

Museopathy: Exploring the Healing Potential of Handling Museum Objects

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Abstract

To coincide with emerging arts and health practices, University College London Museums & Collections and University College London Hospitals Arts partnered to create a pilot project, entitled "Heritage in Hospitals", which sought to assess whether handling museum objects has a positive impact on patient wellbeing. Quantitative data from 32 sessions conducted with patients in May through July (inclusive) of 2008 demonstrated, on average, an increase in self-reported measures of life satisfaction and health status after handling museum objects. Constant comparative analysis of the qualitative data collected from the sessions revealed two major recurring themes: "impersonal/educational" and "personal/reminiscence". The first theme included instances where handling museum objects allowed patients to access truths about the objects ascertainable solely through touch (such as gauging weight, texture, temperature, and spatial relation to the body), to verify what was seen, to facilitate an intimate and imaginative connection with the museum objects and their origins, to investigate and explore the objects, to permit an interaction with the "rare" and "museum-worthy", and to assist with aesthetic appreciation. The second theme illustrated the project's potential to assist with counselling on issues of illness, death, loss and mourning, and to help restore dignity, respect and a sense of identity (particularly among elderly patients) by providing a springboard for reminiscing and the telling of life stories in a highly institutionalized setting. This paper contextualizes the project, explores the implications of the project's methodology and its findings, and provides questions for future research.

Key words: wellbeing, hospitals, reminiscence, handling, objects

Introduction

The idea that museum objects are medicinal is not particularly strange or new. In 'Museum Manners: The Sensory Life of the Early Museum' Constance Classen writes that some objects made their way into late 17th and early 18th century museums precisely because of their medicinal use: 'Characteristic museum pieces which were also items in contemporary pharmacopoeia included not just specimens of plants and animals, however, but also such things as mummy flesh and even fossils and stone axes – which would be taken in powdered form. The rare and wondrous qualities that made an object a likely museum piece might also make it strong medicine' (Classen 2007, p. 905).

The pilot project 'Heritage in Hospitals' created jointly by University College London Museums and Collections (hereafter referred to as UCL M&C) and University College London Hospitals Arts (hereafter referred to as UCLH Arts) proposed a novel research project: to take museum objects to patients' bedsides and to assess whether handling museum objects has a positive impact on patient wellbeing. While several museums are currently widening the scope of their outreach activities by bringing loan boxes into hospitals and nursing homes (Chatterjee, 2008), little evaluation work has been done to measure the impact of these sessions. Concurrent with research projects that seek to clinically demonstrate the health benefits of incorporating the visual and performing arts in hospital settings, the results of this research can

have implications, not only for museums, but also for 'a wide range of professionals including health authorities, policy makers, medical and nursing staff, architects, artists, and administrators' (Staricoff 2003: 3; see also Chatterjee 2008).

This research also highlights the important socio-economic factors that directly impact museum access policies; museums are increasingly asked to justify spending in relation to their access provision, with community engagement top of the list. We note specifically that the Museums, Libraries and Archive Council's 'Outcomes framework' recognises the role Museums, Libraries and Archives have in the delivery of adult health and general wellbeing, and children and young people's health. The Outcomes framework identifies the key contributions which the sector makes and draws together evidence of impact and best practice, along with suggested performance indicators where appropriate (MLA 2008). Innovative public-private health partnerships (for examples see Nikolic and Maikisch 2006) improve the wellbeing of local communities and this is an important element in the MLA's community engagement strategy. The Arts Council and Department of Health's joint prospectus for arts and health recognized the profound impact arts organizations have on people's health (Arts Council England and Department of Health 2007; see also HM Government 2005). A similar directive can also be observed from the Department for Culture, Media and Sport in relation to the wider social care role museums, and other heritage organizations can play, such as offering services directed towards older and more vulnerable members of society.

Notwithstanding the above, there is a dearth of evidence pertaining to the role of museums in improving wellbeing within the context of formal healthcare settings, such as hospitals. This paper examines research conducted in the summer of 2008 (May to July inclusive) by Sonjel Vreeland, a Master's of Museum Studies intern from the University of Toronto, and it contextualizes the project both as an action research study in a postgraduate museum studies programme and among the wider social care role museums may have in the future. The paper also analyses the implications of the project's methodology and its findings and explores questions for future research.

Within the context of a graduate museums studies programme

Sonjel Vreeland participated in 'Heritage in Hospitals' in fulfilment of the internship component of her Master's of Museum Studies Programme at the University of Toronto. The project mirrored the dual nature of her graduate studies by marrying museology and praxis. For one, the internship provided Vreeland with opportunities to gain practical experience in conducting outreach handing sessions and museological research, in analyzing the research's findings, and in disseminating those results via the co-authorship of a paper and the organization of a workshop entitled 'Heritage and Wellbeing' (which was hosted by UCL Centre for Museums, Heritage & Material Culture Studies and held on 25 June 2008). The internship also provided Vreeland with the chance to become immersed in cutting-edge museological research, to network with other professionals within this community of practice, to share the results of her research and her experience with her Canadian colleagues, and to nurture her professional interests in innovative outreach programming. During the course of her internship, Vreeland refined the project's protocol and facilitated 32 sessions with patients at UCLH, the results of which are detailed below.

Study design

Briefly stated, the project's protocol consisted of:

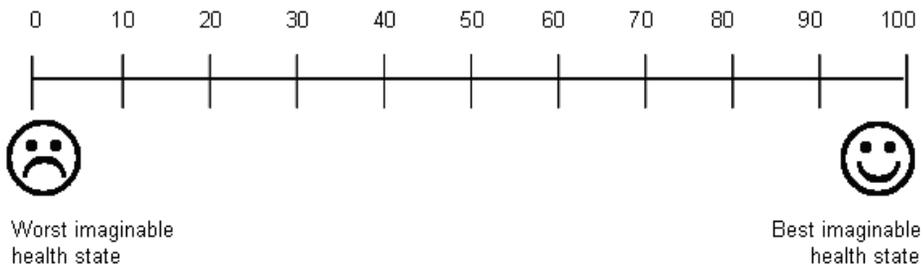
- recruiting patients,
- reviewing the project and ensuring patients and staff understood what was involved,
- completing consent forms (this was a pre-requisite of the Research Ethic Committee's approval of the project),
- recording the session using a digital audio recorder,
- filling out an evaluation form,

- following appropriate infection control measures by both the facilitator and the patient washing their hands (where this was not possible alcohol gel was used),
- handling the objects and discussing them,
- filling out the same evaluation form a second time,
- and concluding the session by washing hands again.

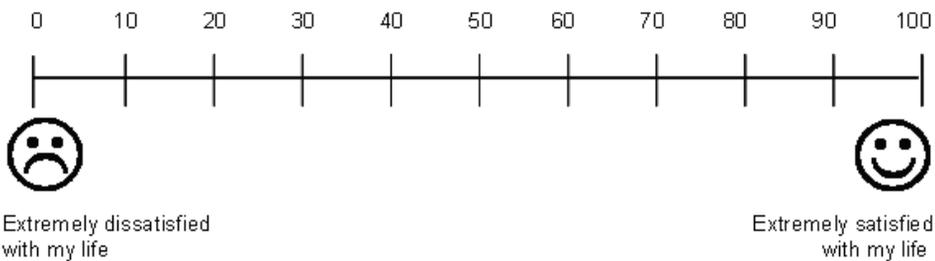
Two of the authors (HC and GN) developed the protocol for running handling sessions in collaboration and discussion with clinicians and museum educator colleagues (Noble and Chatterjee 2008, Chatterjee and Noble 2009). Patients were recruited with the assistance of ward staff who identified patients who were clinically well enough to participate. Ward visits and advertising posters were used to raise awareness of the project. The object handling session began with a general introduction and explanation of the project. The patient was asked if they agreed to being recorded, to filling out the questionnaires, and to sign the Consent Form – the Consent Form was accompanied by a Patient Information Booklet, which outlined the project in writing and was available for the patient to keep. The patient was instructed that the session was entirely voluntary and that they could opt out at any time. Following consent and hand washing (or use of alcohol gel) the audio recorder was turned on and the patient completed the first set of evaluation forms.

The evaluation form (Fig 1), the project's tool to measure the patient's wellbeing, included two generic 'Quality of Life' (QoL) visual analogue scales that asked the patient to assess their life satisfaction and their health status by marking an "X" between 1 and 10 (1 being the worst imaginable state, 10 being the best); this was based on the EQ VAS design (EuroQol Group 1990). The form also included a question that provided 8 adjectives for the patients to choose from in order to best describe their mood; the latter was loosely based on Watson, Clark and Tellegen's (1988) Positive Affect Negative Affect Scale (PANAS).

Fig 1. The evaluation form



Please indicate how satisfied you feel overall with your life at the moment by putting a cross on the line between 0 and 100.



Please indicate how you feel about your health status at the moment by putting a cross on the line between 0 and 100.

Please circle the words which best describe your current mood:

- | | |
|----------------|-------------|
| Lively | Tired |
| Relaxed | Tense |
| Full of energy | Sluggish |
| Cheerful | Discouraged |
| Other: _____ | |

On completion of the evaluation form the handling session began with the facilitator removing objects from the loan box. The project made use of loan boxes developed specifically for use in hospital, containing a range of objects from UCL M&C including natural history and geology specimens, archaeological artefacts (e.g. Fig 2) and artworks (including brass etchings and prints), plus supporting object information. Objects were selected on the basis that they reflected the diversity of material available from UCL M&C and ease of portability. These objects were laid out on a foam mat in front of the patient and the facilitator invited them to choose an object to handle. While handling the objects, the facilitator conducted a semi-structured interview asking the patient a variety of questions such as: What do you think this object is? What does the object feel like? Why have you chosen that object? What does it remind you of? Why do you find it interesting? As the session progressed further prompts were given to make connections between the objects. Typically sessions lasted 20 to 50 minutes although the facilitator allowed patients to determine the length of sessions. The session concluded with the patient completing a final evaluation form (Figure 1) and the facilitator and patient washing their hands.



Fig 2. Bastet, a bronze goddess figurine from the UCL Petrie Museum c. 500 – 650 BC

Following preliminary work undertaken in previous projects using the above protocol (Noble and Chatterjee 2008, Chatterjee and Noble 2009), Vreeland set out to review the existing protocol, which resulted in three key changes.

Firstly, patients were given a small gift when the sessions ended; in this instance the gift was a selection of postcards from the UCL Petrie Museum of Archaeology and the UCL Grant Museum of Zoology (UCL Museums & Collections 2006). Gift giving, a tactic sometimes employed in visitor studies, not only thanked the patients for their time and cooperation with filling out all the paperwork involved, but also provided the patients with something to hold on to after the artefacts were returned to UCL. Some patients became very attached to the museum objects and were reluctant to return them. One patient, (SV2¹), for example, tried to hide Bastet (a bronze goddess figurine from the Petrie Museum, Fig 2) while the museum objects were being packed up, another patient (SV 10) said he wanted to take the puma skull home and care for it, and many patients said they could picture the objects in their homes. In 'Museum Manners', Classen (2007) argues, 'one manual licence is that of possession. One is free to touch what one owns' (p. 898),

and she states that while touch was permissible in early museums, it could lead to the problematic desire to own:

'The most damaging form of touch manifested by visitors to collections was that motivated by the desire to possess the object on display, or some part of it, as when Von Uffenbach wished to scrape off a little of "the famous stone of the patriarch Jacob" in Westminster. While this desire no doubt was customarily thwarted by collection owners and curators, it was also the case that items or fragments of items not deemed to be particularly valuable might be given away to visitors as souvenirs or tokens of esteem. The original statutes of the Ashmolean decreed that the Keeper might make presents of redundant museum items "to some Person of extraordinary quality.' (Classen 207:902)

As visual reminders of the session, the postcard gifts could also possibly prolong the effects of the session and could help patients to explain the session to their family and friends.

The second change to the protocol was the provision of more information on the museum objects. Originally fairly minimal information had been provided to either the facilitator or the patient in order to encourage patients to reminisce and share their thoughts on the objects rather than listen to the facilitator. However, since some patients chose to divulge little about themselves and expected the facilitator to teach them about the objects on behalf of the museum, it was decided to enhance the depth of information available for each object by conducting curatorial research. Often it was the information provided, rather than the objects themselves, which sparked a connection between the patient and the object. For example, one patient (SV 2) picked up the ancient Egyptian figurine of the goddess Bastet and then placed it back on the mat. When the figurine's age was mentioned, she said that she had to hold it again and grasped the object close to her chest, exclaiming, 'I've been there by proxy!'. Another patient (SV 23) had little personal reaction to the two-finger amulet until she asked what it was made of and learned that it was made of obsidian, or volcanic glass. The word "volcanic", as opposed to the object, sparked reminiscence. She then said,

'well it's black. I stood on a volc- I stood on a lava mountain [...] And took a photo. Of lava spewing out of a volcano. I bet...this is years and years ago and me looking over and the lava was coming down and going into the sea and the sulphur and the spewn nearly killed you, killed your throat because it was so sulphury. I got a picture of it. I've trodden all over lava but...so would this have been ordinary lava or you're saying it's lava glass?'

The third change implemented to the protocol involved the addition of warm-up questions to encourage patients to ignore the recorder and to put them at ease. In *Qualitative Research in Health Care*, Nicky Britten states, 'it is usually best to start with questions that the interviewee can answer easily and then proceed to more difficult or sensitive topics' (Britten 2006:15). To this end, the following questions were asked before the tactile handling session began:

Q 1. How do you feel about handling museum objects?

Q 2. Have you handled museum objects before?

Q 3. Do you visit museums?

The warm up questions were intended to illustrate whether UCL M&C was widening its audience, to determine patients' expectations of museums and museum objects, and if patients had any reservations about touching the objects. While the wording of the first question proved insufficiently clear in determining whether the patient was a regular museum visitor it did reveal that only 2 out of 19 patients had visited UCL M&C before, despite its proximity and free admission. The second and third questions helped the facilitator better meet the needs and expectations of patients as they provided them with the opportunity to point out if there were specific museum objects that they feared and preferred not to see or handle, and explain whether they would require assistance in handling the objects.

Of particular museological significance is the project's tactile nature. In 'Can Museums be All Things to All People?: Missions, Goals, and Marketing's Role' by Kotler and Kotler, the recent paradigm shift of viewing the museum as a public space, rather than a temple to its collections, is described:

The traditional standard for collections based museums has been well articulated by a former Director of London's British Museum, Sir David M. Wilson: 'Museums are about the material they contain. The first duty of the museum curator is to look after that material... His second duty is to make that material available to whoever wants to see it.' Yet, as museum activist Kenneth Hudson has pointed out, the shift in museum focus to serving audiences has been developing over nearly a half-century. Hudson writes, '...[O]ne can assert with confidence that the most fundamental change that has affected museums... is the now almost universal conviction that they exist in order to serve the public. The old-style museum felt itself to be under no such obligation... The museum's prime responsibility was to its collections, not to its visitors' (Kotler and Kotler 2000: 271)

Part of this shift includes a rethinking of the rules barring visitors from touching and handling collections. Viewed in light of Classen's argument that early museum visitors were permitted to handle museum objects, the introduction of touch in museums marks a return to earlier modes of interpretation. Fiona Candlin (2007), in 'Hands Off! Don't Touch! Art, Blindness and the Conservation of Expertise' argues that museums are increasingly recognising the desire for touch and its value, and that the impetus to reintroduce touch in museums is twofold. For one, is it motivated by *au courant* museum educators; embodiment theorists have convincingly argued that knowledge is not detached from the body and concepts of physical intelligence and bodily learning have become accepted among learning theory. Secondly, the return of touch is motivated by government policy in the UK, as permitting touch makes museums more accessible to visitors with visual impairment (Candlin 2007: 89).

Although never formally introduced into the protocol, the different types of touch demonstrated by the patients became noteworthy. During the sessions conducted, the following ways of handling the objects were observed:

- stroking, petting and tracing,
- hesitant/cautious,
- pulling the object close to oneself,
- working the object/imaginative touching (for example opening and closing the puma skull's jaw or grasping the dagger and making stabbing motions),
- unconscious or absent-minded touching while looking elsewhere,
- exploratory touch, really getting the feel of things,
- grabbing, rough handling,
- and playful.

These types of touch do not fully address the sorely lacking 'lexicon of touch' (Spence and Gallace 2008), namely an agreed set of descriptions of sensations elicited by touching different materials, but when the types of touch and their frequency are recorded, they can indicate to the facilitator the impact object handling is having on the patient. A closer observance of the varying ways of handling museum objects will have implications for the future of touch-based practices in museums; this presents an interesting direction for future study. Candlin (2007) laments that the touch of the blind is conflated with mass mishandling, in other words there needs to be a recognition by museum professionals of the difference between the 'casual' touching undertaken by general visitors compared to the instructive touching undertaken by visually impaired visitors (Candlin 2007: 94), as to assume all visitors touch objects in the same way or that all tactile activities in the museum encourage the same type of touching is similarly short-sighted. The way in which touch is facilitated can determine what types of touch are encouraged, and what types are discouraged. In the same way that one's gaze is directed by the use of light, by an exhibit's design, and by the interpretation provided, touch can similarly be guided to suit the museum's remit. Consider the difference between the three examples and the types of handling they stimulate:

- small artefacts held in Perspex boxes with two holes for your hands,

- artefacts firmly affixed on three sides to plinths leaving only one side exposed for touching,
- and objects free of restraint but whose handling is guided and encouraged by staff and volunteers.

Recording the patients' ways of handling the museum object as well as the frequency with which objects are handled also highlights a fundamental tension within this research: how much of the impact of the handling sessions are due to the facilitator and how much are due to object handling? One patient (SV13), for example, handled the objects very little and spent most of the session telling stories about working in the merchant marines. Towards the end of the session, he remarked that he enjoyed touching the objects and discussing them although little of either had been done. Despite the lack of attention spent on the objects, this hour-long session was highly emotionally charged as the patient became visibly distressed when he spoke of his death and he gave the facilitator a book as a parting gift. Other patients, such as SV19, spent the entirety of the session repeatedly picking up objects and his hands were never unoccupied.

Acting within this methodology, the facilitator and the objects being handled are intrinsically linked and cannot be separated or analysed individually. In other words, the results of this research demonstrate links between the direction of the session and both the objects selected and the facilitator leading the session. This however does not negate the necessity for guidelines for how the facilitator should behave; guidelines that should be clarified in a further refined methodology. The principles of good practice for reminiscence work as outlined by Arigho (2008: 207) and as applicable to this research are:

- the person-centred approach,
- good communication – active listening,
- genuine interest,
- respect for personal choice,
- fidelity and confidentiality,
- establishing trust and rapport,
- support for painful emotions,
- non-judgemental attitude,
- warmth,
- good facilitation skills – equal opportunities,
- use of inclusive and relevant themes,
- monitoring and evaluation at every stage,
- and support, advice and guidance for fellow workers.

Although this list of principles includes 'support for painful emotions', it does not include a framework for action when things go wrong. When conducting reminiscence sessions on behalf of the British Museum, Laura Phillips (2008) writes:

'If object handling could evoke powerful memories, might they be difficult or negative memories? Were there safe topics of discussion or even safe objects which could be trusted not to cause harm? Might it be therapeutic to work through difficult memories...? Could a museum worker provide the necessary support? Would the voluntary nature of reminiscence protect participants?' (p. 201)

While conducting her sessions, Vreeland was introduced to the ward sisters where she was working in order to know whom to turn to if patients became very agitated and upset. Although this did not occur while Vreeland was conducting sessions, how can the museum ensure responsibility in the project's protocol? Should they? Questions such as these should be addressed in future research.

Results and discussion

The project’s quantitative data will not be explored at length here as ongoing research will provide more clinically robust and elegant data, which comprises a larger sample size, necessary for clinical studies. However, the histogram in Fig 3 provides an overview of the key outcomes for the 32 sets of evaluation data:

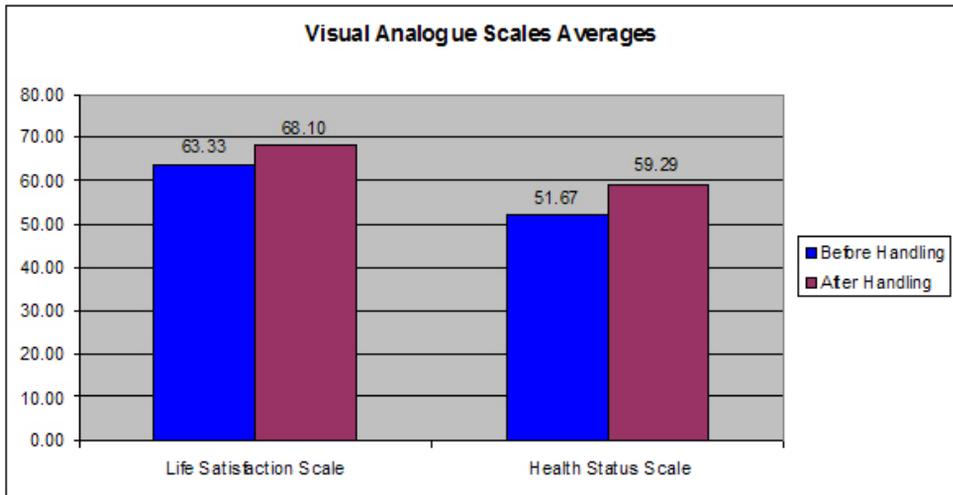


Fig 3. Histogram showing average ‘before’ and ‘after’ Life Satisfaction and Health Status scores, derived from the generic visual analogue scales.

This figure demonstrates an average increase of the life satisfaction visual analogue scale of 4.77% and an average increase of 7.62% for the health satisfaction visual analogue scale.

From a museological perspective, the qualitative data proved much richer. The Constant Comparative method was selected for analysing the qualitative data; this method was originally developed by Glaser in 1965 for the use in grounded theory methodology, and is now applied more widely as a method of analysis in qualitative research. In this method the researcher takes one piece of data (for example, one interview) and compares it to all other pieces of data. During the process, the researcher begins to look at what makes this piece of data different and/or similar to other pieces of data. This method of analysis is inductive, as the researcher begins to examine data critically and draw new meaning from the data (rather than a deductive approach which defines at the outset what will be found). Constant comparative analysis of the session transcripts revealed two overarching categories: personal/reminiscence and impersonal/educational (Fig 4). These two themes capture the dual nature of the project’s protocol which allowed people to talk about themselves and their ideas, to listen and learn about the objects, or to do a mix of both; while some sessions were consistently very personal or very impersonal, many shifted from one to the other, sometimes repeatedly. An example of this shift is demonstrated when one patient (SV 11) handled three objects, then realized that the facilitator knew about the objects. She returned to the first object she had handled, saying:

‘I never asked you what this was. I told you what I thought it was, but I never asked you what it was, this knife thing.’

The personal/reminiscence category included two subthemes, ‘nostalgia’ and ‘meaning making’ (Fig 4). The first subtheme is intuitive: museums and their collections have long been linked to nostalgia and memory. Gregory and Whitcomb (2007) quote Marius Kwent, who ‘has explored the importance of objects for their capacity to invoke memory and sensual engagement. In his analysis, objects are productive forces. They both trigger memory and carry meaning. They

therefore open a space of evocation which, as he argues, implies an open dialogue between the object, the maker and the consumer in constructing meaning' (p. 263). The personal/remembrance theme included when patients reminisced and spoke about places they had been, things they had done, their childhood and their families. This is especially important in an institutional context such as a hospital, as such sessions help to reinforce the identity of patients who may well feel they are on a conveyor belt of care. Awareness of the damaging effects on patients of institutionalisation within hospitals is growing; the benefits of the role of arts in health, including reminiscence, in helping to alleviate these effects are explored in detail in Staricoff (2006) and Arigho (2008).

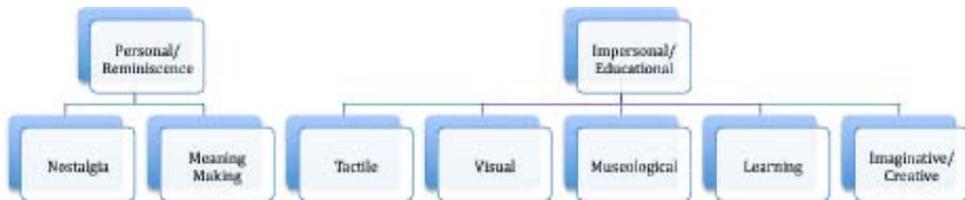


Fig 4. Key outcomes of the study defined as categories and sub-categories established through Constant Comparative analysis of audio transcriptions from object handling sessions.

The possible health benefit of reminiscing was highlighted during the session with one young woman (SV 14) in her 30's suffering from a brain tumour. Many of the objects were familiar to her, but she often could not immediately remember when or where she had seen them before. At one point when discussing a piece of the mineral 'agate' she said:

'it's very... I used to - it's all coming back to me very slowly now. I took a course at the Institute of Archaeology. We - I remember going to Eastbourne - I don't know if you know it but it's sort of south east England and we had to walk along a field full of little... - beautiful - it's really - I - what else can you drag out of my poor head? What would it have been attached to then?'

When asked about whether the session was a good idea she reiterated this, stating:

'I think it's a brilliant idea. I mean it's really good for me because it's taken me back to when I was 18, 19, 20, 21' (here the patient referred to her time at university when her memory was intact).

The personal/remembrance theme included a subcategory which was titled "meaning making" as it included comments patients made about their illness, death, regret, poverty, and loss. It was apparent that many patients, perhaps unconsciously, used the sessions to help make meaning of their lives and to come to terms with illness, as with the example above (patient SV 14). In another example, one patient (SV 2) asked the facilitator's thoughts on life after death.

Unlike other modes of exhibition and interpretation, this project often enabled patients to connect to the objects through Gardner's existential or foundational point of entry (Gardner 2008: 140). Namely, affording hospital patients the opportunity to address deeper, often more philosophical questions about their life, through the handling of museum objects. To illustrate: patient SV 12 picked up a piece of the mineral 'malachite' and rather than asking where it was from or what it was used for, she asked why she had never pursued geology during her lifetime. Such discussions, and how they are handled, can have valuable health benefits. In 'Meaning Construction in Palliative Care: The Use of Narrative, Ritual and the Expressive Arts' Bronna Romanoff and Barbara Thompson state:

'For many individuals and families, the diagnosis of chronic, life-altering, or life-threatening illness requires a revision of the assumptions that have ordered and guided experience and requires the construction of a new life story. How individuals re-create meaning and construe their illness can have significant

implications for long-term physical and emotional wellbeing... Those individuals who find positive meanings in their illness and loss experience less depression, better quality of life and emotional wellbeing. There is also evidence for reduced mortality and enhanced physical functioning in patients living with AIDS who were able to find positive meaning in their illness.' (Romanoff & Thompson 2006: 309)

As well as assisting with providing meaning in their illnesses, the sessions appeared to provide patients with the opportunity to reveal needs that they might not feel comfortable sharing with hospital staff directly. This supports the idea that an impartial third party, such as a museum facilitator, can build a level of trust with a patient, which could be beneficial to both the patient and their clinical care givers. As projects of this kind continue and collaboration is fostered between museums, project facilitators, doctors and nurses, including a patient's 'meaning making' comments in their general medical file could better inform their caregivers and therefore their level of care. This issue also necessarily raises the question of training for those facilitating hospital handling sessions, which is an important component for any future research in this area.

The second overarching category identified was 'impersonal/educational' – where the flow of the session was not coming from the patient and their stories, but rather from the facilitator and the information they provided. Five subcategories emerged from the impersonal/educational category labelled tactile, visual, museological, learning and imaginative/creative. These sub-themes coincide with Classen's reasons outlined in 'Touch in Museums' (2005) for why early museum visitors handled museum objects and what those opportunities to touch meant to them. Fig 5 pairs Classen's reasons with the 'impersonal/educational' subcategories identified in this study.

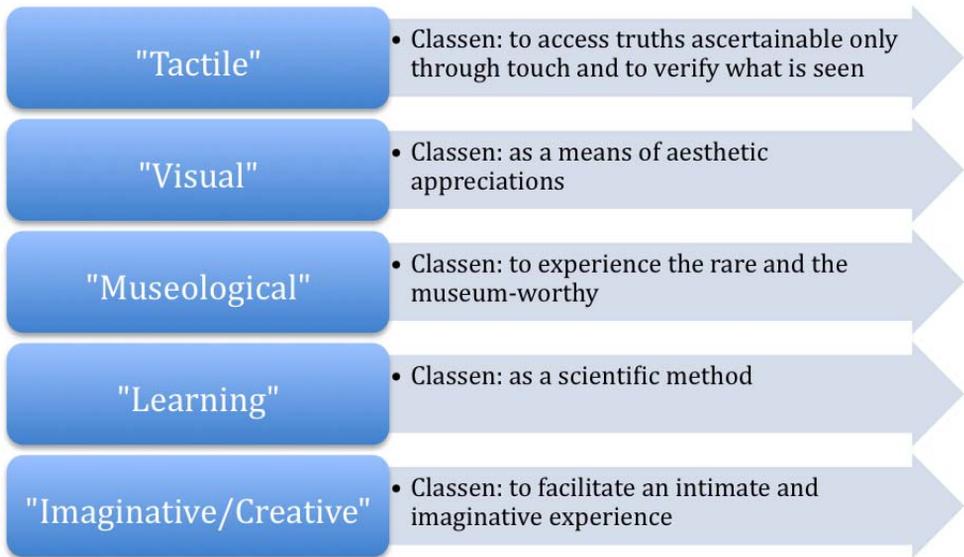


Fig 5. The five 'impersonal/educational' subcategories paired with Constance Classen's (2005) reasons for why early museum visitors handled museum objects

Like Classen's early visitors who touched to access truths about the object only ascertainable through their fingers, instances recorded and labelled as 'tactile' included when patients handled the objects in order to determine texture, weight, temperature and how the object related spatially to their bodies. This category comprised of instances when patients would handle the objects as they would have been handled; for example, patient SV 16 stuck his fingers in the ancient Egyptian cosmetic pot and then pretended to apply kohl to his eyelids and another, SV 26, made stabbing and cutting motions when gripping the dagger. Similarly, touch

was used to verify what was seen. This was demonstrated when SV 3 picked up the malachite specimen and described how it was harder and heavier than she had expected.

When asked why patients chose the first objects they picked up, many provided 'visual' or aesthetic answers. Patient SV 21 immediately picked up the malachite specimen because of her deep love for the colour green and SV 2 first chose the turtle carapace justifying her decision because it was the most beautiful of all the objects.

As Classen (2005) describes, touching the objects was desirable as it permitted a close encounter with the 'rare'. During the 32 sessions conducted, patients repeatedly picked up objects and then asked about their value and what made them museum-worthy. One patient asked whether the facilitator had a bodyguard since she was single-handedly toting treasures in central London.

As outlined earlier, the facilitator began sessions by asking people their thoughts on the objects they were handling, what they thought the objects were used for, what they were made of, where they came from, etc. While this made some patients uncomfortable and they volleyed these questions back at the facilitator, others examined the objects very seriously. One patient brought out a magnifying glass and another jokingly faked being an expert after carefully examining the one of the objects. Although this sub-theme, 'learning', is not rigorously scientific it included instances when patients used the object to ask serious questions and to learn. These questions varied from 'how is agate formed?' and 'what age and gender was the hawksbill turtle?' to 'how do museums know what they know?'. Patients were also educators, telling the facilitator what they knew about the object and at times offering incorrect information. This raises an important tension within the project: is it more important to teach and correct the patient than to facilitate the flow of conversation and allow patients to reminisce? Arigo (2008) writes:

Sometimes an object is chosen because it has been mistaken for something else, or because it looks like something else, and the person is stimulated to share a memory about the object that has been called to mind. It can be helpful to have the 'wrong' object [to] stimulate the imagination to recreate the 'right' object in the memory. (Arigo 2008: 209-10)

Patients also demonstrated imaginative and intimate experiences with the objects. When SV 23 was asked which object was her favourite, she pointed to the Egyptian pot and began describing what she imagined would have been its contents and musing about the variety of smells she could imagine emanating from the artefact. Classen (2007) writes:

Yet, when a collection contained ancient and exotic artefacts, many seventeenth- and eighteenth-century visitors [...] must have felt a thrill at holding in their hands what long-ago and far-away people had held in their hands [...] The seeming ability of touch to annihilate time and space give it a particularly vital role in the museum where so many of the exhibits were from long ago and far away. Touch helped bring the museum to life. (Classen 200: 903)

Researched independently for their impact on wellbeing, these five sub-themes will assist in determining the overall effects of object handling on patient wellbeing. For example, does contact with rare objects enhance self-esteem among patients? Does learning new things shorten a patient's length of stay or the amount of medication consumed? Can an aesthetic experience with a museum object lessen pain intensity?

Finally, just as Candlin argues that the implementation of touch-based practices requires a change in thinking on behalf of museum professionals, museum visitors (or in this case, patients) need to unlearn the ideas they formerly had to internalise in order to quash their impulse to touch (Classen 2005). The assertion on behalf of the museum that people are just as important as the things housed in museums, that their touch is not destructive, and that there is something unique to be gained by touching objects rather than simply looking at them were notions that took some getting used to. For example, when patients were asked whether providing handling sessions in hospitals was a good idea, 4 out of 21 patients replied that it was not and that the objects were exposed to too much risk. Furthermore, while it took varying degrees of encouragement to convince patients that they were allowed to touch the objects, further encouragement was almost always required to motivate patients to handle the art works provided.

Conclusions

The pilot project 'Heritage in Hospitals' demonstrates that handling museum objects can have a positive impact on patient wellbeing as patients, on average, recorded higher scores on visual analogue scales measuring life satisfaction and health status after handling museum objects. The research also reveals the different ways in which museum objects can be handed. The qualitative data illustrated two overarching themes, the 'personal/reminiscence' and the 'impersonal/educational', and seven subthemes.

These findings bear several implications for museums. For one, it outlines the different types of touch used when handling museum objects and argues that these different types of tactile behaviour can be encouraged or discouraged by how the museum experience is shaped, designed and offered to visitors. This research also highlights the need for museum professionals working in this type of outreach project to enact the good practice of reminiscence projects, as outlined above, and asks how the museum, and the museum worker, can act responsibly knowing that reminiscence projects using museum objects may bring up powerful emotional memories. These issues and challenges should be addressed through sensitive training of those facilitating hospital handling sessions, ideally involving a member of clinical staff. The qualitative data mirrored the multi-disciplinarity of the project (which included postgraduate training and tackling a number of research questions as well as increasing access to UCLM&C to a hitherto excluded audience), by revealing several subthemes that require further research in relation to health and wellbeing.

Allowing a museology student, as opposed to a medical student or another type of facilitator, to further this research and to conduct the sessions with patients is also noteworthy. While it not only enhanced Vreeland's postgraduate studies, this ensured that the museology and praxis of the research were deeply incorporated into the project's methodology, its delivery, and its dissemination. In other words, not only did the project afford an opportunity for postgraduate training, the research practice led to ongoing enhancements to the design and delivery of the handling session protocol, i.e. the research constituted an action research study, with several interlinked aims involving a range of different stakeholders (patients, researchers, hospital staff).

Research into the value of museum object handling in hospital enrichment programmes is ongoing between UCL Museums & Collections and University College Hospital and has been rewarded by the allocation of a major grant from the Arts and Humanities Research Council (Award no: AH/G000506/1). The project will explore the psychological impact of 'object therapy' (for patients, clinicians, care givers and family members) in a longitudinal, multidisciplinary, study involving a range of researchers from UCL, UHC, several other hospitals and numerous partner museums. One of the key aims of the project is to produce a set of guidelines for best practice for museums, examples of effective session development and delivery, and guidance on establishing new relationships with healthcare organisations. Future research is also attempting to address the issue of 'object effect' by introducing non-heritage objects and 'facilitator effect' by comparing the quantitative and qualitative differences revealed by different facilitators leading sessions using the same objects.

The results of this research have provided valuable information on the transitional and transformational role heritage could play in healthcare and wellbeing, affording an opportunity for closer engagement between the heritage and healthcare sectors. This is in-line with government directives from the DCMS and the MLA where there is significant recognition of the wider social care role heritage organisations should have in the future. This future landscape could involve partnerships with Primary Care Trusts, Community Health partnerships and third sector organizations such as MIND. These projects may well demonstrate multi-faceted outcomes as the affinity between worklessness, economic deprivation and failing health becomes even more acute in the current economic climate. Raising aspirations, developing self confidence and promoting mental health care through restorative activity such as work related training and placements can be developed in the project focus. The possibilities afforded by considering museum and heritage links with social care organizations, such as hospitals, are potentially far reaching with multifarious opportunities for collaboration.

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Notes

- ¹ Patients are referred to by research number for confidentiality reasons.

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