Using museum objects to improve wellbeing in mental health service users and neurological rehabilitation clients

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Key words:
Museum object, wellbeing, qualitative analysis.

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Reference: Ander EE, Thomson LJM, Blair K, Noble G, Menon U, Lanceley A, Chatterjee HJ (2013) Using museum objects to improve wellbeing in mental health service users and neurological rehabilitation clients. *British Journal of Occupational Therapy, 76(5),* 208-216.

DOI: 10.4276/030802213X13679275042645

Submitted: 20 March 2012.
Accepted: 13 December 2012.

Introduction: The study investigated the impact of museum object handling sessions on hospital clients receiving occupational therapy in neurological rehabilitation and in an older adult acute inpatient mental health service.

Methods: The research used a qualitative approach based on objectivist and constructionist methods, from which themes typical of the object handling sessions were derived.

Results: Themes emerging from detailed analysis of discourse involving clients (n = 82) and healthcare staff (n = 8) comprised: distraction and decreasing negative emotion; increasing vitality and participation; tactile stimulation; conversational and social skills; increasing a sense of identity; novel perspectives and thoughts; learning new things; enjoyment and positive emotion. Critical success factors included good session facilitation for mitigating insecurity, ward staff support and the use of authentic heritage objects.

Conclusion: Museums and their collections can be a valuable addition to cultural and arts occupations, in particular for long-stay hospital clients.

Introduction

Museums are increasingly using collections as a bridge to wellbeing, social inclusion and learning, often taking objects beyond the museum site itself into communities. Mixed methods research into the benefits of museum object handling sessions in hospitals and care homes showed patients or clients demonstrating an increase in wellbeing and happiness, distraction from clinical surroundings and enhanced communication with staff, carers and family members (Chatterjee et al 2009, Thomson et al 2011, 2012a, 2012b).

While occupational therapists have traditionally used objects as tools to enhance mental and physical capacity, museum objects have not been widely used. Hocking and Wilcock (1997) showed therapists to be strongly influenced by the neurological and functional aspects of object use, but to the exclusion of considering subjective responses by clients. Occupational therapists do not traditionally consider subjective responses to objects, which is unlike the situation in museum research – where personal responses and symbolic interpretation are often considered (Lanceley et al 2011). With little existing theory surrounding museums and wellbeing, in particular from an occupational therapy perspective, the current research lent itself to a qualitative enquiry rather than a hypothetical approach. From this, an analysis of clients' subjective responses to objects allowed us to both generate new concepts and determine factors for success in achieving wellbeing outcomes.

Literature review

Museums customarily work with a variety of audiences, notably in both schools and life-long learning. Museum objects have a distinctive impact on learning

and audience engagement since they are intrinsically interesting, have physical qualities that tap into different learning styles (for example visual, kinaesthetic/tactile) and can evoke personal connections, as well as aesthetic and emotional responses (Research Centre for Museums and Galleries 2006, Reading Museum 2002). In addition, the physical spaces and social context in which museum objects are encountered can influence learning and social outcomes (Falk and Dierking 2000). Allowing museum objects to be handled encourages a personal (rather than authoritative) exploration that adds a further dimension to the individual's experience (Chatterjee 2008, Reading Museum 2002).

Research indicates that museum collections, spaces, expertise and experience can all be employed to promote health and wellbeing (Chatterjee et al 2009, Museums Libraries and Archives Council [MLA] 2004, 2010). United Kingdom healthcare strategy has regarded multi-agency approaches, and creative or cultural interventions, as a means both to increase wellbeing and to reduce the need for later medical intervention (Department of Health with Arts Council England 2007, MLA 2004). Museum objects have been used with mental health service users and in residential care to trigger memories (Arigho 2008); such 'reminiscence' activities have demonstrated enhanced socialisation, orientation and validation of life experiences (Rosenberg 2009, Ravn 2009).

In occupational therapy, identity is a key concept. Hocking (2004, p12) examined the relationship between a person's identity and the objects associated with them, specifically those the individual made or used, referring to the 'growing knowledge of the therapeutic application of crafts and the transformative outcomes of occupational therapy intervention'. Client-centred practice is important when establishing interventions, where those that involve making or handling objects become a personal, creative venture that helps to promote recovery from illness.

Recovery has become the focus of mental health policy. In assessing the contribution of an arts programme to recovery from mental illness, Lloyd et al (2007) found participants were able to regulate expressed emotions when participating in arts activities, and could then go on to apply similar control in other aspects of their lives. Stickley (2010) in fact discussed the 'prescription' of participating in arts as helping to promote recovery. Findings from Lloyd et al's narrative inquiry indicated that patients clearly benefited from the programme; especially from having a safe place to visit, from making new friends, and from experiencing peer support and a sense of belonging.

The use of creative arts as a therapeutic medium in mental health services is well established. Reynolds (2000), for example, examined narratives from adults with depression, describing when and why they had first taken up creative needlecrafts and the ways in which this had contributed to managing their low mood. The majority of participants had taken up the activity in later life and the study indicated that needlecraft was mentally and physically relaxing, built self-esteem and enhanced perceived control. The ensuing sense of achievement and confidence could help to moderate depressive symptoms. Griffiths (2008) explored creative activities as a treatment medium for mental health clients, finding that such activities were useful to foster engagement, skills' development and confidence. Similarly, Timmons and MacDonald (2008) undertook a phenomenological study into ceramics as a creative leisure pursuit for people with long-term physical health problems. Their findings suggested that the tactile aspect of working with clay was beneficial to health and wellbeing.

Symons et al (2011) studied participation in visual art from the perspective of adults undergoing physical rehabilitation to determine whether art has a place in this setting. Through the medium of painting, participants with neurological conditions were able to discuss their shared experiences and achieve goals. Outcomes indicated that art contributed to recovery by helping clients both to regain confidence and to meet individual goals.

While the benefits of creating art are apparent in both mental and physical healthcare settings there is limited analysis of the benefits to be derived through handling objects such as museum objects. In this paper we extend previous research to consider the tactile nature of object handling activity and its impact on clients receiving occupational therapy in three healthcare contexts: inpatient mental health services (older adults with degenerative disorders such as Alzheimer's disease and other forms of dementia) and both inpatient and outpatient neurological rehabilitation (adults with vascular disorders such as stroke or degenerative disorders such as multiple sclerosis). This research employed museum object handling to enhance health and wellbeing, with the aim of examining the impact of the sessions on emotions, feelings and life experiences, as encouraged through tactile interaction with museum objects. The sessions also provided opportunities for learning and discussion about the history and use of these objects.

Method

We undertook facilitated museum object handling sessions in three National Health Service healthcare settings (inpatient neurological rehabilitation, London; outpatient neurological rehabilitation, Oxford, and inpatient mental health care, Reading) where occupational therapists routinely work with clients with cognitive deficits due to vascular and degenerative disorders. Sixty-six sessions with clients (n = 85) across the three sites were carried out over 18 months by four facilitators, two of whom were researchers on the project. Facilitators visited inpatient and outpatient rehabilitation weekly and mental health wards every 2 weeks. For rehabilitation wards the sessions were delivered one-to-one, whereas for mental health inpatient wards the sessions were held in groups. Clients took part in one or multiple sessions according to their preference and discharge date. The only exclusion criteria were cognitive impairment to the extent that clients were unable to give their own consent, and positive screening for MRSA or other infection requiring barrier nursing. Ward staff, including occupational

therapists, attended most mental health group sessions and occasional rehabilitation one-to-one sessions. Staff were also interviewed (n = 8).

The procedure comprised: recruitment; explanation and consent; washing hands (for infection control and collections' care); pre-session wellbeing measures (see Thomson et al 2011); facilitated handling session; post-session wellbeing measures and re-washing of hands. Ward staff were informed of the research and the nature of the sessions. On the day of a session, all clients were approached by a facilitator and invited to take part. The study was carried out with medical ethics committee approval (MREC No: 06/Q0505/78) and participants were asked to read an information leaflet prior to signing the consent form to take part in research and for an audio recording to be made. Session protocols were standardised across locations by using the same semi-structured interview format each time, and interview questions were phrased to encourage touching and exploration of the objects (see Table 1). Forty-two museum objects comprising specimens from anthropology, archaeology, art, geology and zoology collections were compiled into seven boxes of six (see Fig. 1), to ensure sufficient variety for repeated sessions while maintaining control over object selection.

Table 1. Semi-structured interview questions

Questions	Additional prompts
Which object would you like to look at first (next)?	Have you seen an object like this before?
What does the object feel like?	Where do you think it has come from?
What do you find interesting about it?	What do you think it was used for?
What does it remind you of?	What material do you think it is made of?
How does the object make you feel?	Do you know anything about this material?
What attracted you to this object?	Do you have any (other) questions about this object?
What do you think this object is?	

Data consisted of interviews with clients, healthcare and museum staff, and field notes. Qualitative analysis considered the ways in which improvements in reported wellbeing, health, social and physical functioning resulting from the sessions might have occurred. Interviews with occupational therapy staff were especially important in identifying specific patient behaviours that might not been recognised by museum facilitators. Transcripts were entered into NVivo, (qualitative analysis software) and then analysed according to Charmaz's (2003) grounded theory methods. Transcripts were first open coded, focusing on core theme coding and analytic memos to generate relationships between themes, particularly session processes, outcomes and wellbeing. The method of constant comparison was used to compare sessions, clients and contexts from inpatient and outpatient rehabilitation and mental health service environments. The research sample relied on the success of recruiting hospital clients to take part in an unfamiliar activity, therefore convenience sampling rather than systematic matched sampling was used.

Fig. 1. A museum handling box of six objects (clockwise from top left): ammonite fossil, Neolithic axe head, elephant tooth section, coral specimen, Roman tile and talc mineral. Image © copyright UCL Museums, reproduced by permission.

To ensure the credibility and trustworthiness of the qualitative strategies, we used Marshall and Rossman's (2006) criteria for reliability and validity, ensured by meticulous record keeping and detailed documentation (Mays and Pope 1996). In keeping with Strauss and Corbin's (1998, p43) proviso of a 'willingness to listen and to "give voice" to respondents … while recognising that researchers' understandings often are based on the values, culture, training and experiences that they bring to the research situations', researchers used reflexive field notes and memos to reflect on their own values, experiences and behaviours in the course of running sessions. Extensive data records included recordings, transcriptions, notes, coding decisions (through NVivo), analytical memos and cataloguing, which ensured 'confirmability', 'dependability' and 'credibility' (Marshall and Rossman 2006) of the qualitative results.

Findings

Participants represented a range of ages, socio-economic status groups and occupations across the healthcare settings (see Table 2). The client sample was slightly skewed towards an older, retired age group since the inpatient mental health wards mainly addressed needs of older adults.

Analysis of museum object handling sessions, interviews and observations, drew upon Charmaz (2003) for objectivist and constructionist methods. The themes revealed were specific to the rehabilitation and mental health contexts and arose from the variety of client engagement and interaction types, session processes and wellbeing outcomes. Key themes included increasing positive emotion, decreasing negative emotion, enhanced vitality, tactile stimulation, improved social skills and sense of identity, development of novel perspectives and thoughts and acquisition of new knowledge. Our findings indicated that engaging with objects alleviated some effects of long-term hospitalisation, such as the deterioration of confidence and identity; the loss of stimulating

Table 2. Sample sizes across contexts

Healthcare context	Sample size
Inpatient rehabilitation (London) n = 17	30 one-to-one sessions: 14 clients (7 female, 7 male) where 5 clients took part in multiple (up to 8) sessions, plus 3 healthcare staff
Outpatient rehabilitation (Oxford) n = 28	26 one-to-one sessions: 26 clients (16 male, 10 female) where each client took part in one session, plus 2 healthcare staff
Inpatient mental health (Reading) n = 45	10 group sessions: 42 clients (13 male, 29 female) where 22 clients took part in multiple (up to 5) sessions, plus 3 healthcare staff

social and environmental occupations; rehabilitation goals; discharge of negative emotions and a preoccupation with illness. In particular, neurologically impaired participants, for whom the effects of hospitalisation were extreme and deeply embedded, demonstrated subtle signs of engagement with the objects, and small improvements in wellbeing for which the sensitivity of qualitative methods was appropriate.

Engagement was initiated in various ways during the session. These included tactile, visual and aesthetic response, learning about an object's significance, personal recollection or connection to an object and through a sense of privilege in having the opportunity to handle such objects. The main sign of engagement was an individual being drawn to the objects, observable through signs of attention, wonder, curiosity, interaction and from asking questions as well as from finding connections between the object and personal lived experience. During sessions we sustained these various routes into engaging with objects, dependent on clients' competences and prior interests, and despite clients initially feeling that museum sessions were 'not for them'. It was evident from our research that object handling stimulated a sense of self-esteem, rekindled social, intellectual, experiential and emotional identity, and acted as a distraction from clinical surroundings. All these factors contributed to an overall improvement in psychological and subjective wellbeing outcomes, derived through engagement with objects. The key themes derived from the analysis are discussed in turn.

Enjoyment and increasing positive emotion

Participants looked forward to 'special' sessions that they enjoyed simply as 'something different'. Sessions were also personalised and interactive; being less arduous than other therapies experienced by participants during their recovery or rehabilitation they were consequently seen in a positive light:

> It's been absolutely fabulous. I'm really thrilled about it (mental health client).

> I love these sessions. Even though I love this stuff, I've enjoyed it much more than I thought I would (mental health client).

> Some of the other sessions are hard work, they can really hurt you and leave you exhausted, but this is different; you can choose how much … and what you want to do or say (rehabilitation outpatient).

> People are so preoccupied with getting out of here and what's going on and it's so nice for them to focus on that and be able to, allow themselves to have time think about happy things (mental health staff member).

> It's just something that they can just relax and … Yeah! Something they can enjoy (rehabilitation staff member).

Distraction and decreasing negative emotion

Participants, in particular mental health clients, came to sessions with depressive or anxious moods that could impair engagement. Sessions visibly calmed anxiety and, in some cases, increased levels of enjoyment in depressed patients. This outcome was linked to 'increased participation', since sessions moved some clients out of solitary rooms or beds into a group situation, potentially reducing their tendency to dwell on depressive feelings:

> I can't listen to pop music at the moment because it reminds me of certain situations that I'm in and having to deal with, whereas this sort of stuff gets you thinking, but because it's 5000 years old … you can't be depressed by looking at a piece of Egyptian pottery, doesn't work that way (mental health client).

> You can spend a lot of time thinking, by yourself, 'what if this is it', and then you realise there might be other things to do — once you get out of here, I mean (rehabilitation inpatient).

> I think that's quite helpful for them — to have another focus on other things and actually look at the happier times, and that actually life isn't that bad … Because here it's such a ward environment, you don't always get the opportunity for engaging in things that will prompt that (mental health staff member).

Vitality and participation

The museum object handling sessions encouraged clients who would normally either sit in their rooms, watch television or give in to tiredness to engage in an active, challenging and yet accessible activity. The activity brought about vitality in their behaviour, conversation and participation that would otherwise have been lacking. For long-term clients with little opportunity to participate in cultural activities, this was an important addition to their week:

> I mean I've been to museums. Not very much as I told you. But this is definitely different because it's kind of personal and … I mean the fact that you can touch and hold them and have a look at them (mental health client).

> And it's … a nice attractive thing. Because the nurses are here all the time and they come and see you, but you still spend long periods of time on your own (rehabilitation inpatient).

> A lot of people find they can't read when they're here because then your own thoughts come in, but this — it's a way of stimulating thoughts, but an easier way — because you're talking (mental health staff member).

Tactile stimulation

Being able to touch objects increased participants' engagement by drawing them into the session but was also an end

in itself. In many hospital contexts tactile stimulation is minimal, and potentially so for long periods of time. By definition, domestic, occupational and self-care tasks are minimised because of incapacity, illness and/or hospital care and catering. Some activities by occupational therapists address this lack of tactile stimulation through helping clients to cook, shop, care for themselves or dress. Yet the hospital environment is often 'object free', especially in mental health inpatient wards where potential aggression means caution is exercised, and clients with neurological damage, for instance, often have reduced motor skills, textural feeling and dexterity — so their range of tactile sensory input is diminished.

In the sessions, participants were given a range of objects with different textures, sizes, shapes, weights and functions. The 'mystery' nature of many objects, and the facilitation, encouraged manual exploration; staff regarded stimulation through touch as an additional benefit of the sessions. Though touch was implicit in other occupational activities it was mentioned by clients, possibly because lack of stimulation meant it remained unnoticed elsewhere or difficult to articulate. For some clients unused to touch, tactile stimulation was difficult to encourage and did not always happen:

> You wouldn't get to touch them, to think it's so old not like an imitation you get in a gift shop (mental health client).

> Quite sharp on the end so it must have worked (rehabilitation inpatient describing Neolithic axe head).

> Quite peculiar, never felt anything like it before (rehabilitation inpatient in response to a turtle shell).

> The nature of the ward is we've not got a lot of things around for them to be touching … because if we've got someone who's a bit aggressive we don't want them to be throwing things, vases and stuff, so maybe the tactile aspect [is of benefit], just having new textures to touch (mental health staff member).

Conversational and social skills

By participating, clients took part in a dialogue with the facilitator and, if in a group session, with other clients. Initially participants may not have known how the session was to be carried out, and what would be expected, but before long they began to use objects as a focus for conversation and discussion. Staff thought this was one of the main benefits of the sessions; particularly in long-term hospital wards, and specifically because of the museum facilitator providing external social presence. Social interactions with people other than close family and ward staff are important in feeling ready to live outside the ward and to return to independence. The novel nature of the sessions also gave clients something to talk about with other people, increasing the quality of their interactions away from the session:

> Visitors, you can have the same conversation with them, so it's something totally different to talk to them about (rehabilitation inpatient).

> I can tell my grandchildren about this when they come to visit me, I can't usually think of anything to say (rehabilitation inpatient).

> So the socialisation aspect, increasing social skills and confidence, I think it's quite beneficial (mental health staff member).

Sense of identity

Much of the participants' engagement, through their behaviour and dialogue, both drew from and reinforced a sense of identity. This is not unexpected when handling museum objects; they already have stories behind them connected to human life, hence their preservation as objects of importance. In the context of a lengthy hospital stay and a transformative health condition, preserving a client's sense of identity is especially important. Many personal objects, people and places are stripped away from their daily experience, and their illness or condition can come to dominate their personality and become connected with much of what they do and think about on a daily basis.

Although seemingly unlikely to elicit personal reactions, due to their sometimes extraordinary or historical nature, museum objects brought about reminiscence and personal responses. Through them, clients remembered times when they were well and previous activities that took them beyond their 'client' status to their premorbid identities. In addition, staff discovered things about clients through these unusual conversations that otherwise would have been difficult to access within normal conversation or clinical assessment:

> When I was a child we used to have a dog, but I've never had cats. I think there's a problem in London with having cats … They would have been alright in Egypt because cars wouldn't have been able to run them over (mental health client in response to Egyptian cat goddess figurine).

> I remember when I was a kid and used to eat them. There used to be a pub on the corner where we used to live. And of a weekend my Nan used to send us down there to get some cockles and shrimps (rehabilitation inpatient, in conversation about shellfish).

> I seen so many people get bit by these little sea monsters, starfish, jellyfish (rehabilitation inpatient, in response to fossil starfish).

> You are coming in, [and] as far as they know are not aware of their problems (mental health staff).

> It's so much easier to prompt conversation when you've got a visual tool (mental health staff).

Novel perspectives and thoughts

Many objects were very old (for example, fossils or archaeological artefacts) and elicited thoughts about the nature of time, change and the participants' place in the world. Seeing their problems in a chronological perspective could help clients to perceive them in a new light. This notion was expressed by a few people, in general those furthest in their recovery. It was these participants who were most capable of using the engagement to reflect on more philosophical issues:

> At the moment everybody's saying in the news, it is going to get hotter, and I've noticed its changed even in my lifetime, I'm not that old, but I can see even in the 70s snow, no 60s, it was snow all the time (rehabilitation outpatient).

> I think when you're dealing with something that's millions of years old it puts your life into perspective (mental health staff member).

Learning new things

Museums already know that object- and collections-based learning can be very effective. Participants in our sessions tended to learn something about the objects, or new skills, and this increased their feelings of confidence and competence. Some relished the chance to practise their reading skills on the relatively simple information sheets. The sessions were tailored by the facilitator to the level of learning in which the participant appeared to be interested. Many participants had not been in learning situations, and certainly not formal learning, for many years and so this activity provided an accessible and sensory way of informally acquiring learning skills:

> I think possibly, I've not got the power of concentration I used to have and yet this is one of things I love (mental health client).

> It gives you a real sense of history when you think somebody we have no record of has made that, has had the awareness, the education, the technology, the skill whatever, it makes the whole thing a lot more real (mental health client).

> My mental cognitive abilities have gone down sharply and memory is really bad, but it's funny because I watch a lot of documentaries on TV, things the Open University do like Coast and stuff and I find all this sort of stuff fascinating (rehabilitation outpatient).

Discussion and implications

As with previous research (Chatterjee et al 2009, Thomson et al 2012a, 2012b), participants in the sessions were distracted from their clinical surroundings and demonstrated a range of benefits that contributed to wellbeing outcomes. In line with Symons's et al's (2011) research, involving participants with neurological conditions undergoing rehabilitation using art materials, engagement with museum objects helped to increase enjoyment and positive emotion for around two-thirds of the clients in this study. Object sessions provided a therapeutic activity, to fill time meaningfully between interventions. It was not evident whether either art participation or museum object handling would have increased positive emotions more effectively; it would be beneficial to carry out a future study directly comparing these two types of activity.

An analysis of five occupational therapists and eight clients by Griffiths (2008) found that clients wanted their minds to be kept active through taking part in creative activities. Our study analysed qualitative data from considerably more participants (eight occupational therapists and 85 clients), and revealed reported increases in feelings of vitality as a result of participation. Griffiths highlighted the value in restoring the balance between work and leisure via creative activity but with many of the clients in our study being institutionalised on a long-term basis, value was derived from providing relaxing, engaging activities as alternatives to passive observation of a television screen, for instance.

Lloyd et al (2007) discovered that clients were able to regulate their extent of expressed emotion through art, and could subsequently apply this sense of control to other aspects of their lives. Likewise, our study found decreased negative emotion as a result of object handling. Although a longitudinal study would have been needed to support whether clients could apply this outside the sessions, the object handling certainly acted as a distraction from daily life on the ward. Reynolds (2000) found that many adults had taken up needlecraft to help moderate depressive symptoms. Similarly, discussing and handling museum objects with others, and contributing associated personal knowledge or life experiences, could help endorse a sense of achievement and increased confidence in participants, in addition to positive emotions such as self esteem. Just as Timmons and MacDonald (2008) suggested that tactile activities, such as working with clay to produce ceramic objects, could benefit health and wellbeing, it is likely that the tactile stimulation derived from touching and handling museum objects, some of which were storage vessels and pottery shards, was itself beneficial to wellbeing.

Many wellbeing outcomes derived from increased levels of conversation, and from improved social skills developed through discussion about museum objects. Stickley's (2010) narrative inquiry into arts participation suggested that outcomes might include making new friends and experiencing peer support; although it was unsurprising to find higher levels of social interaction in our study, this outcome was notably important in ameliorating feelings of social isolation brought about by mental illness. Stickely (2010) also found that clients had reported a sense of belonging. Through finding connections between museum objects and their own lived experience, clients in our study appeared to portray more of their own identity.

Hocking (2004) examined the relationship between a client's identity and associated objects made or used by them. In the same way, handling and engaging with museum objects led clients to learn about new things and also to reminisce about objects they had previously owned, or had used in their working lives. Encountering novel objects appeared to lead to new ways of thinking both about the past and present and this in turn may have provided insight and new perspectives within clients' lives, perhaps helping them to take more of an active role in their recovery.

Handling and discussing museum objects appeared to reveal a range of wellbeing benefits for inpatient mental health service users and neurological rehabilitation clients, implying that it should be considered as a regular activity in occupational therapy, in particular for long-term settings. Finally, certain considerations necessary to ensure the success of museum object handling sessions — including participant interest and security, facilitator and staff support, and the use of heritage objects — are discussed below.

Interest and security

Where clients were interested in museums and had prior knowledge of heritage objects or activities, they were keen to participate. But, otherwise, the strongest obstacles were lack of interest and intellectual insecurity. Some participants regarded museums as 'not for the likes of me', despite efforts in the last two decades to make cultural programming and collections as accessible as possible. Many potential participants had either never visited a museum or had found their museum experience unconstructive or boring. Initially recruitment to the sessions was hampered by a feeling among many potential clients that object handling required a certain level of intellectual ability. Healthcare staff worked well to mitigate this barrier when promoting the sessions, though on occasion staff themselves made pre-judgments about who might be interested. Staff sometimes thought that people who had never seen museums objects or who did not visit museums would be interested to see the objects but in fact it was those with prior experience of museums and museum object who were most interested and, consequently, those clients that benefited most appeared to have a prior interest in museums or heritage. Perhaps if clients with no prior interest had participated in museum object handling then there may have been more negative comments made about the activity.

Wellbeing

The existing wellbeing of clients prior to the sessions was ascertained by wellbeing measures, and through staff and facilitator observation. Severely depressed people found it difficult to leave their rooms or talk to strangers, and very anxious clients could not calm their agitation sufficiently to remain for a whole session. Clients with speech impairments rarely consented to take part, although eligible, and those with severe depression and attentional disorders had difficulty comprehending the nature of the session, and contributed low levels of dialogue, touch and interest. However, merely taking part in a session was seen as progress for some clients. In consequence, while high wellbeing levels were not a prerequisite the facilitator needed to work harder with less engaged clients in order to produce a small, though useful, impact.

Facilitation

Facilitators provided clients with assistance in touching and exploring objects, and in maintaining attention, momentum and focus. They also helped to retain the social nature of the session. In guiding and encouraging participation, answering questions and ensuring the safety of participants and objects, experienced facilitation was essential. Difficult behaviour also needed to be managed (for example wandering, hiding objects, fixating on one object or losing attention). Although it would have been useful to discover that museum object handling might be added to the repertoire of occupational therapists and other healthcare professionals, many staff reported the facilitator being an outside presence contributed to the success of the sessions, in that the person provided museum knowledge and provided a presence not associated with illness, assessment or occupational therapy goals.

Staff support

One of the most important factors for success appeared to be staff support of the facilitator and museum sessions, with higher recruitment and engagement where staff were involved. Attendance was higher when staff members promoted the sessions in client meetings, were enthusiastic about clients participating, and booked them into a time slot and brought them to sessions. When staff members stayed in the session and helped with facilitation and session management engagement was more effective, since any difficult behaviour was managed quickly and efficiently, insecurities were mitigated; sessions were more tailored because staff knew the participant and his or her capacities well. Observation of these sessions helped staff inform their own practice, and they became more enthusiastic the more they witnessed.

Heritage objects

Heritage objects, as opposed to everyday three-dimensional objects, added a positive aspect to the handling sessions; participants felt a sense of 'privilege' from being able to handle these special objects. Some, for example Egyptian artefacts, conveyed a sense of mystery that encouraged participants to explore them, while others reminded them of visits to museums, holidays and heritage sites or television documentaries. Additionally, heritage objects were aesthetically pleasing in their colour, form and pattern while handmade items demonstrated the maker's skills. How the objects had survived to the present day was also intrinsically interesting, and encouraged reflection on time and world changes.

The more negative aspect of museum handling was that for a minority of participants their lack of knowledge of, for instance, zoological or archaeological objects fuelled insecurity. The obscure nature of some objects tended to make engagement difficult, with heritage objects perceived by participants as perhaps too fragile to handle. Facilitator encouragement and demonstration of how to handle objects appeared to help allay these fears. Using a mixture of unfamiliar and familiar objects provided a challenging yet achievable, confidence-building session. Additional flexibility concerning the types of objects used was requested by some staff to increase interest in the wards. The ability to provide a wider range of objects is reliant on the size and nature of the museum collection, although some museums have 'loan collections' that can assist in providing more variety.

Conclusion

Museum object handling sessions introduced in long-term residential hospital contexts offered an idiosyncratic but effective activity to add to occupational therapy. The research

found that the sensory nature of museum objects, combined with a positive narrative, enhanced feelings of confidence, vitality, participation, identity, enjoyment and wellbeing. The activity aided occupational therapists by increasing their understanding of client needs, and in improving client wellbeing and competence, so bringing clients closer to occupational goals of recovery, adaptation and independence. Further research is warranted to understand further the wider applicability of museum-related health interventions in occupational therapy, in particular longitudinal studies to allow evaluation of the sustained effects of such interventions.

Although occupational therapy is concerned with the health and wellbeing of clients through occupations of life, wellbeing arising from interaction with heritage and cultural objects is a relatively under-explored area. Arts and crafts have a long history in professional practice but learning about one's own and other people's heritage and culture is subtly different. It may provide a useful occupation in itself, especially when previous ways of thinking about identity and learning are no longer possible. Findings from the research may be transferable to other occupational therapy contexts, such as community teams working with older people in their own homes or community centres.

Acknowledgements

This research is supported by the Arts and Humanities Research Council (Award No: AH/G000506/1; Heritage in Hospitals) and was conducted with the support and advice of involved hospital staff, notably the Arts Curator. We are grateful to the project partners, Reading Museum and Oxford University Museums, the hospitals involved and all of the patients who participated in this research programme. A portion of this work was carried out within the 'women's health theme' of the NIHR UCLH/UCL Comprehensive Biomedical Research Centre supported by the Department of Health.

Conflict of interest: None declared.

Key findings

- Object handling sessions improved wellbeing for occupational therapy and neurological rehabilitation participants by encouraging engagement and increasing positive emotion.
- Success was reliant on staff participation, skilled facilitation and authenticity of objects.

What the study has added

The study provided evidence of a relationship between museum object handling and client wellbeing. Findings implied that the introduction of heritage-based activities into occupational therapy contexts would benefit client care.

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