and aims with clients before sessions, so that a therapist may feel a sense of mutual direction when planning sessions and tracking their client. Thompson (2020) describes this as involving collaborative goal setting, collaborative assessment, checking the feasibility of therapy with clients and the interventions used in sessions. Jennings and Mitchell (1994) support this by stating that

collaborative CRCT in arts therapy looks at gathering the input of clients as they rate their own feelings, expectations, ideas and perceptions in therapy according to the goals they have set. In doing this, a therapist might feel more equipped to meet the needs of the client in their context, upholding the therapeutic relationship and understanding the values of the client.

Beyond this, CRCT practices that are client-specific are described by Valente and Fontana (1994) as crucial in understanding the whole client. This includes looking at a client's communication, creativity, social interaction, spontaneity, initiative, self-disclosure, trust, mood, concentration, imagination, and courage in sessions. By looking at the whole client, a therapist will observe and evaluate their client in a more client-centred way, as this might aid in understanding the inner workings (what is happening inside the client emotionally, physically, spiritually, mentally, etc. that may not be visible on the outside to others) of their client.

Collaboration (code no. 6), *Client specific documentation* (code no. 13) and *Inclusion of clients' wants and needs* (code no. 17) are all higher-level codes within the thematic analysis in chapter four that address the information provided in the narrative review. It is within these higher-level codes that the practice of CRCT is described as collaborative. It also comes through in the responses from participants such as, "Anything that is created by the client is offered to them to take, and if they wish to leave it with me, then I discuss a plan moving forward". Collaboration in a client-centred manner was further described by participants as giving clients feedback about their therapy process, giving their clients the choice in CRCT practices, and remaining sensitive to the client's needs and wants in therapy. An interesting response was that of Participant E, who comments that "record-keeping is part of the anti-oppressive practice ethic" and provides this as the reason to ask their client for consent before undertaking the practice. In her paper, Dalton (2018) supports the above response but adds that art therapy practice in South Africa can be challenging in the face of the multicultural nature of its communities. An additional challenge is that arts therapies have Western roots whilst the communities within South Africa have their own traditional, non-Western practices and indigenous knowledge. Dalton (2018) expresses the view that arts therapy clients in South Africa will benefit from therapy if their therapists remain culturally sensitive in their practice, as clients will then feel that the therapy is more relevant to their lives. Finally, most participants agree with the above-mentioned literature, which refers to aspects such as CRCT focusing on the client's goals for therapy and other aspects of therapy.

Because client-centred CRCT practices, with special reference to collaboration and inclusion of the client's wants and needs, are supported by both the literature in the narrative review and the responses from participants in this study, they are practices which can answer both research questions one and two of this study. Arts therapists should take special care to ensure that their clients can collaborate in setting clinical goals, thereby empowering clients to address their own needs and wants in therapy. Engaging in such collaboration will not only assist therapists in maintaining client-centered clinical records and tracking practices but also ensure that the client remains a focal point in their clinical thinking and decision-making. It is also worth noting that collaboration aids in creating a culturally sensitive space for clients. Students who are undergoing training in the arts therapies should be made aware of the benefits of collaboration within CRCT practices and how to engage with clients collaboratively. Training in CRCT that is client-centred (caters to the client's needs, the client's wants, the client's strengths, the client's views, etc.) should also be highlighted. Finally, students who are undergoing training should be made aware of the Western roots of arts therapy practice and how to remain culturally sensitive in their work with clients.

5.5 Training in clinical record-keeping and client tracking practices in the arts therapies

The theme of training in CRCT practices appeared in six of the articles in the narrative review and the importance of receiving training (both inside and outside of formal studies) in CRCT practices and tools was discussed. The literature emphasises that arts therapy students should be well trained in the skills, core processes and theoretical underpinnings of their modality, as these become a crucial element within the practice of CRCT. The literature also argues that arts therapists need to enter the workforce well trained and fully equipped to work with clinical records and assessment tools in their modality, as this will ensure that they practice their profession safely (Schuldt & Silverman, 2020). Training also ensures that practicing arts therapists adhere to general standards or guidelines set out for work with clients, are aware of how tools function in clinical settings and may be of aid (Jones, 2008), are feeling more confident in their practice as professionals (Dunphy & Hens, 2018) and are competent in their practice (Dunphy et al., 2021). Ritnour et al. (2015) also make mention of the importance of continuous training in CRCT practices and tools by arts therapists and found that this helps arts therapists to remain knowledgeable in their use of assessment tools and criteria in the profession.

The participants in this study all mentioned some form of training in CRCT practices or tools whilst they were training to become an arts therapist in South Africa. This is supported by higher-level code no. 23 in the thematic analysis of chapter 4, Training provided in South Africa. It was within this training that participants received *Training in clinical note-taking* (code no. 26). This also included some being trained in making and keeping session notes, working with assessment scales, making and keeping transcriptions, making and keeping process notes, making and keeping clinical files and finally, keeping documents. An example of this is provided by Participant E, who mentions that they were trained to "keep clinical files with profiles of clients, reports and analyses of the clinical process." Beyond this, *Resources provided during training* (code no. 27), also appeared within the thematic analysis. Participant D explains this by mentioning that "we were given extensive resources on assessment scales, session note practices and various formats of transcriptions etc. for record-keeping." The literature makes mention of the importance of training arts therapy students in the skills and theoretical underpinnings found within their modality. *Modality specific practice* (code no. 18) speaks to arts therapists using interventions, tools and theoretical underpinnings that are specific to their modality when practicing CRCT.

Despite the training provided to all participants and the resources provided to some, five of the nine participants referred to the *Quality of training* (code no. 24) in South Africa and how the training they received was not adequate to help in preparing them for work with clients outside of their studies. *Training according to site guidelines* (code no. 25) might be a reason for this, as participants mention that their training in CRCT was guided only by what their clinical placement sites requested from them. This might be an indication that training in the practice and tools for CRCT within arts therapies in South Africa may not be consistent for all students. This might also be problematic to new professionals in the field who are working in clinical settings different to those of their training sites, as they may have no knowledge of how to go about practicing in CRCT in new work settings or with different clients. As mentioned by some participants in the study, this inconsistency in training has led to some South African arts therapists seeking further training in CRCT practices and tools outside of their studies.

It is clear from this theme that both the literature and participants in this study view training in CRCT practices as crucial. This is to ensure that professionals in the field feel they have the knowledge and practice necessary to do their work as ethical, equipped, and informed arts

therapists. Consistency in clinical record-keeping and client tracking practices and tools is supported by the literature and draws attention to the training provided to arts therapists in South Africa. It might be beneficial for arts therapy students undergoing training in South Africa to receive information, training and resources in CRCT practices and tools from their institutions. Institutions may consider including training in CRCT tools that covers various clinical settings and clients, so that all students have a baseline of information they may use when entering the workforce. This may also help new professionals in the field of the arts therapies in South Africa to feel better equipped when placed or working in different work settings. Furthermore, professionals in the arts therapies should be encouraged to not only help educate colleagues in CRCT practices through Continuous Professional Development (CPD) events or workshops, but arts therapists should also be encouraged to attend these relevant events or workshops to continuously grow in their knowledge of the practice.

5.6 Reflexive practice in clinical record-keeping and client tracking in the arts therapies

Reflexive practice, such as keeping reflection notes and attending supervision as a standard of practice in CRCT, was mentioned by four articles in the narrative review. Reflexivity is described in these articles as a useful tool for therapists and a practice which should be ongoing throughout their professional lives. Reflexivity by a therapist can take many forms, such as writing reflection notes after each session, attending supervision, and keeping personal reflection notes. This encompasses reflexivity, helping (or aiding) therapists in gaining a deeper understanding of sessions with clients, critically examining the client's process, developing the next steps in the therapeutic process, and making informed choices about the use of arts materials and mediums." By practicing reflexivity, the literature argues that an arts therapist will feel better attuned to the client and process and that this will promote positive transformation in their work. Beyond this, reflexivity aids in understanding a client better, creating a safer environment for a client’s expression and remaining self-aware to ensure good practice with a client.

Participants in the study also viewed reflexivity as an important part of the practice of arts therapies. This is supported by higher-level code no. 28, *Reflexivity is important*. Although this practice is viewed as important by participants, not all choose to include reflexivity within their practice of CRCT.

Participants in this study mentioned how self-awareness is an important aspect of reflective practice in CRCT. Furthermore, self-awareness aids in a therapist acknowledging their own biases, remaining objective, understanding their own thoughts, understanding their own feelings, and avoiding assumptions with clients in therapy. Self-awareness also allows a therapist to acknowledge how they are conducting themselves in their practice. Code no. 20 speaks about how supervision is a critical part of reflexive practice in CRCT and can aid a therapist as they receive guidance in their work. This is highlighted by Jennings and Meldrum (1994) in (article 17), who state that supervision is vital and that arts therapists should be guided in supervision for their full professional lives. Code no. 31 speaks about how reflexivity aids in gathering "zoomed-out" views of sessions with a client, as well as understanding a client's experience, verbal statements in sessions, physical expression of a client, energy levels, vulnerabilities, level of resilience, the wider context of their life and emerging themes in sessions. Participants also find that reflexive practice in CRCT aids in understanding and improving the therapeutic relationship with clients. This is highlighted in both the narrative review and thematic analysis as being an aid to therapists in making and keeping clinical notes that include a therapist's ideas and interpretations in sessions. Finally, reflexivity is described in the thematic analysis as an aid to a therapist to look at transference and countertransference, client responses in sessions, client imagery and relevant content in sessions to assist the client's therapy process. This is supported by Wong (2021) who argues that reflexivity is a standard of practice that should aim to gain a deeper understanding of a client by looking at aspects such as imagery, experiences, therapeutic relationship and what is happening in sessions.

Much like in the narrative review, the higher-level codes within the thematic analysis of the questionnaires also emphasise reflexivity in CRCT as having multiple benefits. This includes reflexivity helping a therapist to gain a better understanding of what is happening in sessions with clients, reflexivity helping the therapist to look at the client's process critically, reflexivity helping therapists develop the next steps in the therapeutic process and reflexivity helping therapists make choices about use of arts materials and mediums in sessions. All these aspects are beneficial in helping an arts therapist feel secure in their understanding of the therapy process, their work, and their clients. Another benefit of reflexive practice that the participants mention is that of ensuring optimal care for clients, as it aids a therapist in making appropriate choices for a client and keeping the client at the forefront of therapy.

Reflexivity as a practice in CRCT answers both research questions one and two of this study and is supported by both the literature in the narrative review and the questionnaire responses. It can therefore be said that practicing arts therapists should be engaging in reflexivity in their work with clients not only to ensure that all the benefits for the client are met, but also the benefits for themselves as professionals (better self-awareness, improved understanding of clients, easier client tracking, etc.). As mentioned previously s, CRCT is sometimes viewed as complex in nature and often difficult to follow in practice, but the findings show that reflexivity is a resourceful aid which holds the potential to make CRCT practices easier for arts therapists. It would also be important then, to explain what reflexivity is, how it aids work as an arts therapist and the many benefits of including it in CRCT practices to students who are undergoing training in arts therapies.

5.7 Ethical practice in clinical record-keeping and client tracking in the arts therapies

Articles in the narrative review speak to the theme of ethical practice in CRCT as being important for arts therapists to remain ethical in their practice. The narrative review makes mention of the ethical obligation that arts therapists have to adhere to guidelines set out by various organisations or bodies. This then becomes the first aspect to consider when practicing ethically within the arts therapies and is supported by higher-level codes no. 1 and no. 9 in the thematic analysis.

Another ethical aspect mentioned both in article 10 and 19 of the narrative review is that of gathering a client's consent, safely storing clinical records, and maintaining clients' confidentiality during the practice of CRCT in arts therapies. The participants in this study made multiple references to aspects such as *Client protection* (codes no. 4 and 10), *Data storage* (codes no. 5 and 11) and *Protection of documents* (code no. 20) in their practice of CRCT, making mention of other aspects too such as client consent and confidentiality as being crucial. Safe data storage is supported by the responses of some participants, for example, Participant D mentions that they store records "in a locked storeroom" and Participant G ensures safe storage by ensuring that "anything that is done on a computer is done on a computer with updated anti-virus programs and that is backed up on a system that is also POPI compliant". The literature in the narrative review and higher-level codes from the questionnaire data bring to focus the

importance of including aspects such as client consent, safe data storage and confidentiality in the practice of CRCT.

(Article 14) makes mention of multiple aspects to consider if an arts therapist wants to practice CRCT ethically. The therapeutic relationship and reflexivity are listed as important aspects of this article. Whilst there is no direct reference in the thematic analysis findings to the therapeutic relationship in terms of practicing ethically, participants in the study do make mention of how reflexivity in CRCT might become an aid to arts therapists in creating and keeping a positive therapeutic relationship with clients. This is supported by higher-level code no. 40, *Self awareness in reflexivity,* which discusses how reflexivity aids in understanding the impact of age, gender, race, etc. in sessions and aids in the therapeutic relationship through reflection of these. higher-level code no. 33, *Therapeutic relationship in reflexivity,* also highlights reflexive practice in CRCT as being a tool for therapists to understand and improve the therapeutic relationship with clients.

(Article 14) also mentions aspects such as ongoing assessment, monitoring a client's progress, keeping evaluation notes of the client's progress, setting therapy goals, using modality-specific mediums in sessions and ensuring adequate training in documentation and assessment as being important practices to uphold in CRCT. All these aspects are discussed in detail previously in this chapter and are supported by the findings of the thematic analysis presented in chapter 4.

Remaining ethical as an arts therapist involves adhering to guidelines, ensuring client protection, practicing safe data storage, protecting records, upholding the therapeutic relationship, engaging in reflexivity, employing appropriate interventions, and conducting client evaluation/assessment. All these aspects are important considerations for arts therapists when practicing CRCT in their work. It is advised that arts therapists then implement these aspects of ethical CRCT to ensure safe and good practice in their work with clients. It is also important that training arts therapists are brought into awareness of the ethical aspects in CRCT in their work and are taught how to adhere to these practices, so that they may feel prepared when entering their work.

5.8 Practicing clinical record-keeping and client tracking manually or digitally in the arts therapies

Articles 4, 21 and 22 in Table 2 of the narrative review referred to the theme of manual (written notes, use of paper, storing of hard copies, etc.) and digital (typed notes, use of a mobile application, storing on computers, etc.) CRCT practices by arts therapists. The articles also address the use of technology in the practice of CRCT and point to this as an emerging practice that is gaining more attention within the field of arts therapies. The authors ascribe this to the need to produce reports timeously, the complex nature of clinical record-keeping, as well as the increasing availability of user-friendly and resourceful technology devices and mobile applications. The use of technology and mobile applications was described in the articles as having a positive impact on the work of therapists, as it allowed therapists to follow the practice of CRCT in a more effective, useful and easy way.

When asking the participants of the study about their use of manual or digital methods for CRCT, it was found that each arts therapist follows their own methods according to what they find most useful, or the guidelines set out by the organisations they work for. For example, Participant C mentions that in their private practice, they make use of "handwritten notes which track the process and will include more of my personal experience of the session; and typed records which are more formal and could be shared with other professionals." Unlike in the literature, no participants made mention of specific mobile applications used when practicing CRCT digitally, and there was also no mention of the reasons behind their choice to use manual or digital methods. This could be due to how question "d" was asked in the questionnaire and the fact that there was no follow-up question pertaining to this (for example: what digital methods do you use and why?). Despite this, it is not a surprise that only one participant of the nine, makes use of only manual methods in their CRCT process, as Dunphy et al. (2016) highlight the complexity of manual CRCT practices in the work of arts therapists and found that there are a lot of inconsistencies within this practice as a result. This is supported by Peterson and Gussak (2006) who argue that digital platforms are there to aid therapists in documenting their work in a way that is more efficient, comprehensive, and useful. This could be the use of digital platforms that directly help arts therapists (for example, the MARA application) or non-arts therapy-related digital platforms that help with administration (for example, typing notes on Microsoft Word, Spotify for music, Google Calendar for sessions, etc.)

Whilst digital platforms are emerging, it is clear from both the literature and the questionnaire data that many arts therapists still use manual methods during their CRCT practices. The choice between digital or manual CRCT practice is that of the therapist. For this reason, it is important that arts therapists explore and choose a method that is most efficient, easy and comprehensive to them. Furthermore, arts therapists should try to be consistent in their CRCT practices and choose a method which will allow them to meet the needs of their work. Finally, when engaging with digital methods of CRCT, such as using mobile applications, arts therapists should ensure that they are knowledgeable about this and undergo available training on the use of these platforms before making it a part of their work. Without such knowledge, arts therapists might become increasingly frustrated and the practice of CRCT might be less useful (Peterson & Gussak, 2006). This should be emphasised to arts therapists during their training in CRCT practices.

5.9 Inclusion of multimedia in clinical record-keeping and client tracking practice in the arts therapies

(Article 4) in Table 2 of the narrative review speaks to research question one by referring to the inclusion and importance of multimedia, such as images, video recordings and audio recordings, whilst practicing CRCT. Dunphy and Hens (2018) praise the inclusion of multimedia in record-keeping for its usefulness to arts therapists and point to how multimedia aids therapists in revisiting session material, making more detailed notes of sessions, noticing interactions in sessions, and reflecting on sessions. This, in turn, helps an arts therapist to be more thorough in their CRCT process.

The data from the thematic analysis helps to answer research question two because it focuses on the use of multimedia in CRCT practices in South Africa. Two codes, namely the *Inclusion of art products and art processes* (code no. 3) and *Including multimedia* (code no. 15) attest to this. These higher-level codes draw attention to how including photographs, video recordings or audio recordings of a client's art product (a drawing, finished song, a final performance of dance, etc.) and a client's art process in sessions are primary components in the practice of CRCT within the arts therapies. For example, Participant A says, "I include photographs or screenshots of digital work/images, so that the creative work that my client is working with can be kept as part of the client tracking process."

Both the literature in the narrative review and the responses to the questionnaires support the inclusion of multimedia when practicing CRCT in the arts therapies. This aids in promoting multimedia usage to both arts therapists and their clients as it is a tool in the CRCT process that helps to keep a client's creative work at the forefront of their practice. The inclusion of multimedia as a practice should be promoted among arts therapy students as an aid in CRCT. The need to maintain confidentiality around this practice should be emphasised.

5.10 Familiarity and use of clinical record-keeping and client tracking practices in other arts therapy modalities

None of the articles reviewed addressed the issue of arts therapists being aware of or the fact that they make use of CRCT practices or tools from other arts therapy modalities when working in the modality they trained in. This fact also came through during analysis of the questionnaire data. Thus, higher-level codes, *Limited to no awareness* (code no. 41) and *Limited to no use* (code no. 42) indicate that the arts therapists surveyed in South Africa have little to no awareness of the CRCT practices and tools found within other arts therapy modalities and make no use of practices or tools from other modalities in their work. The exception to this was Participant I, who is an art therapist undergoing Guided Imagery and Music (GIM) training and is therefore aware of some music therapy practices and tools and makes use of audio recordings for supervision in their practice.

These results are not surprising, as arts therapists are trained to specialise in and meet the requirements of their own specific modalities (for example, a music therapy student is trained in music therapy tools and practices). Although this does not come through in this research, many arts therapists make mention of using different creative mediums (music, art, dance or drama) within their sessions with clients (for example, an art therapist might use music to guide the art-making process with clients) that are not always aligned to their specific arts therapy modality. This is supported by some responses to the questionnaires. For example, Participant B, a drama therapist, mentions keeping "photographs of artwork" in their clinical records and Participant D, a music therapist, "keeps all drawings or art making" of clients after sessions as part of their clinical records.

5.11 Implications for practice and training in arts therapies

CRCT practices become a crucial and valuable aspect of an arts therapist's work and, in many cases, are a regulatory requirement from health organisations or professional councils. Most arts therapists are aware of the ethical importance of CRCT and adhering to these regulations, but there is little literature available pertaining to CRCT practices for all arts therapies modalities.

This study might become a useful document to practitioners who wish to further their knowledge of CRCT practices and what these practices entail. This could be done with the help of looking at the different themes and the information provided under each. For example, the study might be used in training students on the importance of CRCT practices and the various aspects that might make it valuable in their work beyond training. Through a better understanding of why CRCT practices are important and how they might aid in their work as an arts therapist, both students and qualified arts therapists may become more motivated to engage with CRCT. Another example is that an arts therapist or student in arts therapy may wish to explore their understanding of reflexive practice and why this might benefit their work. The theme of reflexive practice in CRCT in this study may help these individuals see the benefit of including reflexive practice in their CRCT practices and the various forms this might take (supervision, notes, etc.). The study might also help to guide arts therapists in how to go about practicing in CRCT. For example, an arts therapist may read the theme about clinical note-taking and gain a better understanding of how session notes, process notes, reflexive notes and assessment notes are an important aspect of CRCT and hold many benefits. Whilst the theme does not provide working examples of clinical notes, an arts therapist will be able to read this study and feel a better sense of what constitutes clinical note-taking in practice and could then do further research into how to implement these practices.

Finally, this study successfully answers both research question one and two, therefore providing arts therapists in South Africa with a resourceful document that scopes both the global literature of CRCT practices, but also the views of other professions on CRCT in the country. This may help an arts therapist in South Africa become aware of what practices in CRCT are deemed valuable, which practices are being followed by other South African professionals and how to better the practice of CRCT in the country.

Chapter Six: Conclusion

6.1 Summary of this study

This qualitative study had two purposes: the first was to conduct a narrative literature review on the practice of CRCT across the world, and the second was to explore the experiences and insights of arts therapists in South Africa regarding their CRCT practices. During the search phase for the narrative review, 22 articles were identified and chosen to be included through screening of their content and how they could help in answering the research question of this study. Articles were also screened to place the literature into themes that could help guide the study. A total of nine participants completed the questionnaire data and Braun and Clarke's (2006) six steps of thematic analysis were followed. A total of 42 higher-level codes were developed and described in chapter four. The themes from the narrative literature review and the higher-level codes from the thematic analysis of the questionnaire responses were analysed alongside one another and then discussed in relation to the research questions.

A total of ten themes in chapter five discussed the practice of CRCT both outside and inside South Africa. These themes are listed below:

- The importance of clinical record-keeping and client tracking as standard practice in the arts therapies
- Clinical notes as a practice in record-keeping and client tracking in the arts therapies
- Assessment as a practice in clinical record-keeping and client tracking in the arts therapies
- Client-centred clinical record-keeping and client tracking practice in the arts therapies
- Training in clinical record-keeping and client tracking practices in the arts therapies
- Reflexive practice in clinical record-keeping and client tracking in the arts therapies
- Ethical practice in clinical record-keeping and client tracking in the arts therapies
- Practicing clinical record-keeping and client tracking manually or digitally in the arts therapies

- Inclusion of multimedia in clinical record-keeping and client tracking practice in the arts therapies
- Familiarity and use of clinical record-keeping and client tracking practices in other arts therapy modalities

6.2 Value of conducting a narrative literature review with questionnaires for this study

The narrative literature review was useful in gathering relevant literature pertaining to the practice of CRCT in arts therapies across the world. The questionnaires were useful in gathering information about CRCT practices of arts therapists working in South Africa. As there is no literature about CRCT practices in arts therapies within South Africa, the questionnaires offered useful insights into how arts therapists are working with CRCT in their work as professionals.

Having both the themes from the narrative review and the higher-level codes from the questionnaires was valuable in creating links between CRCT practices on both a global level and locally within South Africa. It provided useful insight into the practice of CRCT in South Africa and the implementation of these practices for arts therapists and students in arts therapies.

6.3 Limitations of this study

Owing to the fact that the topic of the study is broad in nature and because this is a mini-dissertation with time constraints, only a select number of data sources could be included in the study for the narrative review.

Furthermore, while the study aimed to recruit 12 participants, only nine were available to complete the questionnaires. According to the SANATA database, there are 73 registered arts therapists in South Africa and the limited participation in this study means that only the CRCT practices of a few were explored. This limited data, therefore, is unable to present a fuller picture of what CRCT practices are being followed by arts therapists in the country. There is also no available literature by South African arts therapists on the practice of CRCT which could help guide the study.

6.4 Recommendations for future research

Further research can explore CRCT practices on both a global and local level. It would be useful to gather more relevant articles that address the practices of CRCT and expand on the themes mentioned within this study. The CRCT practice is regarded as important by arts therapists and in the literature surveyed. The insights of more arts therapists on the subject would help in expanding knowledge of CRCT practices in the country. Finally, exploring this topic in relation to how best to guide training programmes in arts therapies would also be valuable.

6.5 Conclusion

The use of both a narrative review with questionnaires was useful in this qualitative study to develop an understanding of CRCT practices on both a global level and within South Africa. Whilst there were limitations to the study and further research is recommended, this study was successful in answering both research question one and two, as themes from the narrative review and higher-level codes from the thematic analysis were discussed in relation to the topic. This study also provides a good platform for understanding CRCT practices in all arts therapies modalities and serves as a good referral document to practitioners who wish to know more on the topic. There has not been a study exploring the CRCT practices of arts therapists across all four modalities and, as such, this study serves to provide arts therapists both outside and inside of South Africa with valuable information pertaining to CRCT practices. This study also serves as a single document that scopes both the literature pertaining to CRCT practices in the arts therapies and the insight of professionals in the field within South Africa. This provides both a broader and more focused lens on CRCT practices for South African-based arts therapists and serves as a document to help guide their own CRCT practices in their work. Finally, this study highlights the importance of training in CRCT and could serve as a document for students who are learning about this practice in their studies.

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Appendices

Appendix A

Informed consent form for research participants

Dear Participant

I am currently enrolled for my master's in music therapy at the University of Pretoria for which I am conducting a research study. I would greatly appreciate your involvement.

Title of the study

Clinical record-keeping and client tracking practices in the arts therapies.

Aim of the study

My study aims to do an integrative systematic literature review of clinical record-keeping and client tracking practices in the arts therapies.

Research procedures

Your involvement entails filling in a short, online questionnaire about clinical record-keeping and client tracking within your specific practice in the arts therapies. It should take a maximum of fifteen minutes to fill in.

Confidentiality

The information that you supply will be treated confidentially and will only be accessed by myself and my supervisors. Due to University regulations, the anonymised data will be kept electronically on Google Drive and will remain the possession of the University of Pretoria for ten years. You may choose a pseudonym for the purpose of confidentiality in the study. Other researchers may have access to this study when published.

Potential risks

There are no potential risks to this study. The information you supply will be treated with the utmost respect.

Potential benefits

This study hopes to provide a comprehensive understanding of record-keeping and client tracking across the four modalities in and out of South Africa. This might be useful for arts therapists who would like access to information about clinical record-keeping or client tracking practices from the four arts therapy modalities, as clinical record-keeping, and client tracking is an HPCSA requirement in South Africa.

Participants' rights

Your responses are voluntary, and you may discontinue your involvement in this study at any time. You may ask any questions pertaining to the study before signing the consent form.

Contact details of researcher

Jodi Batty

Jodz1995@gmail.com

Contact details of supervisor(s)

Andeline Dos Santos

andeline.dossantos@up.ac.za

Carol Lotter

carol.lotter@up.ac.za

Appendix B

Consent Form

I, _____ (name of participant) hereby consent to being involved in this study by filling out a questionnaire.

I understand that I may withdraw from the study without there being any negative consequences.

_____ _____ _____

Participant Name & Surname Signature Date

_____ _____ _____

Researcher Name & Surname Signature Date

_____ _____ _____

Supervisor Name & Surname Signature Date

_____ _____ _____

Co-Supervisor Name & Surname Signature Date

Appendix C

Thematic Analysis Step Two: Developing Initial Codes

Participant	Question	Response of participant	Initial codes
A	a	I believe that most drama therapists keep clinical records to satisfy medical aid requirements, as well as keeping detailed process notes in order to capture where the client is at creatively and in their process. There are also NGO or organisational specific record-keeping practices that we must follow if we work in those spaces.	**Must follow the NGO or organisational specific record-keeping practices.** **Keeping detailed process notes to capture where client is at in process.** **Keep session notes to satisfy medical aid requirements.**
B	a	Notes made after each session; photographs of artwork or projective work (if consent given); storage of all artwork made; regular feedback meetings with parents - summarising and tracking progress of client (if working with child).	**Session notes made after each session.** **Taking photographs of artwork or projective work.** **Consent of client needed before storing of artwork.** **Storage of all artwork.** **Feedback meetings to summarize progress of client (if child).**

C	a	This really depends on the site. For private practice, I generally have two sets of notes: handwritten notes which track the process and will include more of my personal experience of the session; and typed records which are more formal and could be shared with other professionals if necessary. In hospitals: it would include the above. A third set of notes will be provided for the site: this set is far shorter, aims to inform other clinicians regarding observable state of mind, behaviour and/or specific themes that a multi- disciplinary team needs to be aware of.	**Clinical record-keeping practices dependent on site.** **In private practice have written notes and typed notes.** **Written notes in private practice for documenting therapy process, tracking and personal experience.** **Typed notes in private practice for formal reasons and access to external professionals.** **Hospital site will have three sets of notes.** **Written notes in hospitals for documenting therapy process, tracking and personal experience.** **Typed notes in hospitals for formal reasons and access to external professionals.** **Third set of notes for hospitals which document direct observations, client's state of mind, behaviours and themes.**
D	a	Written notes, written reports and audio recordings	**Written notes in clinical record-keeping.Written reports in clinical record-keeping. Audio recordingsin clinical record-keeping.**

E	a	Confidentiality, collaborative documentation, consent and access control	**Confidentiality in clinical record-keeping.** **Collaborative documentation in clinical record-keeping.** **A client's consent in clinical record-keeping.** **Access control in clinical record-keeping.**
F	a	Record-keeping of client basic information (including personal and relevant medical aid details) and session notes for reference between sessions and progress recording over time.	**Record-keeping of basic client information.** **Session notes for reference between sessions in record-keeping.** **Progress of therapy for record-keeping.**
G	a	Keeping thorough written notes of sessions and quarterly reports. Also ensuring it is stored in a safe place where only I have access to it. Anything that is done on a computer is done on a computer with updated anti-virus programs and that is backed up on a system that is also POPI compliant.	**Thorough session notes made.** **Quarterly reports made and kept.** **Stored in safe place where only therapist can access.** **Records on computer done with anti-virus protected device and backed up.** **Compliant with laws - POPIA- when storing.**

H	a	Consistency, good organisation (keeping things in date order, including clients image portfolio), detail in note-taking, corresponding supervision notes, ethical safeguarding of client's personal information (adhering to POPI),	**Consistency in records and client tracking practice.** **Good organisation in record-keeping and tracking practice.** **Detail in note-taking for records.** **Supervision notes that correspond to sessions.** **Identity safeguarding of client's personal information.**
I	a	Process notes, physical storage of images/art made in the session, regular reflection and assessment of progress	**Process notes in clinical record-keeping and tracking.Physical storage of images/art from sessions in clinical record-keeping and client tracking.Regular reflection in record-keeping.Assessment of progress for client tracking and clinical record-keeping.**

A	b	To be honest, I am aware that the last time that I engaged with HPCSA rules on record-keeping was when I was studying for the ethics exam in my MA, though I am not sure if that is the same for everyone. Certainly I hold to strict confidentiality guidelines in terms of safely storing records on a password protected computer, in a locked office. I also keep my records long term as in private practice many clients may come back after a break. I also offer clients access to their records should they want them and require signed permission from the client if other professionals request access to client records or information.	**Engaged with HPCSA rules on record-keeping for last time in studies.** **Strict confidentiality upheld.** **Safe storage on password protected computer.** **Keep records long term in private practice.** **Client access to records if they want them.** **Signed permission needed from client for access to be granted by other professionals.**
B	b	As above: Notes made after each session; photograph s of artwork or projective work (if consent given); storage of all artwork made; regular feedback meetings with parents - summarising and tracking progress of client (if working with child).	**Session notes made after each session.** **Taking photographs of artwork or projective work.** **Consent of client needed before storing of artwork.** **Storage of artwork.** **Feedback meetings to summarize progress of client (if child).**
C	b	Yes.	**Adherence of standards of practice guidelines.**
D	b	I save all notes, reports and audio recordings in a POPIA compliant secure One Drive Vault.	**Safe data storage in POPIA compliant, one drive vault.**

E	b	I ask for consent from the clients whether they want us to keep records of our processes and what form of records or documentation. Record-keeping is part of the anti- oppressive practice ethic. While there is a public interest in keeping personal records in healthcare settings, the client must consent to such record-keeping.	**Ask for consent from clients about if they want records to form part of the process and what form of records. Record-keeping partof anti-oppressive practice ethic.Public interest in record-keeping in healthcare settings but should be client's choice.**
F	b	I keep records for a minimum of 5 years and store behind lock and key. I keep hard copies of client records and session notes as I only run a private practice and do not need to submit electronically or as part of a consulting team.	**Safe storage of records for 5 years and behind lock and key.** **Keep hard copies of records for private practice, as not part of consulting team.**
G	b	Written session notes, weekly WhatsApp voice notes to parents of my clients as requested by parents. This also forms as part of my record-keeping.	**Written session notes.** **Weekly whatsapp voice notes with parents of client's if requested.**
H	b	I create clinical notes after each session. I keep notes and clients personal related documentation, including art works locked away when not in use/in password protected spaces. I engage in supervision .	**Clinical notes for each session** **Client specific documentation.** **Art products kept and locked away in password protected spaces.** **Supervision**
I	b	I keep my client's art work safely stored in a closed cupboard that no one has access to. I maintain confidential records of my client's information and processes. No-one else works in my practice so I am the only one who has access to the files. I find that I don't have sufficient time for client tracking.	**Safely stored art in closed cupboard with no unwarranted access.** **Confidentiality maintained with records, assessment and client information.**

			Not enough time for client tracking.
A	c	Sometimes I include photographs or screenshots of digital work/images, so that the creative work that my client is working with can be kept as part of the client tracking process.Anything that is created by the client is offered to them to take, and if they wish to leave it with me, then I discuss a plan moving forward, of how long I will keep it and where, as well as how I will dispose of it when I do.	**Photos or screenshots sometimes included in records.Creative work part of tracking process in therapy.Client chooses what should happen with their creative work from sessions (keep it, store it, disposal of, etc.).**
B	c	Photos, videos, audio recordings, photographs of artwork of projective installations.	**Photos included in record-keeping.** **Videos included in record-keeping.** **Audio recordings included in record-keeping.**
C	c	Yes. The record-keeping and assessment tools I use are drama therapy specific. Again, in hospitals, I avoid terminology which might be confusing or vague for other clinicians and try to language the reports in a way that will add value to their work with a specific client.	**Drama therapy specific tools used in clinical record-keeping practice.** **Avoid confusing, vague or unclear terminology in hospitals.** **Use of language that adds value to external professional work with client.**

D	c	I keep all audio recordings of GIM sessions as well as of improvisations. I also keep all drawings or art making in a locked store room in client specific files.	**Keep audio recordings of GIM sessions and improvisations.** **Keep drawings or art making.** **Safe storage in locked storeroom.**
E	c	A written song is a from of documentation. Also, reflective notes of the client in song analysis or reflection are records. I consider anything produced during the therapeutic process to be a record that must be protected from unwarranted access.	**Anything produced during therapeutic process to be a record.** **Reflective notes of client in song analysis or reflection are records.** **Protection of records from unwarranted access.**
F	c	I usually include a summary of what interventions I used in my note-taking and many of my interventions are related to movement or dance therapy or somatic psychology in general.	**Interventions used are summarized in note-taking.** **Many interventions related to dance or movement therapy or psychology.**
G	c	Nothing specific to Music Therapy. Written session notes.	**Session notes kept.** **Record-keeping and client tracking not specific to modality.**
H	c	I keep all art works created by client as part of the client tracking/ record-keeping. Any images that I make in response to clients work, is also considered a part of the tracking process.	**Art product of client form part of process.Therapists' art responses form part of process.**
I	c	I sometimes photograph my clients work and store that in a folder on a special Google drive	**Photograph of process/pro duct in record-keeping.** **Google drive storage.**
A	d	Digitally	**Digital record-keeping.**
B	d	Digitally	**Digital record-keeping.**

C	d	Both	**Use of both manual and digital methods.**
D	d	Both	**Both manual and digital methods used for clinical record-keeping practice.**
E	d	Both	**Both manual and written notes for record-keeping practices.**
F	d	Manually	**Manual record-keeping.**
G	d	Both	**Both manual and digital forms used.**
H	d	Both	**Manuel and digital forms used.**
I	d	Both	**Manuel and Digital forms used.**
A	e	Yes, but only on site in my placements, as we needed to adhere to site reporting guidelines	**Yes training provided, but only on placement sites.** **Need to adhere to site guidelines in clinical record-keeping.**
B	e	Yes. Clinical note- taking was taught, as well as necessity of keeping these notes and materials for required number of years.	**Training provided.** **Clinical note- taking taught.** **Keeping materials for required number of years taught.**
C	e	Yes. But I do believe it was not enough. For the most part I needed to find best practice for myself based on previous counseling experience and current requirements	**Yes, training provided, but not enough.** **Needed to find own best practice for work.** **Use of knowledge from previous experience in counselling to guide record-keeping practice.**

D	e	Yes, we were given extensive resources on assessment scales, session note practices and various formats of transcriptions etc. for record-keeping.	**Yes, training provided.** **Extensive resources provided in training.** **Resources given for assessment scales in training.** **Resources given for session note practice in training.** **Resources given for formats of transcriptions in training.**
E	e	Yes. We were trained to keep clinical files with profiles of clients, reports and analyses of the clinical process.	**Trained during studies.Trained to keep clinical files with client profiles.Trained in analyses of clinical process.**
F	e	Yes although I cannot remember specifics because I studied 20 years ago.	**Training provided during studies.**
G	e	Yes, but it was not very detailed and is nothing like working in the real work with real clients. I gained more information regarding this from other clinicians from other professions, as well as from specific CPD events.	**Training provided during studies.** **Training not detailed or like "real work" with clients.** **More information gained from other clinicians from other profession.**
H	e	Yes. This was basic and mostly depended on where your placemen t site was and the practices around clinical record-keeping and client tracking processes at the site (most places seemed to have slightly different practices.	**Training provided, but basic and site dependent.**

I	e	Not really. I would say the training we received was not adequate and only referred to the necessity of process notes and regular reviews with clients.	**Training not really provided and not adequate enough.** **Process notes training referred to in studies.** **Client review training referred to in studies.**
A	f	Everything! This means acknowledging my own bias, recognising when I am interpreting a client's creative work through my own lens, and regular supervision.	**Reflection is everything in practice.** **Reflection involves acknowledging our own biases.** **Reflection involves the recognition of own lens in therapy.** **Reflection involves regular supervision**
B	f	Being reflective in the action of doing the work - taking a step back, finding objectivity, assessing the work by 'zooming out' and noticing what you may miss by being focused on the detail / minutia.Noticing how your 'stuff' impacts the work.	**Being reflection is the action of taking a step back. Being reflective is finding objectivity. Being reflective is assessing the work by zooming outBeing reflective is the action of noticing what may be missed by being focused on detail. Being reflective is noticing how your stuff impacts the work.**

C	f	It is absolutely essential and takes many forms: it entails observing what is happening in the room as objectively as possible; what the client might be experiencing; whether I am having a personal response; what the next step needs to be in the best interest of the therapeutic goals and the client. This happens on so many levels during a session: the verbal statements, the underlying themes, physical expression, the liminal interplay between the client and the therapist; observing the client's energy levels and remaining aware of where the vulnerabilities are and to what extent the client is resilient enough to move closer to these or whether it is advisable to rather create distance. Then there is the post- session reflection: unraveling what happened in the wider context of the client's process and how new information fits into that picture. This happens during record-keeping immediately after the session followed by formal records. And finally in supervision.	**Reflexivity is essential and takes many forms.** **Reflexivity involves observing what is happening in the room objectively.** **Reflexivity is observing what client might be experiencing.** **Reflexivity is observing personal responses in session.** **Reflexivity is finding next step in therapeutic process and goals.** **Reflexivity looks at verbal statements** **Reflexivity looks at underlying themes.** **Reflexivity looks at physical expression.** **Reflexivity looks at interplay between client and therapist.** **Reflexivity looks at client's energy levels.** **Reflexivity looks at client's vulnerabilities.** **Reflexivity looks at a client's resilience.** **Reflexivity unravels what is happening in the wider context of**

			client's life. **Reflexivity happens immediately after sessions.** **Reflexivity happens in supervision**
D	f	Being able to assess your own practices through supervision and always being open to what is most appropriate for the client.	**Reflection is assessment of own practices.** **Reflection is done through supervision** **Reflection is always being open to what is appropriate for client.**

E	f	Reflexivity is an ongoing process of analysing and reflecting on therapeutic interactions. Such interactions involve the client's and therapist's psychosocial dynamics and clinical relations. Somewhere in the therapeutic relationship, worldviews intersect, and life experiences find expression. Ongoing reflection affords the therapist a way to contain the therapeutic encounter with awareness and a hospitable stance.	**Reflexivity is ongoing process.** **Reflection on therapeutic intersections.** **Reflecting on psychosocial dynamics.** **Reflecting on therapeutic relationship** **Self-awareness in reflection.** **Reflection affords way to contain therapeutic encounter with awareness and hospitality.**
F	f	I think it refers to a client-centred approach, which I use in combination with professional guidance when I deem it helpful.	**Reflexivity puts clients at forefront of therapy process.** **Supervision in reflective practice.**
G	f	To remind myself that I do not know everything, I will make mistakes, and it is my job to investigate my own thoughts and assumptions with every client on a regular basis.	**Reflexive practice is to remind myself I do not know everything.** **Reflexivity to investigate own thoughts and assumptions.** **Regular practice and for every client.**
H	f	Capacity to examine my own feelings thoughts and processes related to client work and to my practice as a whole. Working on reflexivity within my own arts based medium as well as writing and in supervision and carefully thinking about how my responses affect the work that I do and how I show up for my clients.	**Reflexivity is examining own feelings, thoughts and processes related to client work and whole practice.** **Reflection of art medium.** **Supervision to think about responses and how I show up for clients.**

I	f	It means the capacity to reflect critically and with self-awareness on how I am conducting myself, identifying and engaging with areas of my own growth and development in service of the client	**Reflexivity means having capacity to reflect critically** **Reflexivity means having self-awareness.** **Reflecting on how I am conducting myself and with own self-growth in service of client.**
A	g	Yes. This was trained into us at DFL. it is important that in my client tracking specifically I am noting where my own ideas/thoughts/interpretations are coming in.	**Reflexivity is included in work.Reflexivity trained at DFL to be important in client tracking.Reflection practice includes note-taking on therapists' ideas.Reflection practice includes note-taking on therapists' thoughts.Reflection includes note-taking on therapists interpretations.**
B	g	Yes, I always have a section in my notes called 'subjective experience' which is where I comment on my experience in the session, what could be unconscious communication, and what could be 'my stuff'.	**Included in practice.** **In session notes under own section called subjective experience.** **Therapists Experiences included in reflective section of session notes.** **Unconscious communication included in reflective section of session notes.** **Therapists "stuff" included in reflective section of session notes.**

C	g	Yes. It depends on who the information is for. For my personal notes, I often take time to note my experiences and reflections, including why I made specific choices in the moment. For clinical notes that will be included in hospital files, I try to avoid as much possibility for interpretation as possible and rather focus on direct observations. If there is a significant theme that a multi-disciplinary team needs to be aware of (suicidality for example) I will make a specific note, but also make an effort to discuss this directly with the relevant clinicians.	**Yes, reflexivity is included in work** **Reflexivity in personal notes** **Personal notes include experience, reflections and choices made by therapist in session.** **Hospital notes for reflexivity focus on direct observations and themes.** **Reflective notes for hospital need clear language.** **Reflective notes at hospital made accessible to external professionals.**
D	g	Yes, I use different colours in my written notes to indicate what transference and countertransference I noticed in the sessions. I also use my session notes during supervision and indicate any feedback from my supervisor in a different colour.	**Yes, reflexivity is used in clinical practice.** **Different colours used in written notes to indicate countertransference and transference whilst reflecting.** **Session notes used during supervision to reflect on practice.**
E	g	NO	**Reflexivity not included.**

F	g	I make notes of client responses, imagery, and relevant content to their therapeutic process.	**Reflexive notes are made.Client responsesincluded in reflexive notes.Client imagery included in reflexive notes.Relevant content to client's therapy process included in reflexive notes.**
G	g	No	**Reflexivity not practiced in clinical record-keeping.**
H	g	I have a separate reflexive process that I practice, not included in clinical record-keeping but following a similar system so that I can personally track alongside clinical record-keeping notes.	**Reflexivity practiced as separate process to clinical record-keeping.** **Not for clinical record-keeping.** **Follows similar clinical record-keeping system.** **Personal aid in client tracking and record-keeping.**
I	g	Yes, if I am reflecting on a client's process, I will wonder about how I handled a situation, what my counter transference was, how I could have responded differently, wondered about how my age, gender and race may have impacted the relationship with the client.	**Reflection practiced if looking at client process.** **Reflect on how situation was handled by therapist.** **Reflection of counter transference.** **Reflection of different responses in session.** **Reflection of how therapists age, gender and race may impact relationship with client.**

A	h	No	**No, not aware of other modalities record-keeping practices**
B	h	No	**No, not aware of other modalities record-keeping practice.**
C	h	Only slightly, so safer to say no.	**No, not aware of other modalities record-keeping practice.**
D	h	No	**No, not aware of other modalities record-keeping practice.**
E	h	No	**No, not aware of other modalities record-keeping practice.**
F	h	No	**No, not aware of other modalities record-keeping practice**
G	h	No	**No, not aware of tools or practices in record-keeping or client tracking in other modalities.**
H	h	No	**No, not aware of tools or practices in record-keeping or client tracking in other modalities.**
I	h	Yes. I am aware that in Music Therapy, videos and sound recordings are used to keep record of client's processes and are also used for supervision purposes. I am not aware of how the other arts therapies keep records or track their clients.	**Aware of music therapy and use of audio recordings and videos for client's process and supervision.** **Not aware of other modalities tools or practices in clinical record-keeping.**
A	i	No	**No, does not use other modalities record-keeping practices**
B	i	No	**No, does not use record-keeping practices from other modalities.**

C	i	No	**No, does not use tools or practices from other modalities for clinical record-keeping or client tracking**
D	i	No	**No, does not use tools or practices from other modalities for clinical record-keeping or client tracking**
E	i	No	**No, does not use tools or practices from other modalities for clinical record-keeping or client tracking**
F	i	No	**No, does not use tools or practices from other modalities for clinical record-keeping or client tracking**
G	i	No	**No, does not use tools or practices from other modalities for clinical record-keeping or client tracking.**
H	i	No, I don't think so. Unless I am unaware of any similarities.	**Does not think they use tools or practices from other modalities for clinical record-keeping or client tracking.**
I	i	Yes. I am finalising my training in GIM which is a part of Music Therapy and I use audio recordings for supervision on purposes	**Use of GIM clinical record-keeping and client tracking practice in work.** **Audio recordings for GIM.** **Supervision for GIM.**

Appendix D

Thematic Analysis Step Three: Development of Level 2 codes

Question	Initial codes	Level 2 Codes
a	Must follow the NGO or organisational specific record-keeping practices. Clinical record-keeping practices dependent on site.	**NGO, organisational specific and site-specific clinical record-keeping practices.**
	Keeping detailed process notes to capture where client is at in process. Process notes in clinical record-keeping and tracking.	**Detailed process notes in clinical record-keeping and client tracking, which track client's process.**
	Keep session notes to satisfy medical aid requirements.	**Keep session notes to satisfy medical aid requirements.**
	Session notes made after each session. Written notes in clinical record-keeping. Session notes for reference between sessions in record-keeping. Thorough session notes made. Detail in note-taking for records.	**Session notes are made after each session, are thorough, detailed and for reference between sessions.**
	Written reports in clinical record-keeping. Quarterly reports made and kept.	**Reports are made and kept as part of clinical record-keeping and client tracking.**
	Taking photographs of artwork or projective work.	**Photographs of artwork or projective work are part of clinical record-keeping and client tracking practice.**

Consent of client needed before storing of artwork. A client's consent in clinical record-keeping.	**Client's consent needed for clinical record-keeping and client tracking practice.**
Storage of all artworks. Records on computer done with anti-virus protected device and backed up. Compliant with laws -POPIA- when storing. Physical storage of images/art from sessions in clinical record-keeping and client tracking.	**All documentation for clinical record-keeping and client tracking purposes is kept safely and in compliance with laws.**
Feedback meetings to summarize progress of client (if child). Progress of therapy for record-keeping. Assessment of progress for client tracking and clinical record-keeping.	**Progress reports/ Assessment reports are part of clinical record-keeping and client tracking.**
In private practice have written notes and typed notes. Written notes in private practice for documenting therapy process, tracking and personal experience. Typed notes in private practice for formal reasons and access to external professionals.	**Private practice to have written notes for therapy process, client tracking and personal experiences, as well as typed notes which are formal and for external professionals.**

Hospital site will have three sets of notes. Written notes in hospitals for documenting therapy process, tracking and personal experience. Typed notes in hospitals for formal reasons and access to external professionals. Third set of notes for hospitals which document direct observations, client's state of mind, behaviors and themes.	**Hospitals to have written notes for therapy process, client tracking and personal experiences, formal typed notes for external professionals and notes which document observations, client's state of mind, behaviours, and themes in therapy.**
Audio recordings in clinical record-keeping.	**Audio recordings in clinical record-keeping.**
Confidentiality in clinical record-keeping. Identity safeguarding of client's personal information.	**Confidentiality should be upheld in clinical record-keeping and client tracking practices.**
Collaborative documentation in clinical record-keeping.	**Documentation in clinical record-keeping and client tracking should be collaborative in nature.**
Access control in clinical record-keeping. Stored in safe place where only therapist can access.	**There should be restricted access to documents for clinical record-keeping and client tracking.**
Regular reflection in record-keeping. Supervision notes that correspond to sessions.	**Reflective practice should form part of documentation in clinical record-keeping and client tracking.**
Consistency in records and client tracking practice.	**Clinical record-keeping and client tracking practices should be consistent and organised in nature.**

	Good organisation in record-keeping and tracking practice.	
	Record-keeping of basic client information.	**A client's basic information should be included in documentation in clinical record-keeping and client tracking practice.**
b	Engaged with HPCSA rules on record-keeping for last time in studies.	**HPCSA guidelines not followed in practice.**
	Strict confidentiality upheld. Confidentiality maintained with records, assessment and client information.	**Strict confidentiality upheld in clinical record-keeping and client tracking practices.**
	Safe storage on password protected computer. Storage of artwork. Safe data storage in POPIA compliant, one drive vault. Safe storage of records for 5 years and behind lock and key. Art products kept and locked away in password protected spaces. Safely stored art in closed cupboard with no unwarranted access.	**All documents for clinical record-keeping and client tracking stored safely and in compliance with laws**
	Keep records long term in private practice.	**Long-term keeping of records in clinical record keeping and client tracking.**
	Client access to records if they want them.	**Client access to own data in clinical record-keeping and client tracking.**

Signed permission needed from client for access to be granted by other professionals. Consent of client needed before storing of artwork.. Ask for consent from clients about if they want records to form part of process and what form of records.	**Consent forms for therapy process and access of documents in clinical record-keeping and client tracking process.**
Session notes made after each session. Written session notes. Clinical notes for each session	**Clinical session notes regular practice in clinical record-keeping and client tracking practice.**
Taking photographs of artwork or projective work.	**Taking photographs of artwork or projective work.**
Feedback meetings to summarize progress of client (if child). Weekly WhatsApp voice notes with parents of client's if requested.	**Feedback given to clients on progress in therapy.**
Adherence of standards of practice guidelines.	**HPCSA standards of practice are adhered to.**
Record-keeping part of anti-oppressive practice ethic. Public interest in record-keeping in healthcare settings but should be client's choice.	**Client's choice in record-keeping and client tracking important due to anti-oppressive nature of practice.**
Keep hard copies of records for private practice, as not part of consulting team.	**Keeping hard copies of records for private practice.**
Client specific documentation.	**Client specific documentation.**
Supervision	**Supervision practiced to adhere to HPCSA guidelines. H4b**

	Not enough time for client tracking.	**Not enough time for client tracking.**
c	Photos or screenshots sometimes included in records. Photos included in record-keeping. Photograph of process/product in record-keeping.	**Photographs included in clinical record-keeping and client tracking practice.**
	Creative work part of tracking process in therapy. Keep drawings or art making. Anything produced during therapeutic process to be a record. Art product of client form part of process.	**Creative products included in clinical record-keeping and client tracking practice.**
	Client chooses what should happen with their creative work from sessions (keep it, store it, disposal of, etc.).	**Client's choice with what to do with art products.**
	Videos included in record-keeping.	**Videos included in clinical record-keeping and client tracking practice.**
	Audio recordings included in record-keeping. Keep audio recordings of GIM sessions and improvisations.	**Audio recordings included in clinical record-keeping and client tracking practice.**
	Drama therapy specific tools used in clinical record-keeping practice. Many interventions related to dance or movement therapy or psychology.	**Use of tools and interventions in sessions that are specific to the arts therapy modality of therapist.**

	Avoid confusing, vague or unclear terminology in hospitals.	**Use of clear and understandable language in clinical record-keeping and client tracking practice at hospitals.**
	Use of language that adds value to external professional work with client.	**Use of language in records that adds value to external professional work with client.**
	Safe storage in locked store room. Protection of records from unwarranted access. Google drive storage.	**Safe storage of documents for clinical record-keeping and client tracking.**
	Reflective notes of client in song analysis or reflection are records.Therapists' art responses form part of process.	**Reflective notes by therapist form part of clinical record-keeping and client tracking practice.**
	Interventions used are summarized in note-taking.	**Interventions used are summarized in documents for clinical record-keeping and client tracking.**
	Session notes kept.	**Session notes are kept as part of clinical record-keeping and client tracking practice.**
	Record-keeping and client tracking not specific to modality.	**Record-keeping and client tracking not specific to modality.**
d	Digital record-keeping. Digital record-keeping.	**Digital forms of clinical record-keeping, and client tracking practiced by therapist.**
	Use of both manual and digital methods. Both manual and digital methods used for clinical record-keeping practice. Both manual and written notes for record-keeping practices. Both manual and digital forms used. Manuel and digital forms used.	**Digital and manual forms of clinical record-keeping, and client tracking practiced by therapist.**

Manuel and Digital forms used.

	Manual record-keeping.	**Manual methods of clinical record-keeping, and client tracking practiced by therapist.**
e	Yes, training provided, but only on placement sites.Training provided. Yes, training provided, but not enough. Yes, training provided. Trained during studies. Training provided during studies. Training provided during studies. Training provided, but basic and site dependent. Training not really provided and not adequate. Training not detailed or like "real work" with clients. More information gained from other clinicians from other profession. Needed to find own best practice for work.	**Training provided to all participants in study on clinical record-keeping and client tracking.** **Training in clinical record-keeping and client tracking was placement site dependent.** **Training in clinical record-keeping and client tracking practices was not adequate.**
	Need to adhere to site guidelines in clinical record-keeping.	**Trained to adhere to site guidelines in clinical record-keeping and client tracking.**

	Clinical note-taking taught. Resources given for assessment scales in training. Resources given for session note practice in training. Resources given for formats of transcriptions in training. Trained in analyses of clinical process. Process notes training referred to in studies. Trained to keep clinical files with client profiles. Client review training referred to in studies.	**Clinical notes, such as session notes, assessment scales, transcriptions, process notes and clinical files was taught for clinical record-keeping and client tracking during training.**
	Keeping materials for required number of years taught.	**Trained to keep materials for required number of years during training in clinical record-keeping and client tracking.**
	Use of knowledge from previous experience in counselling to guide record-keeping practice.	**Use of knowledge from previous experience in counselling to guide record-keeping practice.**
	Extensive resources provided in training.	**Extensive resources provided in training.**
f	Reflection is everything in practice. Reflexivity is essential and takes many forms.	**Reflection is important in practice.**
	Reflection involves acknowledging our own biases.	**Reflection involves acknowledging our own biases in practice.**

Reflection involves the recognition of own lens in therapy. Being reflective is noticing how your stuff impacts the work. Reflexivity to investigate own thoughts and assumptions. Reflexivity is examining own feelings, thoughts and processes related to client work and whole practice.	**Reflexivity involves the therapist recognising own thoughts, assumptions, feelings, and processes in sessions with clients.**
Reflecting on how I am conducting myself and with own self-growth in service of client.	**Reflexivity allows therapist to acknowledge how they are conducting themselves in practice.**
Reflection involves regular supervision. Reflexivity happens in supervision. Reflection is done through supervision Supervision in reflective practice. Supervision to think about responses and how I show up for clients.	**Reflexivity is practiced through regular supervision.**
Being reflection is the action of taking a step back. Being reflective is assessing the work by zooming out	**Reflexivity involves "zooming out" on work with a client.**
Being reflective is finding objectivity. Reflexivity involves observing what is happening in the room objectively.	**Reflexive practice can help a therapist find objectivity in work with a client.**
Being reflective is the action of noticing what may be missed by being focused on detail.	**Reflexive practice involves finding missing details.**

Reflexivity means having capacity to look at client and process critically.	**Reflexive practice is looking at client's process critically.**
Reflexivity is observing what client might be experiencing.	**Reflexive practice is observing client's experiences in therapy.**
Reflexivity is observing personal responses in session. Reflection is assessment of own practices. Reflection on therapeutic intersections.	**Reflexive practice involves assessing own responses and practices in sessions with a client.**
Reflexivity is finding next step in therapeutic process and goals.	**Reflexive practice is finding the next step in therapeutic process and goals.**
Reflexivity looks at verbal statements.	**Reflexive practice looks at verbal statement in sessions.**
Reflexivity looks at underlying themes.	**Reflexive practice looks at underlying themes in sessions.**
Reflexivity looks at physical expression.	**Reflexive practice looks at physical expression in sessions.**
Reflexivity looks at interplay between client and therapist. Reflecting on psychosocial dynamics. Reflecting on therapeutic relationships. Reflection affords way to contain therapeutic encounter with awareness and hospitality.	**Reflexive practice looks at the therapeutic relationship and how to contain it with awareness and hospitality.**
Reflexivity looks at a client's energy levels.	**Reflexive practice looks at client's energy levels in sessions.**
Reflexivity looks at client's vulnerabilities.	**Reflexive practice looks at client's vulnerabilities in sessions.**

	Reflexivity looks at a client's resilience.	**Reflexive practice looks at client's resilience in sessions.**
	Reflexivity unravels what is happening in the wider context of client's life.	**Reflexive practice unravels what is happening in the wider context of a client's life.**
	Reflexivity happens immediately after sessions. Regular practice and for every client. Reflexivity is an ongoing process.	**Reflexive practice is regular and for every client.**
	Reflection is always being open to what is appropriate for client. Reflexivity puts clients at forefront of therapy process.	**Reflexive practice is done to remain appropriate and put client first in therapy process.**
	Self-awareness in reflection. Reflexivity means having self-awareness.	**Reflexive practice is also gaining self-awareness.**
	Reflexive practice is to remind myself I do not know everything.	**Reflexive practice is to remind myself I do not know everything.**
	Reflection of art medium.	**Reflexive practice looks at the art medium in sessions.**
g	Reflexivity is included in work. Included in practice. Yes, reflexivity is included in work Yes reflexivity is used in clinical practice. Reflexive notes are made. Reflection practiced if looking at client process.	**Reflexivity is practiced as therapist.**

Reflexivity trained at DFL to be important in client tracking.	**Reflexivity an important aspect of client tracking practices.**
Reflection practice includes note-taking on therapists' ideas. Reflection practice includes note-taking on therapists' thoughts. Reflection includes note-taking on therapists interpretations. Therapists Experiences included in reflective section of session notes. Therapists "stuff" included in reflective section of session notes. Personal notes include experience, reflections and choices made by therapist in session. Reflect on how situation was handled by therapist.	**Reflexivity in practice includes notes on therapists' thoughts, ideas, interpretations and experiences.**
In session notes under own section called subjective experience. Session notes used during supervision to reflect on practice. Unconscious communication included in reflective section of session notes.	**Reflexivity is included under a section in session notes.**
Reflexivity in personal notes Reflexivity practiced as separate process to clinical record-keeping.	**Reflexivity is practiced under therapist's personal notes.**

Hospital notes for reflexivity focus on direct observations and themes. Reflective notes for hospital need clear language. Reflective notes at hospital made accessible to external professionals.	**Hospital notes for reflexivity focus on direct observations and themes.** **Reflective notes for hospital need clear language.** **Reflective notes at hospital made accessible to external professionals.**
Different colors used in written notes to indicate countertransference and transference whilst reflecting. Reflection of counter transference.	**Reflexive practice looks at counter transference and transference in practice.**
Reflexivity not included. Reflexivity not practiced in clinical record-keeping. Not for clinical record-keeping.	**Reflexivity is not part of clinical record-keeping and client tracking practice.**
Client responses included in reflexive notes. Reflection of different responses in session.	**Reflexivity looks at client's responses in practice.**
Client imagery included in reflexive notes.	**Client imagery included in reflexive notes.**
Relevant content to client's therapy process included in reflexive notes.	**Relevant content to client's therapy process included in reflexive notes.**
Follows similar clinical record-keeping system. Personal aid in client tracking and record-keeping.	**Reflexive notes are aid to therapist in clinical record keeping and client tracking.**
Reflection of how therapists age, gender, and race may impact relationship with client.	**Reflection of how therapists age, gender and race may impact relationship with client.**

h	No, not aware of other modalities record-keeping practices. No, not aware of other modalities record-keeping practice. No, not aware of other modalities record-keeping practice. No, not aware of other modalities record-keeping practice. No, not aware of other modalities record-keeping practice. No, not aware of tools or practices in record-keeping or client tracking in other modalities. No, not aware of tools or practices in record-keeping or client tracking in other modalities.	**Not aware of clinical record-keeping and client tracking practices in other modalities.**
	Aware of music therapy and use of audio recordings and videos for client's process and supervision. Not aware of other modalities tools or practices in clinical record-keeping.	**Aware of music therapy and use of audio recordings and videos for client's process and supervision, but not aware of other modalities.**

i	No, does not use other modalities record-keeping practices. No, does not use record-keeping practices from other modalities. No, does not use tools or practices from other modalities for clinical record-keeping or client tracking No, does not use tools or practices from other modalities for clinical record-keeping or client tracking No, does not use tools or practices from other modalities for clinical record-keeping or client tracking No, does not use tools or practices from other modalities for clinical record-keeping or client tracking No, does not use tools or practices from other modalities for clinical record-keeping or client tracking. Does not think they use tools or practices from other modalities for clinical record-keeping or client tracking.	**Does not use clinical record-keeping or client tracking practices from other arts therapy modalities in work.**
	Use of GIM clinical record-keeping and client tracking practice in work. Audio recordings for GIM. Supervision for GIM.	**Use of GIM clinical record-keeping and client tracking practices, such as audio recordings and supervision, in work.**

Appendix E

Thematic Analysis Step Four: Development of Level 3 Codes

Question	Level 3 Codes	Subcodes
a	**Adherence to third party guidelines is a primary component of record-keeping and client tracking practices.**	Adherence to NGO, organisational, site specific and medical aid requirements as a consideration when practicing clinical record-keeping and client tracking.
	Clinical notetaking/documentation is a primary component of clinical record-keeping and client tracking practice.	Taking and keeping session notes Keeping client reports Keeping progress notes Keeping assessment reports Choice of written notes or typed notes Including client observation notes Keeping notes on the client experiences
	Art process and product included as primary component in clinical record-keeping and client tracking practice.	Use of photographs Use of audio recordings of client's therapy process Use of art product
	Protection of the client as a primary standard of practice in clinical record-keeping and client tracking.	Gathering the client's consent Upholding confidentiality
	Safe storage of data as a primary standard of practice in clinical record-keeping and client tracking.	Storage in compliance with laws Restricted access to documents
	Clinical record-keeping and client tracking practiced in a collaborative	

	manner with client as a primary component.	
	Reflexivity as a primary standard of practice in clinical record-keeping and client tracking.	
	Quality and relevance of documents upheld in clinical record-keeping and client tracking as a primary standard of practice.	Regular documentation Detailed documentation Organized documentation
b	**Adherence to HPCSA guidelines in clinical record-keeping and client tracking practices.**	
	Protection of the client adhered to in clinical record-keeping and client tracking practice.	Gathering client's consent Upholding confidentiality
	Safe storage of data adhered to as a standard of practice in clinical record-keeping and client tracking.	Adhering to laws about storage of documents Long-term keeping of records Restricted access to data Keeping of hard copies of all data
	Updated session material and information in clinical record-keeping and client tracking is adhered to.	Keeping regular clinical session notes Including photographs of artwork
	Adherence of client-specific and client-informed clinical record-keeping and client tracking practices.	Giving client's feedback about their therapy process Giving the client the choice in clinical record-keeping and client tracking practices as to not follow anti-oppressive nature of practice

		Remaining specific about client's needs and wants in therapy.
	Adhering to supervision requirements in clinical record-keeping and client tracking practice.	
c	**Inclusion of multimedia in clinical record-keeping and client tracking to include modality.**	Inclusion of photograph Inclusion of videoInclusion of audio recordings
	Inclusion of creative products in clinical record-keeping and client tracking to include modality.	
	Client's needs and wants form part of clinical record-keeping and client tracking in modality.	Client chooses what to do with art products after sessions.
	Use of modality specific tools and interventions as part of clinical record-keeping and client tracking practice.	
	Use of language in clinical record-keeping and client tracking promotes modality.	Use of clear language Use of understandable language Use of language that adds value to the records
	Protection of documents in clinical record-keeping and client tracking.	Safe storage of documents
	Clinical note-taking that is modality specific as part of clinical record-keeping and client tracking process.	Keeping reflexive notes Keeping session notes Naming the interventions used in sessions

d	**Therapists' choice to use digital, manual or both forms of documentation when practicing clinical record-keeping and client tracking.**	
e	**Training provided to all participants in study on clinical record-keeping and client tracking.**	
	Quality of training in clinical record-keeping and client tracking.	Training inadequate Need for external sources or knowledge to fill gaps in knowledge on clinical record-keeping and client tracking practices needed.
	Adherence to site-guidelines as part of training in clinical record-keeping and client tracking practices.	
	Training in clinical notetaking practices for clinical record-keeping and client tracking.	Training in keeping session notes Training in assessment scales Training in transcriptions Training in process notes Training in keeping clinical files Training in how long to keep documents
	Training provided resources to therapists for clinical record-keeping and client- .	
f	**Reflection is an important practice in clinical record-keeping and client tracking.**	

Self-awareness is an important aspect in reflective practice in clinical-record-keeping and client tracking.	Reflexivity to acknowledge own biases Reflexivity to remain objective Reflexivity to recognise own thoughts Reflexivity to recognise own assumptions Reflexivity to recognise own feelings Reflexivity to acknowledge how one is conducting themselves Reflexivity to assess own practices in work with client Reflexivity as reminder that not all-knowing therapist
Supervision as a critical part of reflective practice in clinical record-keeping and client tracking.	
Reflexive practice aids in understanding clinical details of whole client in clinical record-keeping and client tracking.	Reflexivity for gathering zoomed out view of sessions with a client Reflexivity for understanding client's experience Reflexivity to note client's verbal statements in sessions Reflexivity to understand physical expression of a client Reflexivity to understand client's energy levels Reflexivity to understand client's vulnerabilities Reflexivity to understand client's level of resilience

		Reflexivity to understand how client's session might be an indicator for the wider context of their life
		Reflexivity for understanding emerging themes in sessions with client
	Reflexive practice as a tool for making clinical choices in clinical record-keeping and client tracking.	Reflexivity helping a therapist to find missing pieces in sessions
		Reflexivity helping the therapist to look at the client's process critically
		Reflexivity to help therapist in finding the next steps in the therapeutic process
		Reflexivity to help therapist make choices about use of arts materials and medium in sessions
	Reflexive practice in clinical record-keeping and client tracking as a tool in understanding and improving the therapeutic relationship with client.	
	Reflexive practice in clinical record-keeping and client tracking for optimal client care.	Reflexivity helping a therapist to make appropriate choices
		Practicing reflexivity regularly
		Reflexivity to help keep the client at the forefront of therapy process
g	**Choice of therapist to include reflexive practice in clinical record-keeping and client tracking process.**	Some participants include reflexivity in work and others do not.
	Reflexivity practiced as an aid to therapist in clinical record-keeping and client tracking.	Reflexivity as important aspect to clinical-record-keeping and client tracking.

	Reflexivity practiced as part of clinical note-taking process in clinical record-keeping and client tracking practice.	Reflexive notes on therapist thoughts Reflexive notes on therapists' ideas Reflexive notes on therapists' interpretations Reflexivity included in sessions notes Reflexivity included in personal notes
	Reflexivity practiced as a hospital requirement in clinical record-keeping and client tracking.	Reflection on direct observations for hospital notes Reflection on themes in sessions for hospital notes Reflective notes for hospitals make use of clear language Reflexive notes for hospital are made accessible to external professional.
	Reflexivity practiced in clinical record-keeping and client tracking as an aid in understanding therapeutic process.	Reflexivity to look at transference and countertransference. Reflexivity practiced looking at client responses in session Reflexivity practiced to understand client imagery Reflexivity practiced finding the relevant content in sessions to aid the client's therapy process.
	Reflexivity practiced in clinical record-keeping and client tracking as means to remain self-aware as a therapist. .	Reflexivity aids in understanding impact of age, gender, race, etc. in sessions Reflexivity helps to aid the therapeutic relationship
h	**Limited to no awareness of clinical record-keeping and client tracking**	One participant being aware of multimedia usage in clinical record-

	practices used in other arts therapy modalities.	keeping and client tracking in music therapy.
i	**Little to no use of clinical record-keeping and client tracking practices from other arts therapy modalities.**	Use of multimedia clinical record-keeping and client tracking practices when studying GIM.