

KAIROS: TRANSFORMING WAITING TIME INTO HEALING FOR OLDER MALE
CANCER PATIENTS THROUGH TEXTILE ART THERAPY INTERVENTIONS

HANNAH GRABOWECKY

A Research Paper

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements

for the Degree of Master of Arts

Concordia University

Montreal, Quebec, Canada

SEPTEMBER 2019

© HANNAH GRABOWECKY 2019

CONCORDIA UNIVERSITY

School of Graduate Studies

This research paper prepared

By: Hannah Grabowecky

Entitled: Kairos: Transforming Waiting Time into Healing for Older Male Cancer Patients
Through Textile Art Therapy Interventions

And submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies; Art Therapy Option)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality as approved by the research advisor.

Research Advisor:

Heather McLaughlin, MA, RMFT, ATR-BC, ATPQ

Department Chair:

Guylaine Vaillancourt, PhD, MTA

September 2019

ABSTRACT

KAIROS: TRANSFORMING WAITING TIME INTO HEALING FOR OLDER MALE CANCER PATIENTS THROUGH TEXTILE ART THERAPY INTERVENTIONS

HANNAH GRABOWECKY

This research uncovers the potential benefits of textile interventions with older male cancer patients in waiting spaces, supporting clients through their trajectory of treatment. This theoretical inquiry asks the following questions: “How can art therapy enhance healing within a hospital setting for older men receiving cancer treatment?” and “How could textile-based art therapy interventions, such as knitting, be used during cancer treatment?” A review and synthesis of related literature found that older male cancer patients are at risk for loneliness and social isolation, yet are faced with many barriers to receive social programming. Textile interventions – and knitting specifically – are suggested as a means of increasing sense of inclusion, distracting from symptoms associated with cancer treatment, and providing an opportunity for creativity in clinical and other waiting spaces. The text builds a theoretical foundation from which new frameworks for treatment of this population could be developed.

ACKNOWLEDGEMENTS

Firstly, I would like to thank my parents, Janine and Rick, whose courage and life circumstances inspired this research. Secondly, I extend my gratitude to my research advisor, practicum supervisor, and cherished instructor, Heather McLaughlin, who has provided such great inspiration over the past two years. Finally, I would like to thank my partner, Matt, whose support carried me through the day-to-day and who will always be my moment of blue.

This paper is also dedicated to my great-aunt, Emilie, who didn't win her battle with cancer but who has always been my champion.

Table of Contents

Table of Contents	v
Chapter 1. Introduction	1
Chapter 2. Methodology	2
Chapter 3. Literature Review	6
Part I: Population and Setting	6
Part II: Treatment	16
Part III: Interventions	22
Chapter 4. Findings	30
Chapter 5. Discussion	34
Chapter 6. Conclusion	38
References	40

Chapter 1: Introduction

During my first year of this master's program, my father was diagnosed with oral cancer. It came as a huge shock to me and my family, and to make matters worse, the disease was farther along than anyone had expected. Never did I feel so alone and far from home as I did during those initial weeks. I made plans to fly back as soon as classes wrapped up, since it was nearing the end of my second semester.

As untimely as the news was, it came right as I was attempting to formulate a research proposal. After many tearful moments with friends, family, faculty, and my therapist, I began thinking how I could use this opportunity to make meaning of this tragic and uncontrollable event. I tailored a research proposal to explore how my passion for fibre arts could be used with a population to which my father now belonged.

When I was finally able to visit my parents in Manitoba, I attended chemotherapy sessions with my father. He told me that in order to pass the time during the many hours of daily oncology appointments, he would mainly read, listen to music, or sleep. While he felt very fortunate to be receiving outpatient treatment from CancerCare Manitoba, he felt physically and emotionally drained by all of the waiting involved, on top of the side effects of the medications.

I would later come to learn that CancerCare Manitoba provides extensive support services that include expressive art groups and Art by the Big Blue Chair, an Artists in Healthcare initiative (Norman, n.d.). Having said that, the number of facilitators is limited and there may not be programming during the times that outpatient service users are present. This got me thinking about the potential of an artistic medium that was familiar or easy to learn, could be transported easily, and could be continued without facilitation, in order to maximize healing during times of wait.

In another hospital setting, I was able to experience first-hand the impact of creative diversion in a Western healthcare model during my two-years as a volunteer in Winnipeg at St. Boniface Hospital with the Art at the Bedside program. As another Artists in Healthcare service, this program provides art facilitation to inpatients and visitors on multiple units of the hospital (Hôpital St-Boniface Hospital, 2017). While volunteering in many different units from prenatal and family medicine, to geriatrics and palliative care, I witnessed the healing potential of the arts to enhance patients' experiences of their hospital stay. Art provided a way to distract from pain, build connection with others, and make meaning of long waiting periods.

Back in Montreal, it was through my research that I came across the terms *kronos* and *kairos*. Both of these terms originate from ancient Greek and are translations of the word time in modern-day English (Sibbett, 2005a). While *kronos* describes a linear form of time, *kairos* is experienced as non-linear. It is “the right or opportune moment and reigns where creative purposes are to be achieved” (Sibbett, 2005a, p. 19). I found this definition suitable for what I was trying to study: how time could be influenced by art making. The concept of *kairos* will resurface throughout this research paper as its significance is woven into the various topics explored.

This paper will begin by outlining the chosen qualitative bibliographical methodology, followed by a comprehensive literature review exploring the themes of older male populations, medical art therapy for cancer treatment, waiting room art making, and textile-based interventions. Next, a findings section will intersect these areas of interest, followed by discussion and conclusion sections.

Chapter 2. Methodology

The purpose of this research is to uncover the potential benefits of textile interventions with male cancer patients in waiting spaces, supporting clients through their trajectory of treatment. This theoretical inquiry seeks to answer the following question: How can art therapy enhance healing within a hospital setting for older men receiving cancer treatment? A subsidiary research question asks: How could textile-based art therapy interventions, such as knitting, be used during cancer treatment? The aim of this theoretical research is to review the related literature in order to synthesize the diverse conceptual and practical information into one cohesive body of text. From there, a theoretical foundation will be built from which new frameworks for treatment with this population could be developed. This section of the paper describes the bibliographical methodology chosen to study these intersections. The selected design will be outlined with rationale for method and procedure, data collection and analysis, ethical considerations, and finally, researcher assumptions and bias.

Research Design

Method. A qualitative bibliographical methodology has been chosen to organize and structure the aforementioned areas of study, highlighting the gaps in theory and practice whereby the researcher can “compare what is known and unknown about a topic to locate missing information that would benefit the field” (Kapitan, 2018, p. 45). Marshall and Rossman (2016)

further this idea by proposing that research focusing on a literature review can create potential relationships and connections by linking proposed theories that could arise through data collection. Due to the very limited nature of literature available on medical art therapy with male cancer patients in waiting spaces and use of textiles with this population, this theoretical methodology was determined to be an appropriate first step in formulating a framework for this research.

Procedure. A preliminary literature review was conducted of 50 sources relating to the topics of interest. Initial data was collected in the form of peer-reviewed articles and books through public database searches that include PsycINFO, PubMed, and Google Scholar. Specific databases to Concordia University have also been employed including the library catalogue CLUES, the online discovery search function, and the institutional research repository Spectrum. When seminal texts were not available on these electronic databases, they were scanned from print or microform periodicals and emailed by the Concordia intercampus article delivery service.

Keywords relating to waiting room art making, textile-based interventions (knitting, quilting, etc.), medical art therapy for cancer treatment (oncology, chemotherapy, etc.), and older male participants have been intersected in the research process. Limiting keywords such as “women” and “production, commerce, and manufacturing” in relation to textiles have been implemented to target the intended topics. Since no single peer-reviewed study was found encompassing all of the above keywords, relevant research including other settings, populations, and materials for art therapy interventions were also cited, in order to provide sufficient literature on each area of interest. Notable studies provided further avenues of inquiry in their own reference lists.

Data Collection and Analysis

Original sources were saved to the reference management site Mendeley to compile and consolidate data, as well as saved onto my laptop hard-drive in a folder marked “Research References,” labeled by author name and year of publication. Mendeley’s program also provides personalised suggestions for articles related to the user’s library content, offering another method of data collection through which an additional 20 sources were found. Digitally highlighting relevant passages from these references has provided what Marshall and Rossman (2016) call “theory-generated codes” (p. 345), identifying themes derived from the literature. Employing

other visual aids such as colour-coded bookmarks has also helped with the organization process of non-electronic sources.

In terms of data analysis, Marshall and Rossman (2016) purported that through the process of inquiry, researchers become sensitized to the likely connections – or lack thereof – between themes in the literature in question. Through this practice of coding, categories and themes are generated from various sources including, “the literature review, the actual words and behaviors in the data, and [the researcher’s] own creative insight” (Marshall & Rossman, 2016, p. 345). Since this paper proposes theoretical results based on previous research with no new data being collected, coding will take place of the first and third sources suggested by Marshall and Rossman (2016). The emerging concepts and overlapping connections will be detailed in the literature review and findings sections of this research paper.

Ethical Considerations

Just as studies with participants involves stringent ethical review, theoretical research equally requires ethical considerations. Although the current inquiry does not include participants, attention to research ethics is still needed as it studies a vulnerable population and suggests ways to involve participants in future study. In addition, the proposed medium of textile interventions carries certain gender connotations that may raise assumptions and questions regarding gender identity within participants, specifically those with certain types of cancer. These issues of gender in relation to material and illness will be explored in depth throughout the paper.

It should also be noted that most of the cited research came from western medical settings and findings may not be generalizable to other populations, taking cross-cultural differences into account. Along the same vein, cultural sensitivity should be observed when incorporating research on traditional textile practices and their historical significance. Finally, awareness of personal bias is a pertinent ethical consideration and will be examined in further detail in the following section.

Assumptions and Biases

One of the key assumptions of my research that I have identified is the belief that art therapy is appropriate for everyone. Naturally this is not the case, but the research I am conducting is based on the goal of finding suitable art therapy interventions for older male cancer patients in medical settings. Moreover, I am making the assumption that men undergoing cancer

treatment want a creative outlet and thus, could benefit from one. This is a common occurrence in art therapy research as Kapitan (2018) argued that art therapists often make the mistake of assuming that art somehow transcends culture since images are a “universal language” (p. 86). Cultural humility is an important consideration in this regard as my cultural worldview will differ from anyone with different experiences and social locators, including – but not limited to – age, race, religious affiliation, sex, gender, sexual orientation, ability, social economic status, level of education, and size.

Additionally, this research is written from the perspective of someone that has received two years of formal art therapy education and the intended audience is similar healthcare professionals. With that in mind, it is assumed that any reader will have a basic knowledge of the field of art therapy so its history is not discussed at length in this paper. I am also working from the premise that there will be enough evidence to create valid research and construct a meaningful link between textile-based interventions, older male populations, medical art therapy for cancer treatment, and waiting room art making. My personal bias in this regard should not be overlooked, as the subject matter is very related to the experiences of myself and my family, providing another reason why I would want this research to be successful, and contributing to my biased perspective.

Critiquing bias is a necessary step in research, as bias is “a characteristically human trait” (Kapitan, 2018, p. 23) and cannot be altogether avoided. The very fact that I am conducting this investigation would suggest that I believe that there is something meaningful to be found between the topics of interest. In addition, while I am questioning the appropriateness of these interventions with this population and setting, what I choose to include or exclude from the literature review forms the basis of my research and is inevitably based on inherent bias.

Validity and Reliability

To ensure validity in a qualitative theoretical methodology, Marshall and Rossman (2016) emphasize triangulation, described as “gathering data from multiple sources, through multiple methods, and using multiple theoretical lenses” (p. 103). They also suggest peer debriefing to discuss emergent findings and consider alternate explanations of the data, which will be facilitated through consultations with my research advisor and peer reviewers. Reliability may be strengthened with a clearly outlined methodology, allowing for data collection and analysis to be more easily replicated (Kapitan, 2018).

Now that the research methodology has been outlined, the subsequent chapter will explore the literature surveyed through the data collection process.

Chapter 3. Literature Review

This literature review begins by defining the key concepts and describing the main topics of interest as they are discussed in recent literature. The first umbrella concept of “population and setting” is broken down into the categories of a) older men, b) cancer diagnoses, and c) clinical waiting spaces. Next, the literature on treatment is sectioned into a) Men’s Sheds, and b) medical art therapy, with research on specific textile-based interventions rooted in different schools of theory composing the third part.

Part I: Population and Setting

The population that is the focus of this research is older men with cancer diagnoses. Since insufficient literature is available on the intersections of men, the elderly, and those with cancer, older adults with cancer as well as older men in the general population will also be explored separately in this section. Next, a brief inquiry will be offered into the setting of the research: clinical waiting spaces.

Older men. The term “older men” is used to denote individuals of age 55 and above who identify as men. Although the colloquial term “freedom 55” used to denote the age of retirement in North America, 60-65 is considered the new norm in terms of collecting partial to full pension from the Government of Canada (2019). Having said that, there does not appear to be a consensus in the literature to classify men as old. The age of 55+ has been chosen for the purpose of this study since it is the age that most provinces acknowledge eligibility for senior’s benefits (Yosowich, 2015). It should be noted that since the referenced articles use “men” and “males” interchangeably, this paper does as well, despite the differences between gender identification, gender expression, and sex assigned at birth. For brevity, these distinctions will not be explored at length in this paper.

The reasons for the chosen age and gender focus of this research paper is as follows. According to the World Health Organization (WHO), the proportion of the world’s population aged over 60 years is predicted to increase from 11 percent in 2000 to 22 percent in 2050 (as cited in Papageorgiou, Marquis, & Dare, 2016). In Canada, the proportion of adults aged 65+ is expected to grow from 13 percent in 2003-2007 to 22 percent in 2028-2032, more than doubling from 4.2 million to 9.4 million older adults in the span of 25 years (Canadian Cancer Society’s

[CCS] Advisory Committee on Cancer Statistics, 2015). This increase of the aging population suggests more specialized services may be needed to provide the same level of care as is currently available. The average number of cancer cases is also expected to increase (CCS, 2015), as will be explored in greater depth in a subsequent section.

According to developmental psychologist Erik Erikson (1968; 1982), one's life is comprised of eight stages of development from infancy to late adulthood. For each life stage, there is said to be two potential opposing outcomes. For older adults, the two most significant stages are the seventh and eighth: generativity vs. stagnation, and integrity vs. despair, respectively (Erikson, 1982). It should be noted there exists fluidity in the classifications of the developmental stages, including a ninth stage completed by Joan Erikson (1997) in the revised edition. Erikson (1997) pointed out that no exact age brackets are provided for these stages since human development varies so greatly between individuals, although the seventh stage is said to occur between 40-64 years of age (Carragher, 2017) while the ninth stage would account for the final decades of life (80+ years). Briefly, if the older adult fails to be a productive or creative member of the community, they might experience stagnation, boredom, and even despair. However, Erikson (1982) postulated that older adults generally have the desire to be generative, contributing to their community and personal well-being, in "active anticipation of dying" (p. 63). These stages of development in older adulthood will be examined further as they pertain to the research at hand.

From a Western viewpoint of gender, prominent American sociologist Talcott Parsons (1951) used the term "sex roles" (p. 155) to differentiate between the ways that children of different sexes have been socialized. He argued that only through adopting normative masculine behaviour and values can boys win the approval of their parents. While this perspective may seem outdated, current research continues to claim that men have largely been socialized to value independence, strength, and dominance (Liebmann, 2003; Mackenzie et al., 2017; Nurmi, Mackenzie, Roger, Reynolds, & Urquhart, 2018). Liebmann (2003) described how men are often taught to turn off their emotional sides as children, then find it difficult to relate to others in their lives. These ideas were validated by Carragher (2013) in her description of men's challenges to acknowledge emotional needs through internalised socialization of masculinity. She cited Harland (2009) whose research explored the concept of contemporary masculinity in Northern Ireland. Harland's (2009) study found that young men in Belfast struggled with the

contradictions they were facing between their internalized stereotypical masculine values and what they were truly experiencing as emotional, maturing adolescents.

These values are seen socially through evidence indicating that men – compared to women – tend to have smaller social networks and are less emotionally involved in those members of their networks (Carragher, 2017). This notion was identified in Kendler and Gardner’s (2014) opposite-sex twin study investigating risk factors for major depression in men vs women. They discovered that while risk variables for developing major depression in women related to neuroticism and the quality of their interpersonal relationships, risk factors for men demonstrated greater sensitivity to specific life-stressors, a history of depression, or externalizing psychopathology such as drug abuse. Kendler and Gardner’s (2014) research supported previous social science literature (Cross & Madson, 1997; Eagly, 1987) stating that women’s sense of self and self-worth is largely linked to their interpersonal relationships, while men’s emotional involvement mostly derives from work and monetary success.

Due to the aforementioned ways in which gender and masculinity are constructed and socialized in relation to pursuing and maintaining interpersonal relationships, men are less likely than women to seek help when dealing with mental health concerns (Nurmi et al., 2018). Mackenzie, Gekowski, and Knox (2006) noted that women were more inclined than men to seek help from mental health professionals due to positive attitudes towards “psychological openness” (p. 574). Besides professional, individual services, men are also not as likely to participate in therapeutic community programming because the existing programs tend to be more female-oriented in their activities and composition (Reynolds, Mackenzie, Medved, & Roger, 2015). Based on data from the Canadian Community Health Survey in 2002, Cairney, Corna, and Streiner (2010) discovered that more than half (60%) of older adults aged 55+ who met the criteria for a DSM-IV diagnosis were not receiving mental health services. It should be noted that this underrepresentation could be linked to other factors of self-report surveys such as recall bias or purposefully relaying false information considering the potential stigma associated with the use of mental health services. Cairney et al. (2010) acknowledged that the data provided by the survey does not include attitudes towards mental health service use or knowledge of available resources.

For best art therapy practices when working with men, Liebmann (2003) stated the importance of

- recognizing the added difficulties men may face in accessing therapy;
- placing emphasis on the process of art making during sessions, especially at the beginning of therapy;
- providing structured exercises to help contain any anxiety about exploring emotional content;
- dividing emotional work into smaller steps that may seem more attainable;
- providing group spaces for solidarity amongst men who find individual therapy too intimate; and
- fostering the group's ability to address their specific needs as men (p. 124).

Of course, Liebmann's (2003) spoke generally here as she acknowledged that these suggestions are perpetuated by gender norms and could not realistically reflect every man's experience of therapy. Ikeda (2009) argued for awareness of variability between genders, including how they intersect with other cultural identifiers including but not limited to race, age, sexual orientation, religion.

A recent Canadian study on community services for older men completed by Nurmi et al. (2018) identified two themes within their research: needs and access. These themes will be explored in greater detail individually as they provide a foundation on which the literature and discussion surrounding treatment will be based.

Needs. Requirements of relevant community programming were recognised through the sub-themes: a) reducing isolation, b) forming friendships, and c) engaging in continued learning (Nurmi et al., 2018, p. 802).

Reducing isolation. The theme of experiencing isolation was identified with great importance in the study by Nurmi et al. (2018), as participants across all focus groups spoke of lacking opportunities for socializing. Men who tied a strong sense of identity to their employment felt their retirement contributed another layer of isolation through the loss of their close co-workers. The phenomenon of social exclusion amongst older adults – and older men specifically – is not unique to this study, as the reviewed literature confirmed that isolation and loneliness are commonly recognized issues for this population (Ang et al., 2017; Crabtree, Tinker, & Glaser, 2018; Golding, 2011; Knit for Peace, 2017; Milligan et al., 2015; Milligan et al., 2016).

In addition to these issues being widespread, exclusion and loneliness are thought to lead to a variety of adverse health effects (Reynolds et al., 2015; Milligan, Payne, Bingley, & Cockshott, 2015). Among the mental and physical conditions associated with a lack of social inclusion are cancer, cardiovascular disease, cognitive decline, and depression (Reynolds et al., 2015). Meanwhile, being socially connected has been known to improve overall health by promoting generative cognitive functioning (Ybarra et al., 2008) and reducing mortality rates in a longitudinal study (Giles, Glonek, Luszcz, & Andrews, 2005). These observed benefits suggest an important element to consider in organizing community programming.

Forming friendships. The potential to form meaningful bonds was another sub-theme that emerged through the research by Nurmi et al. (2018). Participants stated the importance of meeting people and developing friendships with those outside of their current networks in order to expand social connection beyond their work spheres.

Engaging in continued learning. Activities that including learning new skills or teaching others were viewed as significant contributions to men's socializing (Nurmi et al., 2018). These social activities were equally described by Reynolds et al. (2015) as pillars for successful aging. This is based on Activity Theory (Havighurst, 1961; Rowe & Kahn, 1997) which emphasizes participating in new activities in the face of retirement, illness or reduced mobility, and ongoing social engagement for older adults to maintain their well-being. Activity Theory also appears to share commonalities with Erikson's (1968; 1982) generativity, a concept which will be further discussed as this paper progresses.

Access. Accessibility of these services were identified through the sub-themes: a) points of contact, b) sustaining attendance, and c) barriers (Nurmi et al., 2018, p. 805).

Points of contact. In order for men to first access community programming, participants in the study by Nurmi et al. (2018) discussed creating opportunities in their workplaces to learn about the services when planning for their retirement. Other suggestions for reaching the male public were identified as creating links through community organizations and through signs, papers, or word of mouth in their local neighbourhoods.

Sustaining attendance. In order to sustain attendance in men's programming, participants shared that a warm, welcoming atmosphere would make them feel more likely to return (Nurmi et al., 2018). This concept was highlighted by participants who did not identify as heterosexual

and felt that some men's spaces could appear unwelcoming due to implicit or explicit expression of hegemonic values of masculinity.

Barriers. Barriers were identified as the final sub-theme of the research by Nurmi et al. (2018), including challenges associated with distance and travel, language barriers within the groups, and health-related difficulties, both mental and physical. Accessibility barriers for older adults were also discovered through the study of Papageorgiou et al. (2016), notably that some programming explicitly targets seniors over a certain age (e.g. 60 years and over) and does not take into consideration aging adults who have not yet met that milestone. This provides another reason for the chosen age of inquiry in this research paper. Furthermore, Nurmi et al. (2018) found that exposure to male-focused programming should ideally begin before age of retirement for optimal benefits.

In addition to the aforementioned needs and access of men's programming in Canada, a study by Mackenzie et al. (2017) examined whether men's only community services could support more flexible views of gender and masculinity. They identified three themes: a) focus on work, b) independence, and c) male-focused spaces (p. 1227).

Focus on work. Male participants stated that there is an association with men being hardworking in relation to their careers, and thus do not have as much time for social or leisure activities as their female counterparts (Mackenzie et al., 2017). Because of this focus on work and their work identity, the men felt more isolated post-retirement and conflicted upon entering "women's spaces" (Mackenzie et al., 2017, p. 1228) which they identified as the home, complicit to traditional gender roles.

Independence. Within independence, two subthemes were identified: choice and self-reliance (Mackenzie et al., 2017). First, men felt it was important to participate of their own volition and have freedom in how they spent their time while also enjoying some leadership roles and group organization. Second, participants discussed how the hegemonic masculine value of self-reliance could conflict with efforts at social connection. Mackenzie et al. (2017) suggested that conceptions of masculinity may be shifting as participants showed preference for interdependence and togetherness, against traditional expectations.

Need for male-focused spaces. In addition to the needs of men's programming mentioned above, Mackenzie et al. (2017) identified men's only community services as spaces where they could feel more comfortable to discuss physical or psychological challenges and experience

“male-friendly banter” (p. 1231). Diversity was also seen as an important element of these programs as topics relating to sexual and racial diversity received support of and opposition to the hegemonic discourse (Mackenzie et al., 2017). As the majority of the participants were White, heterosexual-identifying males, ways of promoting cultural diversity were explored. Finally, although these men-focused spaces emphasized activities that generally appealed to the male participants such as building and fixing things, Mackenzie et al. (2017) found that female participants equally enjoyed the activities directed to a male audience.

In contrast to traditional, hegemonic views of masculinity detailed by the literature mentioned above, Mackenzie et al. (2017) witnessed opportunities for fluidity in conceptualizing masculinity. Both their research and the study by Nurmi et al. (2018) took place in programming targeted to older men called Men’s Sheds, a movement that will be explored in detail later in this paper.

Cancer diagnoses. As Minar wrote, “once you have cancer, it becomes part of your life” (as cited in Malchiodi, 1999). Although not referencing cancer specifically, prominent American sociologist Parsons’ (1951) text on the social system offered a viewpoint of how illness can be conceptualized within a capitalist society. He defined illness as “deviant behaviour” (p. 285) which is motivated by a withdrawal and desire for dependency. He continued by stating that sickness becomes a social role through which individuals gain leverage or control over others, while still conforming to the Western social structure.

Parsons’ (1951) theories have been critiqued considerably since then. Assouline (2009) studied art therapy’s effect on identity within the experience of chronic illness. She argued that Parsons’ (1951) sick role paints the person with illness as dependent and ultimately passive. She continued that the model does not account for chronic illnesses – such as certain types of cancer – and how they are experienced and conceptualized differently than acute illness (Assouline, 2009). Varul (2010) applied Parson’s (1951) theories to what he terms “chronic health” (p. 86), comparing the treatment plans for chronic illness (dietary regimens, home remedies, exercise, and self-observation) to that of maintaining healthy lifestyles.

Although critics of Parsons have argued that his theory has contributed to the disempowerment of individuals with illness, the attitude unfortunately remains (Assouline, 2009). Receiving a cancer diagnosis can still be a very stigmatizing experience today, arousing feelings of guilt and shame (Sibbett, 2005b). Assouline (2009) argued that because Western

societal values of work and success are also held on a personal level, the new existence of life with illness might also induce feelings of anxiety. As mentioned above, strong affiliations to one's work identity may also be determined by gender, suggesting that men may experience additional psychosocial difficulties through this loss.

From diagnosis to complete remission or death, no two individual's cancer journeys are alike. Since treatment planning can vary greatly depending on the type of cancer, stage, and patient's age and preference – among other factors – cancer care can look entirely different for each case (CCS, 2019a). This could mean the use of chemotherapy, radiation therapy, or surgery, or a combination of those or other drug therapies administered by an oncologist. In order to identify the individuals with a cancer diagnosis, the literature surveyed at times uses the terms “cancer patient” and “cancer survivor” interchangeably (Norris, 2016; Waller & Sibbett, 2005), despite the connotation that surviving the disease may indicate a full remission or being cured of the illness. In order to promote clarity, this paper will use the term “cancer patient” to denote anyone with a cancer diagnosis, regardless of their trajectory through treatment, although the majority of this research will involve individuals who are receiving some form of medical assistance for their cancer.

Contrary to popular belief, cancer is not simply one disease, but a classification of over a hundred different types (CCS, 2019c). According to the CCS (2019c), cancerous cells are generated within all of us but human bodies are generally capable of preventing the growth and metastasis of abnormal, cancerous cells. The persistence of growing and dividing abnormal cells may form lumps that result in tumours. Unfortunately, there are multiple elements which may increase incidence of cancer, such as exposure to carcinogenic chemicals, radiation, and viruses, along with genetic predispositions (CCS, 2019b).

Despite advancements in testing and treatment, cancer continues to be the leading cause of death (30.2%) among Canadians, according to Statistics Canada in 2012 (as cited in CCS, 2017). Half of the population is expected to develop cancer in their lifetime with a quarter of the population dying from the disease (CCS, 2017). Of all new cases of cancer diagnosed in Canada, a slightly larger portion (51%) of those are males compared to females (49%), and the vast majority (89%) of Canadians who develop cancer are over the age of 50 (CCS, 2015). Aside from females aged 20-59 – due largely to breast and thyroid cancers – cancer rates are highest

for men in all age groups. These statistics suggest that there may be a demand for alternative treatments for older men.

Fortunately, many individuals who survive a cancer diagnosis are able to live rewarding, productive lives. This does not mean however that there are not great physical and psychological challenges that persist, even long past treatment of the disease. In addition to the internalized stigma mentioned above, feelings of alienation, isolation, distancing, and loss can occur. Moreover, cancer patients may feel that they are being punished for past wrong-doings, or that they have the potential to contaminate others (Sibbett, 2005b). All of these perceptions may further an individual's desire to withdraw and separate themselves from their social familiars.

Looking forward, by 2028-2032, the annual amount of new cancer cases is estimated to grow by 79% compared to 2003-2007 (CCS, 2015, p. 7). This increase is primarily due to the increase in the aging population, as mentioned above. Additionally, general population growth and changes in the risk of developing cancer are thought to influence this statistic as well. Due to these facts, the CCS (2015) highlighted the importance of preventative measures and planning of additional health resources. As the aging population increases, it will be important that those affected by the disease have sufficient access to differing treatments, and that public spaces be optimized to promote healing.

Clinical waiting spaces. For this paper, the term “waiting rooms” refers to the areas where people congregate as they await medical or clinical procedures. “Waiting spaces” refers to any area where an individual might find themselves in wait, including but not limited to in transit, in their own homes, or in public spaces unrelated to clinical treatment, unless specified.

In 2017, the Canadian Institute for Health Information (CIHI) stated that 9 out of 10 patients received radiation therapy within 15-27 days of diagnosis and cancer surgery within 38-88 days, depending on the type of cancer being treated. It is worth noting that these numbers represent the wait times leading up to the beginning of any given procedure, not including duration of treatment, and that the CIHI (2017) has yet to develop a standard definition for IV chemotherapy wait time indicators. Since duration of treatment for cancer depends greatly on the type of cancer, stage, grade, and many other factors, no estimate was found for how much time a cancer patient spends actually receiving treatment. This gap in the literature suggests an area of inquiry that could provide greater insight when planning complementary programming for cancer patients.

Although information is currently unavailable on how long patients with cancer spend receiving treatment, various sources do explore how periods of wait are experienced in clinical settings. Speaking broadly, Bournes and Mitchell (2002) described how waiting can become a “vivid experience” (p. 58) when you or someone you love is ill. They elaborated that individuals can feel isolated and frustrated, with diminished satisfaction in their health services due to wait times. Corsano, Majorano, Vignola, Guidotti, and Izzi (2015) echoed that hospital waiting rooms can be places of great stress as well as boredom for patients and their families. In this study of an Italian pediatric oncology waiting room, adult participants suggested the addition of entertaining, positive distractions that could alleviate their current emotional states and be more relaxed for their children (Corsano et al., 2015). The concept of positive distractions was also mentioned in research by Henize, Beck, Klein, Morehous, and Kahn (2018) into redesigning an American pediatric primary-care waiting space. Other important factors noted in their study were the goals of creating a welcoming atmosphere and providing connections with community resources.

Approaching the waiting space from an environmental perspective, Klingemann et al. (2018) studied the effect public art had on public spaces. Their artistic intervention focused on influencing felt time and social time, by creating a more pleasurable and more relaxed waiting experience in a Swiss hospital and administrative environment. By appealing to diverse senses through “visual, acoustic, tactile/haptic and olfactory elements (fragrance management)” (p. 70), positive outcomes were observed in waiting areas with participants with long wait times. Klingemann et al. (2018) also discovered that “basic waiting needs” (p. 87) should be identified as regularly returning patients and those in palliative settings would have different needs than those coming in for infrequent check-ups.

Catania et al. (2011) surveyed 355 patients in an outpatient oncology clinic in Italy to study their experiences of wait. Of those surveyed, 12.3 percent were male with an average age of 63 years. Through the 15-point questionnaire, 83 percent of most participants responded that waiting took an emotional toll on them (Catania et al., 2011). As an alternative for their waiting time, 89 percent of patients responded that they would like to be able to schedule meetings with medical and mental health professionals during that time, and 65 percent of individuals suggested “fun activities (music therapy, drawing courses, library, TV)” (p. 388). It should be noted that the researchers categorized creative arts therapies as purely diversional and separate from professional mental health services. Finally, 78 percent of participants also reported that

they would like the option to leave the hospital during waiting periods – with the use of a pager or other notification system – in order to regain a sense of control in their lives (Catania et al., 2011).

According to other literature (Cooper & Foster, 2008; Waldon & Thom, 2015), music is an intervention used by researchers to improve patients' waiting experiences. Cooper and Foster (2008) studied cancer patients' stress levels in relation to music played in a radiotherapy waiting room and found clear benefits of anxiety reduction when they enjoyed the music being played. While the effect achieved was small, Waldon and Thom's (2015) participants who listened to music while filling out paperwork in a mental health waiting room reported a higher satisfaction with their overall clinical experience than participants in the control group.

Finally, a topic which is often overlooked is how gender and culture may affect waiting experiences. Figueroa (2016) studied waiting rooms in a public hospital in Kuwait, where gender segregation is still common in educational settings, places of worship, and some government buildings. In gender-neutral spaces such as the waiting room studied, Figueroa (2016) found that people tended to cluster in distinct "gender zones" (p. 33) for optimal privacy and distancing between sexes respectful of religious, cultural, and political practices. Figueroa (2016) proposed that medical waiting spaces offer opportunities for clients to wait alone, with same-sex patients, or those of differing sexes. She also argued the importance of professionals working in these clinical settings to be aware of these cultural differences how they affect the patients' individual needs.

Part II: Treatment

Now that a general context has been provided, this next portion of this literature review investigates current clinical art therapy treatments and community services for the population in question. Firstly, the topic of Men's Sheds as therapeutic programming is examined. Next, medical art therapy is discussed generally, narrowing in on art in cancer care and art in waiting rooms.

Men's Sheds. A recently growing body of literature has studied older men's engagement in a men's-only community program model termed "Men's Sheds" (Ahl, Hedegaard, & Golding, 2017; Ang et al., 2017; Carragher, 2013; Carragher, 2017; Crabtree et al., 2018; Ford, Scholz, & Lu, 2015; Golding, 2011; Mackenzie et al., 2017; Milligan et al., 2015; Milligan et al., 2016; Nurmi et al., 2018; Reynolds et al., 2015; Wilson, Cordier, Parsons, Vaz, & Buchanan, 2016).

Men's Sheds are non-profit organizations that are mostly volunteer based, providing community engagement for older and retired men (Ang et al., 2017). This model originated in South Australia in 1978 and encompassed activities such as carving, woodworking, cooking, gardening, model building, game playing, and more (Reynolds et al., 2015). They are a place for men to “interact, volunteer and share ideas about common interests, learn how to deal with their problems, restore self-esteem and self-respect and connect with their traditions and culture” (Ang et al., 2017, p. 1989). As the Men's Sheds movement continues to grow, more than 1000 sheds have been established across Australia (Ford et al., 2015), with new locations in Ireland (Carragher, 2013; Carragher, 2017), the UK (Crabtree et al., 2018; Milligan et al., 2015; Milligan et al., 2016), Denmark (Ahl et al., 2017), and Canada (Mackenzie et al., 2017; Nurmi et al., 2018; Reynolds et al., 2015).

Benefits of Men's Sheds. The following paragraphs will explore the benefits associated with participation in community programming and Men's Sheds specifically.

Connection. One main goal of the Men's Sheds movement is to engage men in their communities through relationship formation with other men (Ang et al., 2017). As older – especially retired – men run a high risk of social exclusion, these spaces could provide means of connection and reduce social isolation (Golding, 2011; Nurmi et al., 2018; Reynolds et al., 2015). Unlike women who tend to socialize more outside of work spheres (Carragher, 2017), men transitioning into retirement often experience a deeper sense of loss in the face of losing social time with work colleagues (Nurmi et al., 2018).

Being socially connected has been known to “improve health and reduce mortality rates, enhance cognitive functioning, and decrease the risk of dementia and depression” (Reynolds et al., 2015, p. 531-32). Furthermore, increased social connection and support has been known to positively affect resiliency when facing age-related changes, including declining health (Nurmi et al., 2018). Since social connectedness and social engagement are protective factors for older adults' mental and physical health, reducing isolation should be a priority when constructing services for this population.

Generativity. Returning to the concept of generativity (Erikson, 1968; 1982), Carragher (2017) argued that community participation in Men's Sheds offers a way to promote generativity among older adults. McAdams & de St Aubin (1992) stated that generative behaviours include “creating, maintaining, or offering” (p. 357), with woodwork and metalwork consistently

accessible in the sheds as opportunities for creativity and production (as cited in Carragher, 2017). According to the literature, these actions of creating or offering associated with generativity should not be merely altruistic, but represent an extension of oneself through creative expression (de Medeiros, 2009).

In the same vein, Golding (2011) suggested that Men's Sheds provide ways to cope with post-employment related stagnation, particularly "the difficulties of developing a non-work identity, a reason to get up in the morning and something to socially and productively occupy their week days" (p. 37). According to Golding's (2011) studies in Australia, many men over 50 years reported age-related discrimination in the workforce and found difficulties transitioning beyond paid work, both in circumstances of retiring early due to reasons of disability or with a planned pension at the age of 65. In response to these issues, Men's Sheds community organizations provided opportunities for voluntary employment and meaningful work from a social perspective.

Golding's (2011) research also suggested that community-based activity has the capacity to reduce stress related to aging through enjoyable and therapeutic recreation such as social outings and hands-on engagement. These activities have also been studied to help older men positively build on difficult "past lives" (p. 37), especially those who were unable to receive a formal education due to war-related conflicts. Finally, added benefits have also been mentioned of positively addressing older men's substance abuse issues and promoting the value of sharing healthy food as a physical and social need.

But who are the men using these services? According to a 2009 survey completed by the National Seniors Australia Productive Ageing Centre, 67 percent of the community organization participants were retired men (as cited in Golding, 2011). The remaining 33 percent were comprised of men over 50 years of age still in the workforce (20%) and those who were unemployed (13%). Of the older men studied, many self-reported "a significant loss in their lives" (23%) or "a new impairment or disability" (23%) in the past five years (p. 38). An even larger number (33%) reported that they had experienced a major health crisis during that time, experienced depression (19%) or had a separation from a partner (12%). Although statistics on a national scale were unable to be found for Canadian men's sheds, the participants surveyed in the study by Nurmi et al. (2018) also mostly consisted of retired men (71%), often whom had dealt with some form of anxiety, stress, or depression. These numbers suggest a demand for

programming that addresses emotional and social needs, while respecting individuals of differing abilities.

Critiques. While the research suggests that there are potential health and wellbeing benefits of regular, practical, hands-on involvement in older men, it is hard to say for certainty that the benefits are unique to Men's Sheds or if people who are motivated to participate in these organisations are already more likely to have positive health trajectories (Golding, 2011; Milligan et al. 2016). Milligan et al. (2015) also stated that there is insufficient evidence to conclude that this model of programming imparts health and wellbeing benefits to this population since studies in this field vary in quality, although the current body of research is growing (Nurmi, et al. 2018). These limitations of the current literature could provide avenues for further study.

Medical art therapy. Medical art therapy is defined as, "the specialized use of art expression and imagery with individuals who are physically ill, experiencing trauma to the body, or who are undergoing aggressive medical treatment such as surgery or chemotherapy" (Malchiodi, 1999, p. 13). Although the term "medical art therapy" has been used mostly in contemporary clinical settings, the practice of medical art therapy dates back to British artist Adrian Hill, a pioneer of the field of art therapy in the 1940's (Case & Dalley, 2014; Hill, 1945; Malchiodi, 1999). He put great emphasis on the art-making process for its healing purposes, practicing it himself while recovering from tuberculosis, and suggesting it to others in the same hospital (Hill, 1945; Malchiodi, 1999). Through a program implemented with WWII veterans in a sanitarium-turned-rehabilitation centre, Hill helped relieve their boredom and despair following grave injuries and illness (Hinz, 2009).

In general, medical art therapy has been used help individuals cope with clinical diagnosis, treatments, surgery, symptoms, and disability (Malchiodi, 1999). Art therapy can enhance rehabilitation efforts towards recovery, fostering meaning-making of the experience of illness. Although there are many benefits associated with art expression in medical settings, Malchiodi (1999) identified four categories: 1) offering a visual means of expression; 2) achieving a sense of mastery and empowerment; 3) as complementary therapy for physiological benefits; and 4) discovering spiritual awakening through a process of transformation (p. 14). Within the third category, Malchiodi (1999) described her work with patients who reported feeling absorbed in meaningful creative activity that allowed relief from physical symptoms

including pain. They also mentioned the ability to achieve a relaxation response – namely “a relaxed state of being that is known to build the immune system and alleviate some symptoms of illness” (p. 18). This concept will be discussed further in other sections of this paper.

Now that medical art therapy has been briefly defined, the remainder of this research paper will explore this branch of art therapy as it pertains specifically to cancer treatment, from point of diagnosis and throughout treatment.

Art in cancer care. According to Malchiodi (2012), medical art therapy for cancer patients can take on many approaches through the lens of psychotherapy, psychoeducation, or even recreation. Nainis’ (2008) study providing art therapy to cancer inpatients at the bedside found that the diversional aspect of the art process alleviated some of patients’ pain and distress, while the symbolic nature of the art product acted as a vehicle to express their emotions.

Minar (1999) stated that in order assist individuals to adapt to their cancer experience, the therapist should support the client in maximizing their current capacities while living within the limitations of their condition. This is seen as a realistic way to manage personal expectations while undergoing treatment, without compromising a sense of ability and resilience. Recommended goals for art therapy include fostering expression of emotion and discovery of inner strengths which may act as a buffer against inevitable losses and recurring stressors (Minar, 1999).

In the field of medical art therapy, interventions for cancer patients at any stage in treatment are readily available. Bozcuk et al. (2017) offered on-site watercolour facilitation during chemotherapy sessions in a Turkish oncology ward, and provided painting materials for patients to bring home between treatment to continue their creative expression. According to their research, patients who painted during chemotherapy and at home noticed an improvement in quality of life and depression, compared to the control group who received no artistic treatment (Bozcuk et al., 2017). It should be noted that although the intervention was named the “painting art therapy program” (p. 67), facilitation was provided by a professional artist and not an art therapist.

In a community art studio, Baba (2016) created an intervention for post-treatment cancer patients making mosaics. Through a community model, adults who have already undergone cancer treatment could connect with one another to reduce feelings of social isolation and reconstruct their self-identities within society. While Baba’s (2016) research provided an

example of a 10-week group art therapy program for this population, the proposed intervention was not implemented with participants, offering a foundation for further study.

Group art creation and storytelling also provided opportunities for participants to learn novel ways to express their emotions, in turn, reframing their cancer experience (Heiney, Darr-Hope, Meriwether, & Adams, 2017). The six-session healing arts program of Heiney et al. (2017) demonstrated that by combining three elements – art expression, story, and group processes – participants achieved a sense of emotional healing in the face of their cancer diagnoses. These above examples are only some of the ways that art making has been studied with adult cancer patients, both in medical settings and in the community at large.

For people with cancer, time may become an important concept. Sibbett (2005a) argued that time may be perceived paradoxically by those living with cancer, experiencing a vague sense of timelessness while also being acutely aware of time, viewing it as precious, and dividing their lives into “the time before and after cancer” (p. 19). Here, the distinction between *kronos* and *kairos* is important to reconsider. During life-threatening illnesses such as cancer, art creation can offer the maker an experience of *kairos*, wherein the soul feels nourished and satisfied (Murray, 2000). To elaborate, art making may provide another, more productive lens through which to view their cancer trajectory, creating transformative moments in time instead of adhering to a linear timeline of before and after the disease.

Sibbett (2005) purported that using art therapy with cancer patients could enable experiences of “flow and *kairos* by creating an opening or opportunity for ritual and aesthetic performances” (p. 20). She deduced that through these actions, the at-once maker and performer may lose their objective perception of time. Flow and *kairos* are two concepts that will be further explored as this paper progresses, and describe ways of experiencing time and their relationship to art making that provides a natural transition into the following section.

Art in the waiting process. The use of art during periods of wait is not a new proposal. One of Sibett’s (2005) patients was quoted saying that “during art making time disappears” (p. 20). Hill (1945) found that the act of drawing “set the pendulum in motion again” (p. 14), after weeks of marking time in bed. Before him, Adolf Meyer – a psychiatrist in the early 1900s – used diversional activity to treat and prevent mental illness by keeping the mind and body active (Lee, 2003). Diversional therapy, as it later came to be, includes art therapy interventions to support individual’s physical, psychosocial, and spiritual well-being (Friedland, 1988). Although

art therapy and diversionary creative activity are not synonymous, some of the available benefits may overlap, especially during times of wait, as will be discussed further throughout this paper.

Medical waiting rooms may be adapted with art activities to provide calm and inclusive environments for patients and families awaiting appointments and test results (Miller, 2016; Huisman, Leech-Porter, Spencer, & Van Soeren, 2015). For Miller's (2016) intervention research, she provided a space emulating an open studio model in a crowded waiting room at a low-barrier clinic. Participants' positive outcomes included, "focus, relaxation, containment, connection, and distraction from physical and emotional pain" (p. 39), through art making and discussion.

Huisman et al. (2015) found similar results with their program at the Victoria Cool Aid Society's Access Health Clinic in B.C., explaining that patients felt empowered through the therapeutic nature of art to express their thoughts, feelings, and frustrations. It should be noted that while this study did not employ art therapy interventions specifically, program facilitators chose artistic diversional activities for this waiting room space to provide this population with services which they may not usually be able to access for socio-economic reasons (Huisman et al., 2015). Despite these examples of art being used in times and spaces of wait, no research was found that specifically studied the population in question (older male cancer patients) using art therapy techniques during the waiting process.

When developing a new cancer care program, Norris (2016) urged the engagement of trained artists to work with patients at the bedside and in the waiting room to decrease frustration of wait times. She has seen the benefit of this collaboration at the Smith Center for Healing and the Arts in Washington, DC, but recognizes that artists-in-residence are not clinicians and that an art therapy model would provide a different approach. This suggestion provides a point of departure for further research to be done in inpatient and outpatient oncology settings, namely art therapists at the bedside and chairs of those receiving cancer treatment.

Part III: Interventions

This part of the literature review will briefly define the models of feminist art therapy, positive psychology – including positive art therapy and flow – and art as therapy approaches such as the Expressive Therapies Continuum in order to ground the discussed textile-based interventions in theory.

Feminist art therapy. Within a feminist approach, Hogan (2012) argued that art therapists must be aware of social differences between genders, races, sexual orientations, socio-economic realities, and other cultural identifiers, and how they may be perpetuated by traditional psychotherapy. The power dynamic between therapist and client must be addressed, through a strength-based and non-pathologizing approach. (Halifax, 2003). Challenging dominant narratives and questioning gender constructions through art making are considered essential (Halifax, 2003; Hogan, 2012).

Positive art therapy. Positive art therapy is another strength-based approach with a focus on improving upon what is already functioning in clients' lives instead of alleviating mental or physical illness (Chilton & Wilkinson, 2016). This model combines positive psychology's foundational knowledge of positive experience and positive character traits (Seligman & Csikszentmihalyi, 2014) with the visual vocabulary of art making. Positive art therapy uses the creative process to foster a high level of fulfillment and increase overall well-being (Chilton & Wilkinson, 2016).

Flow. Within the realm of positive psychology lies a concept called "flow" (Csikszentmihalyi, 1975; 2014). Csikszentmihalyi (2014) coined the term flow to denote a subjective condition where an activity's challenges are matched with the skills of an individual, fostering high levels of well-being. When one is totally engaged in an appropriately stimulating activity, a holistic sensation emerges explained as the flow experience.

According to Csikszentmihalyi (2014), what is appropriately stimulating depends on

- merging one's action with awareness, where one is aware of one's own actions but not of the awareness itself;
- centering one's attention, blocking out potentially intrusive stimuli;
- losing one's ego or self-consciousness;
- feeling in control of one's action and merged with the environment;
- receiving clear feedback, compatible with an ultimate goal; and
- finding the action rewarding in itself, also described as "autotelic" in nature (p. 145).

Kapitan (2013) stated that art therapists can offer their clients environments that foster flow experiences by providing the time and attention needed to meet these criteria, promoting attainment of optimal engagement.

Art as therapy. While art making has long been known anecdotally as a healing agent, Edith Kramer and other art therapists have emphasized the process of art making as the therapy over other more psychotherapeutic approaches focused on tapping into the unconscious (Moon, 2010). From a more systemic point of view, art therapists within community studios are also proponents of the arts for healing, urging divergence from clinical art psychotherapy (Timm-Bottos, 2016).

Expressive Therapies Continuum. Within an art as therapy approach, the Expressive Therapies Continuum (ETC) model (Kagin & Lusebrink, 1978) offers a framework that focuses on the process of art making as much as the product. How something is made is emphasized equally as what is made. Hinz (2009) suggested that the ETC conceptualizes the healing power of creativity through diverse artistic experiences, offering an appropriate model for the interventions explored in this paper.

Textile creation. In art therapy, the properties of the media used is an important consideration in any intervention, to which art therapists should be attuned (Hinz, 2009; Moon, 2010). Moon (2010) described materials in art therapy as the vehicles for meaning making. She questioned the limited range of traditional art media and techniques often associated with art therapy such as drawing, painting, and clay, and argued for the use of “alternative” media in artistic interventions such as fibre, wood, and metal. Moon (2010) examined how materials are situated within social and cultural contexts, recommending the use of media that is developmentally suitable and adaptable to diverse sensory needs, such as odorless art materials for cancer patients who may be sensitive to smells. Above all, Moon (2010) emphasized media that enhances accessibility and independence, while creating a stimulating and appropriately challenging experience.

The effects of materials form one of the bases of the ETC model (Kagin & Lusebrink, 1978) and explain the significance of understanding materials’ properties. Hinz (2009) studied how these qualities can affect the maker’s process and product, using continuum of fluid to resistive media in order to induce affective or cognitive experiences. This portion of the literature review will provide a brief history of how textile creation has been used in a therapeutic context.

For the purpose of this research, the terms “textiles” and “fibre art” will be used interchangeably, with the awareness that these terms may hold different significance depending on the setting and cultural context. The textiles in question created or altered by hand or with the

aid of manual tools (needles, looms, etc.) and not in a manufacturing process. In addition, the terms “art” and “handcrafts” will be used interchangeably. It is recognized that there is a classist hierarchy separating art and crafts in the field of fine arts (Auther, 2008; Moon, 2010), however this will not be explored in this paper to respect the brevity and scope of this research. The term “textile interventions” will be used when referring specifically to textile practices used in an art therapy context. The following paragraphs will explore the benefits associated with creation of fibre art and textile handcrafts.

Benefits of textile creation. In Knit for Peace’s (2017) report on the benefits of knitting and similar repetition-based handcrafts for older adults, the findings demonstrated that knitting may

- reduce symptoms of depression and anxiety;
- slow the onset of dementia;
- distract from symptoms of chronic pain;
- provide a relaxing activity such as yoga;
- lower blood pressure;
- provide opportunities for continued creativity in the face of reduced physical capacity;
- reduce feelings of isolation and loneliness;
- increase overall sense of wellbeing; and
- increase feelings of purpose and inclusion in society (p. 3).

While these statements should be seen as generalizations that could not apply to all participants and circumstances, the benefits were validated by some of the peer-reviewed literature, as will be cited throughout this paper.

Knit for Peace’s (2017) 44-page report comprises two parts: a literature review of evidence-based research on the health benefits of knitting, and a survey of over 1,000 artists who sent their knitting to the British non-profit organization. According to their findings, knitting is both process and product oriented. The process requires repetitive tasks of physical and cognitive skills, while the product is tangible as the knitter works. The visible aspect of knitting creates “satisfaction at completing a task, and reinforces a sense of capability” (p. 6). It is important to note that the research conducted by Knit for Peace (2017) refers to therapeutic art activities and not art therapy specifically.

Connection. Despite the connotation of knitting being a solitary activity (Knit for Peace, 2017), women have a long history of using textile handcrafts to build connections and reduce isolation (Futterman Collier, Wayment, & Birkett, 2016). It can be a vehicle for social connection, demonstrated through the rise of online knitting sites and local knitting groups alike (Knit for Peace, 2017). In Piercy and Cheek's (2004) study, participants commented that relationships and friendships were fostered through various aspects of quilting through skill-sharing, gift-giving, and community building.

Knitting groups were also seen as non-threatening communication spaces where it is deemed acceptable to avoid eye contact while maintaining conversation (Knit for Peace, 2017). Knit for Peace (2017) argued that this parallel activity provides a sense of privacy and safety within a social setting that may otherwise provoke anxiety for some.

Myselev (2009) has studied past and current trends of domestic needle crafts in Canada. In the fifteen years leading up to Myselev's (2009) article, she noticed a revival of these handcrafts that were once considered old-fashioned. Of these activities was knitting. She contended that because of its relation to the past and sense of nostalgia – connecting us to our parents and grandparents – younger adults are using the art as a form of empowerment. By undertaking something purely inefficient and impractical, knitting “provides a conceptual link and helps redefine the historical and contemporary significance of domesticity in society” (p. 149). Of course, the creation of textiles goes back much farther than our older relatives in the context of connection.

The literature proposed that there is a strong cultural and historical link connecting fibre arts practices and female identity (Garlock, 2016, Moon, 2010). Moon (2010) elaborated that the tactile component stressed themes of integration and togetherness. Textile roots exist in cultures around the world and are still prevalent to this day, from Surinamese weaving (Sae-Wang, 2015) and Japanese *Basho-fu* (Sarashima, 2013), to Native American beadwork (Bien, 2005), and Icelandic *lopapeysa* (Helgadottir, 2011) to name a few. Textiles have been used, and remain as an expression of identity, social status, and personal stories, amongst other purposes. Not only have diverse cultures mastered various fiber techniques, they have used this medium to incorporate meaningful symbols, reminding the maker and/or wearer of their origins (Garlock, 2016; Helgadottir, 2011).

Empowerment. Textile art has also been used as a means of empowering individuals and communities (Adams, 2002). To combat oppression during the dictatorship of Augusto Pinochet in Chile (1973-1990), women in shantytowns all over Santiago came together to create “solidarity art communities” (p. 14). They were instructed how to make *arpilleras* (appliqué pictures in cloth) by the *Vicaría de la Solidaridad* (Vicariate of Solidarity) – a group of middle-class professionals who had become unemployed in the Allende government (Adams, 2002). In addition to arts and crafts workshops, the Vicaría provided food, therapeutic services, and medical assistance to those in need.

The Chilean women used the traditionally feminine craft of sewing to portray their suffering on the *arpilleras*, namely “hunger, lack of jobs, and political repression” (Adams, 2002, p. 30). Through these creations, women whose husbands were unemployed were empowered to earn an income for their families while depicting to others what they were experiencing. Women met in secret, hiding the textiles under their clothes and smuggling them out of the country. Buyers included human rights groups and nongovernmental institutions, as well as Chilean nationals exiled to North America and Europe. In that way, the work of the Vicaría and the shantytown women played an important role in the prodemocracy movement, providing sites of socialization, connection, and empowerment (Adams, 2002).

Moon (2010) also proposed that fibre art making can be empowering for clients with medical illnesses. She suggested that textile practices such as quilting, costume making, and doll-making act as functional activities that can validate patients’ sense of capability in the face of reduced self-esteem.

Emotional expression and regulation. There is evidence that creative activities contribute to positive development of individuals of all ages, supporting well-being by fostering hope and positive moods (Futterman Collier et al., 2016; Pöllänen, 2015; Hill, 1945). Textile arts in particular have been found to assist their maker in coping with grief and depression by restoring feelings of joy and self-confidence (Futterman Collier, 2011). The term “textile rejuvenation” (Garlock, 2016, p. 61) was used to identify improved mood with a prolonged effect after participation in textile work. Thus, textiles were shown to be a constructive method of dealing with difficult moods, both short and long term (Futterman Collier, 2011).

With the goal of bringing awareness to internal emotional states, Hinz (2009) stated that focusing on external tactile sensations can encourage this awareness by matching external with

internal stimuli. In Homer's (2015) study, patchwork or quilting was presented as an intervention for clients who felt like their lives were in disconnect, offering the perfect metaphor of "piecing together" their emotions (p. 21). Garlock (2016) also suggested that the "slow" nature of textile art can give the maker time to process difficult or intense affect, while data from Pöllänen's (2015) study revealed that the sense of touch in the textile process deepened expression of the makers' inner feelings.

Repetitive acts such as knitting, crochet, stitching, and weaving are said to share commonalities with mindfulness and meditation (Riley, Corkhill, & Morris, 2013; Robins, 2016). This process can be explained through Perry's (2006) Neurosequential Model of Therapeutics (Homer, 2015; Perry & Hambrick, 2008). Art therapy interventions that fall under this model would need to be relational, relevant, repetitive, rewarding, and rhythmic, akin to elements of meditation and mindfulness (Croghan, 2018). Homer (2015) purported that working with fabric collage would satisfy the "Five Rs" (p. 20) by combining tactile sensory experiences and rhythmic movement, to stimulate multiple regions of the brain, ultimately strengthening treatment. While Perry's (2006) model was initially developed for clinical work with traumatized and maltreated children, Homer (2015) extrapolated the framework to implement an art therapy intervention that met the developmental needs of an adult.

Relaxation. Benson et al. (1974) coined the term "relaxation response" to denote a decrease in sympathetic nervous system activity and stress hormones, making one feel more relaxed. There are four elements necessary to elicit such a response including, "relaxed musculature, a quiet environment, passive disregard of everyday thought, and the focus of attention on a repetitive mental stimulus" (Jacobs, 2001). Dittrich (2001) postulates that knitting can elicit the relaxation response since it is repetitive and even meditative once mastered. Croghan (2018) goes so far as to compare the fibre art with yoga by its means of producing pleasure chemicals such as serotonin and opioids while decreasing heart and breathing rate.

Knitting has been used to reduce anxious preoccupation and enhance relaxation in a variety of settings (Riley et al., 2013). According to the survey by Riley et al. (2013), knitters from 31 countries around the world responded that they knitted in their homes and in public spaces to receive psychological benefits such as stress relief and other therapeutic qualities. It should be noted that their research stems from occupational therapy literature, examining the use of knitting as a therapeutic activity and not as an art therapy intervention.

Cognitive stimulation. Although not specifically discussing the use of textiles, Hinz (2009) spoke generally about the ways in which therapeutic outcomes can be affected by altering task instructions through complexity and structure. She described complexity in relation to how many steps are involved, and structure as how many types of responses are necessary to achieve a specific outcome. Hinz's (2009) findings demonstrated that activities with high complexity and high structure tend to evoke information processing on the Cognitive component of the ETC as there are multiple, precise steps in order to attain a desired goal. Meanwhile, activities with low structure and complexity may evoke more Affective or Symbolic processing, as it allows the art experience to "flow more freely and liberate emotional potential" (p. 35). Depending on the task instruction, more or less cognitive stimulation may be experienced.

Long term advantages of working with textiles among the general population consisted of cognitive coping and intellectual stimulation (Futterman Collier, 2011). According to Futterman Collier (2011), this could lead to a decreased risk of mild cognitive impairment, protecting older individuals against memory loss and emotional or cognitive maladjustment. More research on the aging population in question will be discussed in the findings section of this paper.

Kairos. As previously discussed, *kairos* refers to a non-linear experience of time. In relating textiles practices to the experience of *kairos*, White (1987) explained that the term itself originated from weaving (as cited in Sibbett, 2005). In the context of weaving, *kairos* is described as "the critical time when the weaver must draw the yarn through a gap that momentarily opens in the warp of the cloth being woven" (p. 19-20). In this example, the moment of *kairos* is the time wherein an opportunity presents itself and a forward movement occurs in order to achieve a successful outcome. By transforming passivity into moments of productive, creative time, *kairos* can be experienced.

Critiques. With any art therapy intervention, it is important to consider the counter-indications. The only risk associated with knitting mentioned in all of the reviewed literature was the possibility of developing carpal tunnel syndrome with long-term use (Dittrich, 2001). Having said that, there may be other counter-indications to take into account. The use of fibre art may not be suggested for what Elaine Aron (1996) termed the highly sensitive person. She explained that the highly sensitive person is more susceptible to sensory stimulation than the average individual, due to a nervous system condition. This could be exemplified as moderately arousing stimuli in one's environment that is experienced as overly arousing for the person in question.

While tactile stimulation is but one way that sensations are perceived, it is a critical deliberation to make when considering an art therapy intervention for a given population, especially during times of distress, pain, or other potential physical and psychological effects of cancer diagnosis and treatment. One's physical and mental capabilities under these conditions should also be taken into account as certain competences like hand-eye coordination, working memory, and fine motor skills could perhaps be affected and cause feelings of failure in the participant.

Another critique of the literature is the gap in gender representation in relation to textile creation. Although there is no evidence discrediting its potential benefits with men, there is virtually no research on textile specific art therapy interventions with male participants. This is unsurprising as an overview of art therapy interventions for cancer patients in particular demonstrated a clear predominance of female participants (Geue et al., 2010). Furthermore, as is customary in many cultures, historical textile practices were, and continue to be, largely a female craft (Helgadottir, 2011; Sae-Wang, 2015), even with literature targeted towards men (Myselev, 2009). With this apparent gender bias in the literature, one might infer that this material use is actually counter-indicated. A potential risk of note may be perceived shame towards textile creation when facing traditional views of masculinity and gender beliefs. In order to address these issues, research that intersects the use of fibre art with a male population will be explored in the following chapter of this paper, as well as examined in depth in the subsequent discussion section.

Chapter 4. Findings

A quick search of social media sites and popular press journals online reveal a trending use of fibre art among feminists (de la Guardia, 2019), activists (Barnett, 2018), men from various continents and eras (Meier, 2017; The Observers, 2017), and everyone in between (Hunter, 2019; Ritschel, 2018). All of these articles list some sort of therapeutic benefit, whether it be emotional, physical, cognitive, or social. Alas, since these are not valid and reliable peer-reviewed sources, they can hold little sway in this academic paper. It is unfortunate that despite the significant and ever-growing amount of anecdotal evidence appearing through online platforms that encourages textile practices among diverse ages, genders, and other social locators, there remains essentially no scientific research, at the time of this writing, being conducted that intersects all areas of interest in this paper.

This chapter focuses in on literature that is specific to the intersections of older male populations, medical art therapy for cancer treatment, waiting room art making, and textile-based interventions. Topics explored are: men’s use of textiles in contemporary culture, fibre art making for cancer care, and textile creation in waiting spaces.

Older Men and Textiles

According to the 2017 survey completed by Knit for Peace, only 5 of 1053 respondents identified themselves as male (1048 females). Of these knitters, over half (50.5%) were between the ages of 60-74, with the second largest (25.3%) category belonging to 45-59-year-olds. Unfortunately, the literature does not identify to which age group the male respondents belonged, and little else is mentioned in their research regarding sex or gender.

Although not referencing textile work specifically, Hinz (2009) stated that art materials that stimulate at least two senses at once can be particularly engaging with the elderly who may have reduced sensory abilities. She elaborated by saying that these older clients may experience “lessened interest in their environments as a result of vision loss” (p. 65), and that art therapy interventions that increase varied sensory input could have a positive outcome for this population. Since tactility is such a significant quality of fibre art making, it makes sense that including this sensorial element into art therapy could provide new ways of experiencing for older adults.

Of the literature studied, two references (Fontichiaro, 2013; Huisman et al., 2015) hinted at the potential of textile-making with men on a casual, drop-in basis. The targeted populations were not limited by gender and observed that knitting was popular among all ages and genders. The article by Huisman et al. (2015) featured an older man knitting in a B.C. clinic waiting room. In a high school library, Fontichiaro (2013) noted that teenage boys needed a “face-saving narrative” (p. 54) – such as making gifts for women in their lives – in order to participate in the stitching activities. Apparently, they were worried about facing criticism for engaging in “girls’ stuff” when, in reality, they may have found the needlework soothing for themselves. This is perhaps another reason why more textile-based interventions should be explored with men, to normalize their involvement and decrease stigmatization, while also considering the potential risks as earlier discussed.

Myselev’s (2009) article on contemporary craft offered insights into how knitting in today’s society attempts to redefine gender norms. She cited knitting books targeted specifically

for men, with names like “Knitting with Balls: A Hands-on Guide to Knitting for the Modern Man” (p. 160). The books are thought to appeal to the stereotypical, heterosexual man, described as assertive and determined, with an inclination for mathematics. Myselev (2009) argued that by targeting young, straight men, this literature may in fact miss an audience who may be more interested in knitting, notably gay men.

Although there is no data available on the sexual orientation of knitting book users, more recent literature (Daniel, 2016; Vaccaro, 2010; Vaccaro, 2015) has demonstrated how queer textile artists have been using the fibre medium to explore social issues. Transgender man Emmett Ramstad found that textile processes offered means of critiquing patriarchal views of masculinity (Vaccaro, 2010). In Vaccaro’s (2015) research, the creation of fibre art served two purposes by symbolically relating the sensual materials to the physicality of transgender and non-binary bodies, and by critiquing gender stereotypes of a craft that is often considered woman’s work. Queer artist LJ Roberts also used mediums such as knitting and embroidery for social change, as they considered feminist theory and politics to be “embodied in the materiality in fibre” (as cited in Daniel, 2016, p. 72).

Textiles in Waiting Spaces

One major benefit of certain textile handcrafts such as knitting is its portability, flexibility, and low preparation needs, making it apt for using in spaces and times of wait (Dominick, 2015; Knit for Peace, 2017; Riley et al., 2013). Clave-Brule, Mazloun, Park, Harbottle, and Birmingham (2009) specified that knitting is an easily learned, inexpensive tool that can provide a sense of accomplishment while not interrupting social interaction. It is seen as a means of productivity both during passive activities and unproductive times including, watching television, in transit, and of course, while waiting for appointments (Riley et al., 2013). Dittrich (2001) argued that patients may find knitting to be a more beneficial way to spend waiting-room time than reading magazines, for previously stated reasons.

Textiles in Cancer Care

According to Lowenfeld and Brittain (1987), there are two ways of experiencing art: 1) visually, witnessing as an outside observer; and 2) haptically, feeling involved in the art through kinesthetic and sensory means (as cited in Sibbett, 2005b). During cancer treatment, many if not all human senses may be affected in the process. For example, medications such as chemotherapy can greatly alter one’s sense of touch, smell, taste, sight, and hearing. Since art

making and working with fibres is a “visceral experience” (Rogers, 1993), it may lend well to expression of these bodily sensations (as cited in Sibbett, 2005b, p. 54). That being said, it would be important to be aware of the patient’s changing sensory profile in attempt to prevent sensory overstimulation.

Frances Reynolds (2002; 2003; 2004a; 2004b) explored in depth the benefits of textile arts in coping with long-term illnesses, including cancer. Through her research, Reynolds found that art making allowed participants to regain an element of control in their lives, on top of the aforementioned benefits. This is a very significant gain of textile creation that should not be overlooked with a population whose physical, cognitive, emotional, and social competencies may be affected by a cancer diagnosis and treatment. Fusible quilting was also shown to work well with geriatric, palliative, and cancer care populations who may be unable to use a sewing machine or hand-stitch in a long-term care facility (Bookbinder, 2016).

Regarding knitting specifically, the program Threads of Life initiated at the University of Washington Medical Centre offered cancer patients a relief from emotional stress, reducing unpleasant sensations of chemotherapy, such as nausea (Marer, 2002). The work with cancer patients in palliative settings by La Cour, Josephsson, Tishelman, and Nygard (2007) also demonstrated that the creative activity offered a means of coping with the declining physical abilities and existential concerns often associated with this population. Knitting was even been adopted by nurses in oncology wards to manage stressors and combat compassion fatigue (Anderson & Gustavson, 2016). It should be noted that the above examples are again instances of the therapeutic arts and were not implemented by trained art therapists.

Social prescriptions. As long as the world population continues to grow and the expected lifespan lengthens, medical services will likely increase in demand. Research from the UK shows that there is a rising need for first-line care and general practitioners in particular (Knit for Peace, 2017). The National Health Service (NHS) in the UK is underfunded, and the burdens placed on medical professionals is unsustainable. Nuffield Trust (2013) advocated for a “national framework for care” (p. 27) that would include an overarching vision for prevention and care (as cited in Knit for Peace, 2017).

Part of this national framework includes a concept called “social prescribing” (Knit for Peace, 2017, p. 27). It acts as a way of linking first-line care with support services within the community. This would enable doctors to refer their patients to holistic, non-clinical services,

targeting more emotional, social, and even practical needs such as healthy eating or exercise groups. In the available research, the UK appears to be leading the way in research on social prescribing (Brandling & House, 2009; Knit for Peace, 2017; Local Government Association, 2017).

That being said, new Canadian literature (Clements-Cortés, 2019; Kelly, 2018) on social prescribing is surfacing. Clements-Cortés (2019) advocated for social music prescriptions due to benefits associated with music listening and creation. This same concept has been implemented with visual arts in Montreal with the initiative of having doctors prescribe visits to the Museum of Fine Arts (Kelly, 2018). The Montreal Museum stated that the one-year pilot program is the first of its kind in the world aimed at improving mood by increasing serotonin and cortisol levels through museum visits (Kelly, 2018).

Additionally, Clements-Cortés (2019) urged that patients would be more likely to receive the psychosocial benefits of social programming in this form as they might be more likely to adhere to a structured cultural intervention when it is prescribed by their doctor than simply suggested by health care professionals. She suggested that social prescribing could be adopted for individuals with long-term conditions such as chronic pain (Clements-Cortés, 2019). For cancer patients, this could provide an integration of health and social care for optimized treatment, reducing social exclusion as well. Due to its therapeutic potential, Knit for Peace (2017) argued that knitting groups should be among the social prescriptions given by doctors. Since the activity can be tailored to the strengths and challenges of the individual and group, it may provide a cost-effective method of alternative healing.

Chapter 5. Discussion

Due to the exploratory and theoretical quality of this investigation, the results are interpretive in nature. With that in mind, the projected outcomes of this research were to establish a potential relationship between art therapy, waiting spaces, older male cancer patients, and textile practices. From the research gathered, there appears to be a clear gap in the literature when attempting to intersect all of the areas of interest. Having said that, I postulate that men could benefit from using textile interventions, such as knitting, in medical art therapy. Specifically, I believe that older men could promote their healing by using knitting and other handcrafts during waiting times while undergoing cancer treatment.

Drawing from the models of feminist art therapy and positive art therapy, I suggest that a strength-based approach may be appropriate for this population to increase times of healing and well-being within their cancer trajectory. The risks involved with implementing a historically gendered intervention such as textile work should inevitably be considered, however I believe that the choice of a non-traditional medium may provide means of challenging potentially harmful gender constructions and hegemonic social values.

From an art as therapy perspective coupled with the model of the ETC, the chosen media and how one interacts with it can provide increased therapeutic value, perhaps achieving a sense of flow in creation. From the perspective of material, I propose that textile creation and manipulation can be effectively used to support multiple levels of functioning. Fibre is at once resistive and fluid. Fabric can be cut up into shapes for patchwork quilts in the same way that paper would be used for collages. Embroidery thread can simulate lines achieved by pencil or marker. Knit pieces offer flexibility and stretch that can be shaped into any configuration.

Knitting and crochet can vary in amount of structure and complexity, from a single repeated stitch to a complicated pattern. It is easy to see how these activities, for example, could activate a flow experience, with clear control over each physical stitch and continuous tangible feedback, all the while occupying the hands and mind in an attentive awareness. Weaving may be relatively uncomplicated yet highly structured as the weft moves over and under the warp repeatedly. Quilting can be quite cognitively stimulating with planning and preparing the layout of the blocks. Other textile work offers more freedom, such as free-hand embroidery. Each choice of textile intervention could be designed in order to offer the desired amount of cognitive processing.

As the literature has also presented, older populations are at a great risk of social exclusion and loneliness. Men too have been identified as a population at risk for these negative consequences due to how they have been socialized. Moreover, cancer patients may be even more likely to isolate themselves because of the stigmatizing nature of the disease. Because of these factors, older men – and specifically those with cancer – could benefit from programming designed to enhance their social inclusion.

Knitting has been identified as an activity that reduces loneliness and isolation. Although the majority of this research has been done with female subjects, I argue that the benefits of social participation can be transferable to men as well. Especially since knitting groups offers a

means of communication and sharing without direct eye contact, male knitters may feel that they can focus on their craft while maintaining conversation. This is congruent with the research provided on best practices with men in art therapy, suggesting that the art making be a large focus of the treatment, and that more structured interventions might be helpful at first.

Men's Sheds and other programming targeted for older men is a great step towards fostering socially-oriented spaces for this population. Although I agree that they provide excellent spaces for community engagement, they might not be the most suitable places for men currently undergoing cancer treatment. With the physical, emotional, and other constraints that the disease places on the individual, these community models may be too draining for this population to participate in, at least while undergoing medical procedures.

For this reason, I propose the alternative of knitting, a handcraft that generally offers freedom and flexibility of use. By making adjustments to the patterns, needles, yarn composition, and colours used, the sensory and tactile input may be tailored to the patient's level of experience, mental and physical capabilities, and time to devote to the craft. For these reasons, it may provide a great use of cancer patient's waiting time, offering an opportunity for creativity while distracting from symptoms of pain, nausea, and other side effects. Awareness of one's sensory profile during cancer treatment and optimal level of challenge to induce a flow experience could also cater the activity to the maker, an area of increased significance for an art therapist to be present.

As mentioned in the literature section, medical art therapy is increasingly being found in hospitals, clinics, and other areas where cancer patients frequent. Despite this fact, I did not come across any instances of textile-based interventions in oncology settings while reviewing the available research. Due to the possible benefits listed above relating to the use of fibre arts with this population, it seems a natural step to integrate these activities into waiting rooms and areas where cancer patients would be receiving treatment. Future research would need to take into account that public clinical settings are generally not segregated by gender and consider this factor accordingly in potential intervention studies. Through facilitation provided by medical art therapists, I believe that these interventions could transform waiting time into opportunities for healing, creating tangible gains that are felt by the maker and visible to the world.

Although I am suggesting knitting as an intervention implemented by an art therapist in an oncology waiting space, I believe that it is an activity which could be continued – and

possibly enhanced – at home and out in the community. Continuation in structured community programming and open or closed men’s knitting groups could provide opportunities to further the gains achieved in the clinical setting.

Limitations and Future Research

Inherently in my paper, there are multiple shortcomings which were not evaluated simply due to the nature of the research design. Primarily, since this is a graduate-level paper intended for an academic audience, the majority of sources discussed were received from academic settings and databases. These parameters mean that other means of knowledge acquisition were left out of the data collection process. It should also be noted that the findings will be disseminated in a similar scholarly fashion as data was collected – namely through Concordia University’s research repository – and will not be made available through other media platforms.

Additionally, the chosen research design was entirely bibliographical, meaning no new inquiry has been done aside from reviewing the relevant literature and intersecting the topics in question. For that reason, much of the research is speculative and inevitably non-exhaustive. In order to thoroughly study these phenomena, creating intervention research based on the findings is a recommended next step in the investigation process.

Reflections on My Personal Experience

Doing this research proved to be a challenging experience. In one way, I was emotionally challenged by the very personal content. When beginning to formulate my research proposal, it was suggested by some that I steer away from a topic that might be too emotionally triggering. Although these concerns were very valid and in my best interest, I felt that studying this population might help me make some meaning of the experience. At the end of this process, I am glad I chose to continue. Studying the statistics of cancer prevalence and prognosis and reading about the experiences of patients receiving medical art therapy provided a perspective of chronic illness that I have no way of feeling myself. This educational journey also provided a way to understand and relate to what was happening to my father – and my family – in a way that was familiar to previous academic learning and volunteer experience.

In another way, it was challenging to synthesize the literature on four diverse topics – older men, medical art therapy for cancer treatment, waiting rooms, and textile interventions – into a cohesive body of text. Since I was guided by a personal investment in the project, I found literature that pertained to the areas of interest with the research question already fully formed in

my head, almost in a top-down fashion instead of finding patterns in the pre-existing research and going from there. Throughout each step of the process, I imagined myself going into oncology spaces and implementing textile interventions with older men, something not unlike my volunteer work in Winnipeg. For this reason, I still believe that intervention research would be an important avenue to explore, now that a foundational body of literature has been assembled.

Since beginning this inquiry, I have tried to test the theory that knitting can positively affect mood, make the knitter more focused or mindful, and of course, change one's perception of time. I took my knitting along with me on a daily basis, into clinical waiting room settings, university classes, and on airplanes. From my anecdotal perspective, the stimulating tactile activity made times of wait pass much faster than anticipated. It was nice to see that something productive was being created out of time otherwise spent passively scrolling on my phone or reading a magazine. Instead of fidgeting my hands during lectures, knitting helped keep them occupied, allowing my mind to stay focused on the class.

I even taught my partner how to knit in the hopes of gaining a male's perspective. Although he was faced with the initial frustration common to learning any new skill, he quickly overcame his hesitations and thoroughly enjoyed the activity. Having never joined a knitting group, knitting with him showed me that it could also be a very social activity as we knitted while talking or watching television simultaneously. Whilst he nor I are the intended population of this research paper, it was an enlightening experience nonetheless.

Chapter 5. Conclusion

This concludes my theoretical research uncovering the potential benefits of textile interventions with older male cancer patients in waiting spaces. The selected design was described, providing rationale for the theoretical method and procedure, including data collection and analysis. Ethical considerations, researcher assumptions and bias were also briefly discussed.

Next, an in-depth literature review offered critical analysis of the current research available through academic databases. The population and setting of older male cancer patients and waiting spaces were explored at length. Current treatment strategies including medical art therapy and the Men's Sheds movement were also investigated. Brief examinations of feminist, positive psychology, and art as therapy approaches to art therapy were then offered to ground the

textile-based interventions in relevant theoretical frameworks. Intersections of the above topics were explored in the findings.

Finally, a discussion of the literature and a personal reflection were outlined. Challenges were identified in the research process including gaps in the literature and mental, physical, and social barriers to the proposed interventions, however additional theoretical and intervention-based research is recommended to grow this body of knowledge and further the field of art therapy.

To close my paper, I would like to return to the concept of *kairos* and its context in weaving. Not only does the concept provide an appropriate visual metaphor for the opportune moment of creativity, it may also afford a concrete example of how to induce *kairos*; transforming a moment of passive wait time through textile creation into a productive and healing experience for older male cancer patients.

References

- Adams, J. (2002). Art in social movements: Shantytown women's protests in Pinochet's Chile. *Sociological Forum, 17*(1), 21-56. doi:0884-8971/02/0300-0021/0
- Adams, J. (2013). *Art against dictatorship: Making and exporting arpilleras under Pinochet*. Austin, TX: University of Texas Press.
- Ahl, H., Hedegaard, J., & Golding, B. (2017). How the men's shed idea travels to Scandinavia. *Australian Journal of Adult Learning, 57*(3), 316–333.
- Anderson, L. W., & Gustavson, C. U. (2016). The impact of knitting interventions on compassion fatigue in oncology nurses. *Heart of Oncology Nursing, 20*(1), 2016. doi:10.1188/16.CJON.102-104
- Ang, S. H., Cavanagh, J., Southcombe, A., Bartram, T., Marjoribanks, T., & McNeil, N. (2017). Human resource management, social connectedness and health and well-being of older and retired men: the role of Men's Sheds. *International Journal of Human Resource Management, 28*(14). <https://doi.org/10.1080/09585192.2015.1088886>
- Aron, E. N. (1996). *The highly sensitive person*. Secaucus, NJ: Berol Publishing.
- Assouline, A. (2009). *Uncovering identity within the experience of chronic illness: Art therapy and integration*. (Unpublished graduate project [non-thesis]). Concordia University, Montreal, Canada.
- Auther, E. (2008). Fiber art and the hierarchy of art and craft, 1960–1980. *Journal of Modern Craft, 1*(1), 13–33. doi:10.2752/174967708783389896
- Baba, N. (2016). *How can mosaic artwork be used in a community art studio to assist posttreatment cancer patients to reconnect with their lives?* (Unpublished graduate project [non-thesis]). Concordia University, Montreal, Canada.
- Barnett, T. L. (2018, December 18). When crafts become activism: A more beautiful movement. *Yes!* Retrieved from <http://yesmagazine.com/peace-justice/when-crafts-become-activism-a-more-beautiful-movement-20181218?fbclid=IwAR3hugeH1tGUm6M2cDerhRI3fZWuGibmlK8oUiJLGNI-jgO85GvYXpJ-rGc>
- Benson, H., Beary, J. F., & Carol, M. P. (1974). The relaxation response. *Psychiatry, 37*(1), 37–46. doi:10.1080/00332747.1974.11023785

- Bien, M. B. (2005). Art therapy as emotional and spiritual medicine for Native Americans living with HIV/AIDS. *Journal of Psychoactive Drugs*, 37(3), 281-292.
doi:10.1080/02791072.2005.10400521
- Bookbinder, S. (2016). Fusion of a community using art therapy in long-term care. *Canadian Art Therapy Association Journal*, 29(2), 85–91. doi:10.1080/08322473.2016.1239186
- Bournes, D. A., & Mitchell, G. J. (2002). Waiting: The experience of persons in a critical care waiting room. *Research in Nursing and Health*, 25(1), 58–67.
<https://doi.org/10.1002/nur.10019>
- Bozcuk, H., Ozcan, K., Erdogan, C., Mutlu, H., Demir, M., & Coskun, S. (2017). A comparative study of art therapy in cancer patients receiving chemotherapy and improvement in quality of life by watercolor painting. *Complementary Therapies in Medicine*, 30, 67–72.
doi:10.1016/j.ctim.2016.11.006
- Brandling, J., & House, W. (2009). Social prescribing in general practice: Adding meaning to medicine. *British Journal of General Practice*, 59(563), 454-456.
doi:10.3399/bjgp09X421085
- Canadian Cancer Society. (2019a). *Treatment*. Retrieved from <http://www.cancer.ca/en/cancer-information/diagnosis-and-treatment/treatment/?region=qc>
- Canadian Cancer Society. (2019b). *What causes cancer?* Retrieved from <http://www.cancer.ca/en/cancer-information/cancer-101/what-causes-cancer/?region=qc>
- Canadian Cancer Society. (2019c). *What is cancer?* Retrieved from <http://www.cancer.ca/en/cancer-information/cancer-101/what-is-cancer/?region=qc>
- Canadian Cancer Society's Advisory Committee on Cancer Statistics. (2015). *Canadian Cancer Statistics 2015* [PDF file]. Retrieved from <http://www.cancer.ca/~media/cancer.ca/CW/cancer%20information/cancer%20101/Canadian%20cancer%20statistics/Canadian-Cancer-Statistics-2015-EN.pdf?la=en>
- Canadian Cancer Society's Advisory Committee on Cancer Statistics. (2017). *Canadian Cancer Statistics 2017* [PDF file]. Retrieved from <http://www.cancer.ca/~media/cancer.ca/CW/cancer%20information/cancer%20101/Canadian%20cancer%20statistics/Canadian-Cancer-Statistics-2017-EN.pdf>
- Canadian Institute for Health Information. (2017). *Wait Times for Priority Procedures in Canada, 2017* [PDF file]. Retrieved from

- https://www.cihi.ca/sites/default/files/document/wait-times-report-2017_en.pdf
<https://secure.cihi.ca/estore/productSeries.htm?pc=PCC395>
<https://secure.cihi.ca/estore/productSeries.htm?pc=PCC395>
- Carragher, L. (2013). *Men's sheds in Ireland* [PDF file]. Retrieved from <http://menssheds.ie/wp-content/uploads/2013/10/Men%E2%80%99s-Sheds-in-Ireland-National-Survey.pdf>
- Carragher, L. (2017). Opportunities for generativity in later life for older men. *Australian Journal of Adult Learning*, 57(3), 351–365.
- Case, C. & Dalley, T. (2014). *The handbook of art therapy (3rd ed.)*. London, UK: Routledge.
- Catania, C., De Pas, T., Minchella, I., De Braud, F., Micheli, D., Adamoli, L., ... Nolè, F. (2011). Waiting and the waiting room: How do you experience them? Emotional implications and suggestions from patients with cancer. *Journal of Cancer Education*, 26(2), 388–394. <https://doi.org/10.1007/s13187-010-0057-2>
- Chilton, G. & Wilkinson, R. A. (2016). Positive art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy: Theory and technique (3rd ed.)*, (pp. 249-267). New York, NY: Routledge.
- Clave-Brule, M., Mazloum, A., Park, R. J., Harbottle, E. J., & Birmingham, C. L. (2009). Managing anxiety in eating disorders with knitting. *Eating and Weight Disorders*, 14(1), 1-5. doi:10.1007/BF03354620
- Clements-Cortés, A. (2019). A social prescription for music please. *Canadian Music Educator*, 60(2), 31–33. Retrieved from <http://0-eds.b.ebscohost.com/mercury.concordia.ca/eds/detail/detail?vid=0&sid=82d05a31-e3b9-4411-9c7d-bb6f3f81e095%40pdv-sessmgr05&bdata=JnNpdGU9ZWRzLWxpdmU%3D#db=a9h&AN=136738341>
- Cooper, L., & Foster, I. (2008). The use of music to aid patients' relaxation in a radiotherapy waiting room. *Radiography*, 14(3), 184–188. <https://doi.org/10.1016/j.radi.2007.02.001>
- Corsano, P., Majorano, M., Vignola, V., Guidotti, L., & Izzi, G. (2015). The waiting room as a relational space: Young patients and their families' experience in a day hospital. *Child: Care, Health and Development*, 41(6), 1066–1073. <https://doi.org/10.1111/cch.12239>
- Crabtree, L., Tinker, A., & Glaser, K. (2018). Men's sheds: The perceived health and wellbeing benefits. *Working with Older People*, 22(2). <https://doi.org/10.1108/WWOP-09-2017-0026>

- Croghan, C. (2013). *Knitting is the new yoga? Comparing techniques; physiological and psychological indicators of the relaxation response*. (Undergraduate thesis). DBS School of Arts, Dublin, Ireland.
- Cross, S. E., & Madson, L. (1997). Models of the self: Self-construals and gender. *Psychological Bulletin*, 122(1), 5–37. Retrieved from <http://psycnet.apa.org/journals/bul/122/1/5.pdf>
- Csikszentmihalyi, M. (1975). *Beyond boredom and anxiety*. San Francisco, CA: Jossey-Bass.
- Csikszentmihalyi, M. (2014). *Flow and the foundations of positive psychology: The collected works of Mihaly Csikszentmihalyi*. Dordrecht, NL: Springer.
- Daniel, D. (2016). Landing places. *American Craft*, 72(2), 68–73. Retrieved from <http://0-eds.b.ebscohost.com/mercury.concordia.ca/eds/detail/detail?vid=0&sid=ddb65961-e640-498c-8597-d337994c6c2a%40pdc-v-sessmgr02&bdata=JnNpdGU9ZWRzLWxpdmU%3D#AN=113412676&db=aft>
- de la Guardia, M. (2019, January 16). The feminist knitting circle in India upending patriarchal norms. *Al Jazeera*. Retrieved from https://www.aljazeera.com/indepth/features/feminist-knitting-circle-india-upending-patriarchal-norms-181219220607167.html?fbclid=IwAR3_fHjuTJuLYAkqNSxOYGFvBctSRPG9CFUOmhm7xSIKgsxmwHjH4-KpKA8
- de Medeiros, K. (2009). Suffering and generativity: Repairing threats to self in old age. *Journal of Aging Studies*, 23(2), 97–102. <https://doi.org/10.1016/j.jaging.2008.11.001>
- Dittrich, L. R. (2001). Knitting. *Academic Medicine: Journal of the Association of American Medical Colleges*, 76(7), 671. doi:10.1097/00001888-200107000-00001
- Dominick, C. M. (2015). *Knitting as a therapeutic group technique with 4th grade elementary school students*. (Doctoral dissertation). University of Arkansas, Fayetteville, United States.
- Eagly, A. H. (1987). *Sex differences in social behavior: A social-role interpretation*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Erikson, E. H. (1968). *Identity, youth and crisis*. New York, NY: WW Norton & Co.
- Erikson, E. H. (1982). *The life cycle completed: A review*. New York, NY: WW Norton & Co.
- Erikson, E. H. & Erikson, J. M. (1997). *The life cycle completed: A review – extended version*. New York, NY: WW Norton & Co.

- Fontichiaro, K. (2018). Making as self-soothing: the power of stitches. *Teacher Librarian*, 45(5), 53–56.
- Friedland, J. (1988). Diversional activity: Does it deserve its bad name. *The American Journal of Occupational Therapy*, 42, 603–608. doi:10.5014/ajot.42.9.603
- Futterman Collier, A. D. (2011). The well-being of women who create with textiles: Implications for art therapy. *Art Therapy*, 28(3), 104–112. doi:10.1080/07421656.2011.597025
- Futterman Collier, A. D., Wayment, H. A. & Birkett, M. (2016). Impact of making textile handcrafts on mood enhancement and inflammatory immune changes. *Art Therapy: Journal of the American Art Therapy Association*, 33(4), 178-185. doi:10.1080/07421656.2016.1226647
- Gardner, J. (2016). *Quilting a connection: The use of quilting in group art therapy to promote well-being for older women*. (Unpublished graduate project [non-thesis]). Concordia University, Montreal, Canada.
- Garlock, L. R. (2016). Stories in the cloth: Art therapy and narrative textiles. *Art Therapy*, 33(2), 58–66. doi:10.1080/07421656.2016.1164004
- Geue, K., Goetze, H., Buttstaedt, M., Kleinert, E., Richter, D., & Singer, S. (2010). An overview of art therapy interventions for cancer patients and the results of research. *Complementary Therapies in Medicine*, 18(3–4), 160–170. doi:10.1016/j.ctim.2010.04.001
- Giles, L. C., Glonek, G. F. V., Luszcz, M. A. and Andrews, G. R. (2005). Effect of social networks on 10 year survival in very old Australians: The Australian longitudinal study of aging. *Journal of Epidemiology and Community Health*, 59(7), 574–9. doi:10.1136/jech.2004.025429
- Golding, B. (2011). Older men’s wellbeing through community participation in Australia. *International Journal of Men’s Health*, 10(1), 26–44. doi:10.3149/jmh.1001.26
- Government of Canada. (2019). *Canada pension plan: Overview*. Retrieved from <https://www.canada.ca/en/services/benefits/publicpensions/cpp.html>
- Halifax, N. V. D. (2003). Feminist art therapy: Contributions from feminist theory and contemporary art practice. In S. Hogan (Ed.), *Gender issues in art therapy* (pp. 31-52). London, UK: Jessica Kingsley.

- Harland, K. (2009). *Acting tough: Young men, masculinity and the development of practice in Northern Ireland* [PDF file]. Belfast, UK: Nowhere Man Press. Retrieved from <http://www.man-ni.org/resources/kenspeech.pdf>
- Havighurst, R. J. (1961). Successful Aging 1. *The Gerontologist*, *1*, 8–13. <https://doi.org/http://dx.doi.org/10.1093/geront/1.1.8>
- Heiney, S. P., Darr-Hope, H., Meriwether, M. P., & Adams, S. A. (2017). Healing by creating: Patient evaluations of art-making program. *Journal of Creative Behavior*, *51*(1), 35–44. doi:10.1002/jocb.84
- Helgadottir, G. (2011). Nation in a sheep's coat: The Icelandic sweater. *Formakademisk*, *4*(2), 59-68. doi:10.7577/formakademisk.201
- Henize, A. W., Beck, A. F., Klein, M. D., Morehous, J., & Kahn, R. S. (2018). Transformation of a pediatric primary care waiting room: Creating a bridge to community resources. *Maternal and Child Health Journal*, *22*(6), 779–785. <https://doi.org/10.1007/s10995-018-2508-z>
- Hill, A. (1945). *Art versus illness: A story of art therapy*. London, UK: George Allen and Unwin.
- Hiltebrand, E. U. (1999). Coping with cancer through image manipulation. In C. Malchiodi (Ed.). *Medical art therapy with adults* (pp. 113-136). London, UK: Jessica Kingsley.
- Hinz, L. D. (2009). *Expressive therapies continuum: A framework for using art in therapy*. New York, NY: Routledge.
- Hogan, S. (2012). *Revisiting feminist approaches to art therapy*. New York, NY: Berghahn Books.
- Homer, E. S. (2015). Piece work: Fabric collage as a neurodevelopmental approach to trauma treatment. *Art Therapy*, *32*(1), 20–26. doi:10.1080/07421656.2015.992824
- Hôpital St-Boniface Hospital. (2017). *Volunteer services: Year in review 2016-2017* [PDF file]. Retrieved from <http://www.sbgf.mb.ca/files/vsYearReview.pdf>
- Huisman, L., Leech-Porter, K., Spencer, J., & Van Soeren, M. (2015). A therapeutic waiting room: Medical students run an art group for vulnerable populations [PDF file]. *UBC Medical Journal*, *5*(1), 35–37. Retrieved from http://med-fom-ubcmj.sites.olt.ubc.ca/files/2015/04/ubcmj_5_1_2013_35-36.pdf
- Hunter, C. (2019, February 23). The calming effects of sewing can help people express and heal themselves. *The Guardian*. Retrieved from

- <https://www.theguardian.com/lifeandstyle/2019/feb/23/the-calming-effects-of-sewing-can-help-people-express-and-calm-themselves?fbclid=IwAR2N2SpRetVblq-604fVPHUx5CZO11pflteeyCucoQSN7TYgeNzQncGMBBQ>
- Ikeda, S. (2007). Masculinity and masculinism under globalization: Reflections on the Canadian case. In M. Cohen & J. Brodie (Eds.). *Remapping gender in the new global order* (pp. 111-130). New York, NY: Routledge.
- Jacobs, G. D. (2001). The physiology of mind–body interactions: The stress response and the relaxation response. *The Journal of Alternative and Complementary Medicine*, 7, 83–92. doi:10.1089/107555301753393841
- Kagin, S. L., & Lusebrink, V. B. (1978). The expressive therapies continuum. *Art Psychotherapy*, 5, 171-180.
- Kapitan, L. (2013). Art therapy’s sweet spot between art, anxiety, and the flow experience. *Art Therapy*, 30(2), 54–55. doi:10.1080/07421656.2013.789761
- Kapitan, L. (2018). *Introduction to art therapy research* (2nd ed.) [eBook]. Retrieved from Google Play Books.
- Kelly, B. (2018, October 11). Doctors can soon prescribe visits to Montreal Museum of Fine Arts. *Montreal Gazette*. Retrieved from <https://montrealgazette.com/news/local-news/doctors-can-soon-prescribe-visits-to-montreal-museum-of-fine-arts>
- Kendler, K. S. & Gardner, C. O. (2014) Sex differences in the pathways to major depression: A study of opposite-sex twin pairs. *The American Journal of Psychiatry*, 171(4), 426–435. doi:10.1176/appi.ajp.2013.13101375
- Klingemann, H., Scheuermann, A., Laederach, K., Krueger, B., Schmutz, E., Stahli, Si., ... Kern, V. (2018). Public art and public space – Waiting stress and waiting pleasure. *Time & Society*, 27(1), 69–91. doi:10.1177/0961463X15596701
- Knit for Peace. (2017). *The health benefits of knitting* [PDF file]. Retrieved from <https://knitforpeace.org.uk/wp-content/uploads/2017/05/The-Health-Benefits-of-Knitting-Preview.pdf>
- Knit for Peace. (2019). *About*. Retrieved from <https://knitforpeace.org.uk/about/>
- La Cour, K., Josephsson, S., Tishelman, C., & Nygard, L. (2007). Experiences of engagement in creative activity at a palliative care facility. *Palliative & Supportive Care*, 5(03), 241-250. <https://doi-org.lib-ezproxy.concordia.ca/10.1017/S1478951507000405>

- Lee, C. O. (2003). Part I: Expanded psychosocial interventions in cancer care: an introduction to diversional therapy. *Clinical Journal of Oncology Nursing*, 7(6), 682–684.
doi:10.1188/03.cjon.682-684
- Liebmann, M. (2003). Working with men. In S. Hogan (Ed.), *Gender issues in art therapy* (pp. 108-125). London, UK: Jessica Kingsley.
- Local Government Association. (2017). *Just what the doctor ordered: Social prescribing – a guide for local authorities – case studies* [PDF file]. Retrieved from <https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--5c4.pdf>
- Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging and Mental Health*, 10(6), 574–582. <https://doi.org/10.1080/13607860600641200>
- Mackenzie, C. S., Roger, K., Robertson, S., Oliffe, J. L., Nurmi, M. A., & Urquhart, J. (2017). Counter and complicit masculine discourse among Men’s Shed members. *American Journal of Men’s Health*, 11(4), 1224–1236. <https://doi.org/10.1177/1557988316685618>
- Malchiodi, C. (1999). *Medical art therapy with adults*. London, UK: Jessica Kingsley.
- Malchiodi, C. A. (2012). Using art therapy with medical support groups. In C. A. Malchiodi (Ed.), *Handbook of Art Therapy, 2nd Ed.* (pp. 397–408). New York, NY: Guilford Press.
- Marer, E. (2002). Knitting: the new yoga. *Health*, 16(2), 76–80. Retrieved from: <http://connection.ebscohost.com/c/articles/6267405/knitting-new-yoga>
- Marshall, C, & Rossman, G. B. (2016). *Designing qualitative research* (6th ed.) [eBook]. Retrieved from Google Play Books
- Meier, A. (2017, November 6). The wartime quilts made by men from military uniforms. *Hyperallergic*. Retrieved from <https://hyperallergic.com/398931/wartime-quilts-folk-art-museum/?fbclid=IwAR1TZUL9JWc2V491EB7b0jbf-g0btlOazSz0ZesFaFXJvT3fy6rTFVzhWU>
- Miller, G. G. (2016). Art therapy in a community clinic waiting room: Examining challenges and effectiveness. *Canadian Art Therapy Association Journal*, 29(1), 38-51.
doi:10.1080/08322473.2016.1184365
- Milligan, C., Neary, D., Payne, S., Hanratty, B., Irwin, P., & Dowrick, C. (2016). Older men and social activity: A scoping review of Men's Sheds and other gendered interventions. *Ageing & Society*, 36(5), 895-923. doi:10.1017/S0144686X14001524

- Milligan, C., Payne, S., Bingley, A., & Cockshott, Z. (2015). Place and wellbeing: Shedding light on activity interventions for older men. *Aging and Society*, 35(1).
<https://doi.org/10.1017/S0144686X13000494>
- Minar, V. (1999). Art therapy and cancer: Images of the hurter and healer. In C. Malchiodi (Ed.). *Medical art therapy with adults* (pp. 227-242). London, UK: Jessica Kingsley.
- Moon, C. H. (2010). *Materials and media in art therapy: Critical understandings of diverse artistic vocabularies*. New York, NY: Routledge.
- Murray, T. J. (2000). Personal time: The patient's experience. *Annals of Internal Medicine*, 132, 58–62. doi:10.7326/0003-4819-132-1-200001040-00010
- Myzelev, A. (2009). Whip your hobby into shape: Knitting, feminism, and construction of gender. *Textile: The Journal of Cloth and Culture*, 7(2), 148–163.
<https://doi.org/10.7208/chicago/9780226179292.001.0001>
- Nainis, N. A. (2008). Approaches to art therapy for cancer inpatients: Research and practice considerations. *Art Therapy*, 25(3), 115–121.
<https://doi.org/10.1080/07421656.2008.10129597>
- Norman, L. (n.d.). Art by the big blue chair, CancerCare Manitoba. *Artists in Healthcare Manitoba*. Retrieved from <http://www.artistsinhealthcare.com/programs/art-by-the-big-blue-chair-cancercare-manitoba/>
- Norris, S. (2016). Evoking spirit: Utilizing the arts with adults with cancer. In P. Dewey Lambert (Ed.), *Managing Arts Programs in Healthcare* (pp. 213–228). London, UK: Routledge.
- Nurmi, M. A., Mackenzie, C. S., Roger, K., Reynolds, K., & Urquhart, J. (2018). Older men's perceptions of the need for and access to male-focused community programmes such as Men's Sheds. *Aging and Society*, 38(4). <https://doi.org/10.1017/S0144686X16001331>
- Observers, The. (2017, January 13). Chilean men take to the streets... to knit. *France 24*. Retrieved from <https://observers.france24.com/en/20170112-chile-men-cute-knit-hombres-tejedores?fbclid=IwAR2DUa0VhpgG0C61LB0fJIBbpQI1ckN3z6siC4mPwuZhisCjxzCUbzG4Fug>
- Papageorgiou, N., Marquis, R., & Dare, J. (2016). Identifying the enablers and barriers to community participation amongst older adults. *British Journal of Occupational Therapy*, 79(12). <https://doi.org/10.1177/0308022616656195>

- Parsons, T. (1951). *The social system*. Glencoe, IL: The Free Press.
- Perry, B., & Hambrick, E. (2008). The neurosequential model of therapeutics. *Reclaiming Children and Youth*, 17(3), 38–43. Retrieved from <http://gateway.library.qut.edu.au/login?url=http://proquest.umi.com/pqdweb?did=1609912641&Fmt=7&clientId=14394&RQT=309&VName=PQD>
- Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. In N. Boyd Webb (Ed.), *Working with Traumatized Youth in Child Welfare* (pp. 27-52). The Guilford Press: New York, NY.
- Piercy, K. W. & Cheek, C. (2004). Tending and befriending: The intertwined relationships of quilters. *Journal of Women and Aging* 16(1-2), 17-33. doi:10.1300/J074v16n01_03
- Pöllänen, S. (2015). Elements of crafts that enhance well-being: Textile craft makers' descriptions of their leisure activity. *Journal of Leisure Research*, 47(1), 58–78. doi:10.1080/00222216.2015.11950351
- Reynolds, F. (2002). Symbolic aspects of coping with chronic illness through textile arts. *The Arts in Psychotherapy*, 29, 99–106. doi:10.1016/S0197-4556(01)00140-X
- Reynolds, F. (2003). Conversations about creativity and chronic illness I: Textile artists coping with long-term health problems reflect on the origins of their interest in art. *Creativity Research Journal*. *Creativity Research Journal*, 15(4), 393–407. doi:10.1207/S15326934CRJ1504
- Reynolds, F. (2004a). Conversations about creativity and chronic illness II: Textile artists coping with long-term health problems reflect on the creative process. *Creativity Research Journal*, 16(1), 79-89. doi:10.1207/s15326934crj1601
- Reynolds, F. (2004b). Textile art promoting well-being in long-term illness: some general and specific influences. *Journal of Occupational Science*, 11(2), 58-67, doi:10.1080/14427591.2004.9686532
- Reynolds, F., Lim, K. H., & Prior, S. (2008). Images of resistance: A qualitative enquiry into the meanings of personal artwork for women living with cancer. *Creativity Research Journal*, 20(2), 211–220. doi:10.1080/10400410802060059
- Reynolds, K. A., Mackenzie, C. S., Medved, M., & Roger, K. (2015). The experiences of older male adults throughout their involvement in a community program for men. *Ageing and Society*, 35(3), 531–551. doi:10.1017/S0144686X13000858

- Riley, J., Corkhill, B., & Morris, C. (2013). The benefits of knitting for personal and social wellbeing in adulthood: Findings from an international survey. *British Journal of Occupational Therapy*, 76(2), 50-57. doi:10.4276/030802213X13603244419077
- Ritschel, C. (2018, March 13). Knitting can reduce anxiety, depression, chronic pain and slow dementia, research reveals. *Independent*. Retrieved from https://www.independent.co.uk/life-style/knitting-reduces-anxiety-depression-chronic-pain-slows-dementia-research-knit-for-peace-uk-a8254341.html?fbclid=IwAR2vA9Ib8qfYomxJ-HCBLlgL9S86IE0XuH6ybezjz7YXN9F_z0WoAtscAPs
- Robins, F. (2016). Yarn Bombing. *Selvedge Magazine*, 70–75. Retrieved from <http://digitalcommons.unl.edu/tsaconf/50>
- Robinson, E. M., Baker, R., & Hossain, M. M. (2018). Randomized trial evaluating the effectiveness of coloring on decreasing anxiety among parents in a pediatric surgical waiting area. *Journal of pediatric nursing*, 41, 80-83. doi:10.1016/j.pedn.2018.02.001
- Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37(4), 433–40.
- Sae-Wang, R. (2015). Spirit of the loom: The conservation and commodification of Surin's textile cultural heritage. *International Journal of Intangible Heritage*, 10, 85-100. Retrieved from <http://0-search.ebscohost.com/mercury.concordia.ca/login.aspx?direct=true&db=edselc&AN=edselc.2-52.0-84944062769&site=eds-live>
- Samuelson, M., Foret, M., Baim, M., Lerner, J., Fricchione, G., Benson, H., ... & Yeung, A. (2010). Exploring the effectiveness of a comprehensive mind–body intervention for medical symptom relief. *The Journal of Alternative and Complementary Medicine*, 16(2), 187-192. doi:10.1089/acm.2009.0142
- Sarashima, S. (2013). Community as a landscape of intangible cultural heritage: Basho-fu in Kijoka, a Japanese example of a traditional woven textile and its relationship with the public. *International Journal of Intangible Heritage*, 8, 135-152. Retrieved from <http://0-search.ebscohost.com/mercury.concordia.ca/login.aspx?direct=true&db=edselc&AN=edsel>

- Seligman, M. E. P., & Csikszentmihalyi, M. (2014). Positive psychology: An introduction. In M. Csikszentmihalyi (Ed.), *Flow and the foundations of positive psychology: The collected works of Mihaly Csikszentmihalyi* (pp. 279-298). Dordrecht, NL: Springer.
- Sibbett, C. (2005a). Betwixt and between: Crossing thresholds. In D. Waller & C. Sibbett (Eds.), *Art therapy and cancer care* (pp. 12-37). Berkshire, UK: Open University Press.
- Sibbett, C. (2005b). Liminal embodiment: Embodied and sensory experience in cancer care and art therapy. In D. Waller & C. Sibbett (Eds.), *Art therapy and cancer care* (pp. 50-81). Berkshire, UK: Open University Press.
- Timm-Bottos, J. (2016). Beyond counseling and psychotherapy, there is a field. I'll meet you there. *Art Therapy: Journal of the American Art Therapy Association*, 33(3), 160–162. <http://dx.doi.org/10.1080/07421656.2016.1199>
- Vaccaro, J. (2010). Felt matters. *Women and Performance*, 20(3), 253–266. <https://doi.org/10.1080/0740770X.2010.529245>
- Vaccaro, J. (2015). Feelings and fractals: Woolly ecologies of transgender matter. *GLQ: A Journal of Lesbian and Gay Studies*, 21(2–3), 273–293. <https://doi.org/10.1215/10642684-2843347>
- Varul, M. Z. (2010). Talcott Parsons, the sick role and chronic illness. *Body and Society*, 16(2), 72–94. <https://doi.org/10.1177/1357034X10364766>
- Waldon, E. G., & Thom, J. C. (2015). Recorded music in the mental health waiting room: A music medicine investigation. *Arts in Psychotherapy*, 46, 17–23. <https://doi.org/10.1016/j.aip.2015.07.006>
- Waller, D., & Sibbett, C. (Eds.). (2005). *Art therapy and cancer care*. Berkshire, UK: Open University Press.
- Wilson, N. J., Cordier, R., Parsons, R., Vaz, S., & Buchanan, A. (2016). Men with disabilities - A cross sectional survey of health promotion, social inclusion and participation at community Men's Sheds. *Disability and Health Journal*, 9(1), 118–126. <https://doi.org/10.1016/j.dhjo.2015.08.013>
- Ybarra, O., Burnstein, E., Winkielman, P., Keller, M. C., Manis, M., Chan, E. and Rodriguez, J. 2008. Mental exercising through simple socializing: Social interaction promotes general cognitive functioning. *Personality and Social Psychology Bulletin*, 34(2), 248–59. [doi:10.1177/0146167207310454](https://doi.org/10.1177/0146167207310454)

Yosowich, M. (2015). What age is someone considered a senior? Retrieved from <https://elder.findlaw.ca/article/what-age-is-someone-considered-a-senior>