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The art and nature of health: a study of therapeutic practice in museums

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Abstract Drawing on ethnographic fieldwork and interviews at a major metropolitan art museum and botanic garden, this article considers the practical accomplishment of American museums' 'health turn' by tracing how museum staff develop therapeutic programmes for visitors with disabilities. In doing so, it considers one of medical sociology's fundamental theoretical questions – how ideologies of health order social life – in an unconventional empirical setting. Acknowledging contemporary arguments for both the relative merits and unintended consequences of this policy trend, I focus instead on the particular institutional arrangements, professional norms, and material cultures of art and nature that shape museums' therapeutic work, so as to reveal its effects. Data reveals ideological similarities, but practical differences, between museological and medical understandings of wellness. Extending a 'medical sociology of practice' to new contexts ultimately foregrounds the contingencies, and diversity, of therapeutic mechanisms and meanings, thereby broadening sociological research on healing and healthism.

Keywords: disability, healthicisation, medical humanities/arts, medicalisation, culture, wellbeing

Introduction

In June 2013, the American Alliance of Museums (AAM 2013) – the largest and only non-profit accredited museum in the United States – released a report detailing the 'significant role' museums have begun to play in US healthcare. The report's state-by-state appendix details specific initiatives contributing to 10 areas of healthcare, half of which – Alzheimer's, autism, mental health, military and veterans' health, and visual impairment – directly concern patrons often classified as people with disabilities. Among these initiatives are workshops for people with Alzheimer's disease, led by museum staff trained to 'trigger memories using works of art as prompts' (AAM 2013: 2). Also included are 'specialty tours' in botanic gardens including 'hands-on activities' for groups of visitors with low vision (AAM 2013: 3), and 'Wounded Warriors' programmes in art museums and zoos that provide services to veterans 'in the areas of mind, body, economic empowerment and engagement' (AAM 2013: 8).

More than policy idiosyncrasy, the AAM report reflects one of many statements on the healing potential of museums echoing across the landscape of contemporary cultural policy (Americans for the Arts 2015, NEA 2013, UCL 2016) and museum research (Chatterjee and Noble 2013, Silverman 2002, 2010). Acknowledging the field-level diffusion of museums' 'health turn', this paper examines how the broader trend unfolds through practice, so as to identify its

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effects. If 'health, competence, identity, and transcendence are needs of the self that museums serve', as the museum studies scholar and social worker Lois Silverman (2010: 43) has suggested, what follows provides an answer to her subsequent questions: 'How, and for whom?'

It does so by comparing a subset of therapeutically-oriented museum initiatives developed for people with disabilities across two types of American museums: the art museum and the botanic garden. Museums are unconventional case studies for sociologists of health and illness, and art and nature unusual medical technologies. To investigate them necessarily raises the more general question of what is gained when studying core medical sociology questions in non-medical settings. Tracing the specific therapeutic assemblages of museums, I find ideological similarities, but practical differences, across medical and museological 'imperatives of health' (Lupton 1995) and discuss how these findings can diversify medical sociologists' study of health and healing.

On living well in museums

'Gone are the days when museums were viewed as static and inert', reads the foreword to a recent volume on *Museums and Health* (Chatterjee and Noble 2013: x). A more 'contemporary perspective' illuminates how museums offer 'an interactive environment that can contribute positively to present day well-being'. Recent work across disciplines has addressed diverse areas of inquiry along these lines, embracing museums' recent engagement with health issues as a fundamentally favourable rupture in practice. These studies include evidence-based efforts in arts policy and museum studies to assess museums' role in healthcare initiatives increasingly focused on the role of communities, third-sector organisations, and preventative care (Chatterjee and Noble 2013, see also NEA 2013, Silverman 2002). Historical, anthropological, and cognitive science investigations of what Levent and Pascual-Leone (2014) term the 'multisensory museum' have additionally highlighted the therapeutic potential of visitors' tactile engagements with museum artifacts (Chatterjee 2008, Classen 2007), thereby challenging both the privileging of visual perception in contemporary museums and the mechanisation of contemporary biomedical therapies. Even those who describe museums' long histories as institutions of social service nevertheless acknowledge favourable tides of change, describing critics as limited by resolvable hesitation or an enduring attachment to an elite status quo (see Silverman 2010: 2–4).

Such studies, however, admittedly bracket instrumental or paternalistic motives driving museums' therapeutic commitments, choosing instead to gather evidence on the trend's altruistic and innovative potential (Chatterjee and Noble 2013). Museums, after all, have continually sponsored projects to cultivate 'good' citizens, projects often framed by a politics of difference: getting workers from the pub to the museum, for example, and indoctrinating them into norms associated with high culture (Silverman 2010; see also Bennett 1995). While notions of the civilising edification of culture arrived to Western European museums in the late 1800s, they became notably embedded in the institutional origins of major American art museums (DiMaggio 1982). Seen through this lens, the emergence of health as a frontier for the moral projects of museums may be an evolution, rather than an innovation, of practice. At minimum, the generalised ideal of 'living well' constitutive of museums' history raises important questions of what's at stake and whose values may guide calls for these institutions to contribute to health care.

Such questions make these institutions potentially interesting cases for investigation by medical sociology. Greater demands for accountability in the culture and non-profit sector have necessitated demonstration of both diverse, high-volume visitor participation in museums and these organisations' commitments to public service (Scott 2002, Weil 2004). Given this, the epistemic authority associated with science and the 'super' value placed on good health (Crawford 1980, Metzl and Kirkland 2010) may be contributing factors toward museums' increasingly visible preoccupation with health promotion. Research on medicalisation (Conrad and Schneider 1992, Zola 1972, 1991), and healthicisation (Conrad 1987) or 'healthism' (Crawford 1980; Lupton 1995), proves useful for investigating the relationship of well-being and morality in museums. These processes respectively explain how a social problem (such as promoting access for people with disabilities) can be resolved through medical means (therapeutic 'pathways to inclusion' (Silverman 2002)); or how lifestyle and behavioural choices (going to a museum, or not) may become potential medical risk factors or interventions.

Rather than adjudicating whether contemporary museums promote good health, this article aims to explain how they purport to do so. Acknowledging diverging perspectives on the stakes of museums' health turn, I trace its practical accomplishment by describing how ideologies of health operate in a context not traditionally of concern to medical sociologists. In keeping with Timmermans's (2006: 29) formulation of a 'medical sociology of practice', this approach foregrounds 'the structural elements, policies, and relationships' that predate the therapeutic commitments of museums, but regardless are reconstituted through them. Ultimately, I show how art and nature function as 'central mediators in the construction and reproduction of novel [therapeutic] worlds' (Timmermans and Berg 2003: 104) and illuminate the social arrangements shaping what therapeutic practice can both make possible and limit.

To illustrate these mechanisms and draw out their implications, I organise my analysis in two parts following a brief discussion of methodology. The first section, 'Conditions for Therapeutic Practice', places the therapeutic programmes in their specific organisational contexts. I identify the institutional conditions constraining the standardisation of therapeutic protocols in museums and explain how consulting art and horticultural therapists nevertheless frame art and nature as tools in the service of therapeutic ends. Next, in 'Materials for therapeutic practices', I illustrate differing therapeutic approaches across the gardens and galleries. I discuss how these relate to broader histories of therapeutic work, promote distinct affective and sensory engagement with museum objects and environments, and, under particular conditions, limit the scope of museum-going experiences for visitors with disabilities. I conclude by addressing implications of these findings and how they may broaden medical sociologists' attention to, and understandings of, therapeutic worlds.

Background on case selection and methods

The data for this article comes from a larger ethnographic study comparing museum education programmes for visitors with disabilities – typically called 'accessibility' or 'access' programmes – at art museums and botanic gardens across the United States (Mangione 2016a).[1] This broader project includes fieldwork spanning five years across four museums in New York and Chicago: an art museum and a botanic garden in each city. The research design facilitates comparisons of accessibility programmes within the organisational field of American museums (AAM 2000, Goode 1896). Studying accessibility programmes makes analytically explicit the practical articulations of museums' therapeutic value. As today's museums address diverse concerns relating to health and wellbeing, many, as discussed above, focus on those visitors who fall under the label of disability.

I focus on my Chicago field sites in this article to isolate therapeutic museum programmes as the primary dimension of empirical contrast, as these museums, in contrast to my other case studies, offer programmes for visitors led by therapeutic professionals and geared toward therapeutic outcomes. The first is the Art Institute of Chicago's (AIC) 'Art in the Moment', a gallery and studio-based programme co-led during my fieldwork by a staff educator, Lucas Livingston, and collaborating art therapist, Deborah (Deb) DelSignore (Livingston *et al*. 2016). The second is the Chicago Botanic Garden's (CBG) horticultural therapy (HT) programme, which is located in the garden's Education and Community division and is run by three full-time staff members, including two – Barbara (Barb) Kreski and Alicia Green – who oversee on-site programmes (Kreski 2016). These four professionals are named with written permission.

I began fieldwork in each institution with a three-month period of pilot research in 2010. From autumn of 2012 to autumn of 2015, I completed an additional 18 cumulative months of fieldwork at the CBG and nine months of continuous observations at the AIC. I concentrated observations on programmes for visitors with disabilities but for context also observed a sample of programmes for other audiences (families; schools; the general public), as well as training and professional development sessions for educators. I additionally draw on interviews with 28 education staff members and therapists, including the full sample of personnel associated with the primary programmes of interest, and interviews with 12 adult participants in the CBG's HT programme. I use pseudonyms and change identifying information for those quoted, excepting my key informants, whose names are publicly available and associated with the programmes discussed.

Conditions for therapeutic experience

Despite the presumptive novelty of museums' therapeutic interventions, some key features of museums, and museum education in particular, made the programmes a rather natural institutional fit. Therapists like Deb, Barb, and Alicia worked within the area of their museums' education department specifically dedicated to people with disabilities. These therapists thus worked largely to contribute to these institutions' predefined sense of what was worthwhile to undertake – promote a democratically inclusive museum – and they did so while working alongside the museum professionals historically tasked with this responsibility (Zolberg 1992). Education departments serve a wide range of audiences: from families participating in campouts through the CBG's 'Nature Nights', to schoolchildren visiting from the Chicago suburbs and South Side, to high-level donors. Given this, and given that third parties (parents; teachers) brokered the museum visits of many, educators were particularly attuned to a wide range of potential visitor experiences and backgrounds.

Specific institutional norms mediated educators' and therapists' differing professional identities. In particular, many museum programmes consist of one-time visits by people about whom educators know little in advance. For example, a staple AIC programme format was drop-in public tours of the galleries; advance registration for CBG family programmes requested only the child's first and last name, birth date, and number of attending adults. Information acquired in advance or through third-party staff could, further, be lost in translation and required that programme staff be flexible. In one programme, for instance, Alicia – waiting in the garden for a group to arrive – received a radio call from a staff member to which she responded, calmly: 'Oh, they are children? I thought they were adults today. That'll be interesting'. Programme staff also acknowledged particular challenges preparing for visitors with disabilities. As one AIC staff member explained, she typically had her school programme educators follow up on a classroom teacher's online registration with a phone call asking whether students had 'special needs'. Regardless, in our interview she acknowledged these teachers' discretion: 'Sometimes a teacher doesn't wish to identify students with special needs, but they currently have special needs. We find out when they come for their visit'.

While most contemporary health professionals, for better or worse, work within a world of standards (Timmermans and Berg 2003), the informal learning environment of the contemporary museums is not a similarly standardised world (Timmermans and Epstein 2010). Further, in acknowledging both the programme structures and information deficit within which they worked, none of the therapists I interviewed described the museum programmes they led as a form of therapy. As Elisa, another consulting arts therapist for Art in the Moment, noted: 'I guess you can't really say that [Art in the Moment] is therapy, per se. In that it's not like we're doing a really [tailored] assessment of where you [the visitor] are, you know, and what's our treatment plan for you'. Or, as Barb explained: 'We're [in the HT programme] not like therapists in the sense that we see the same clients over and over again and can work towards goals or biomarkers'.

Given shared organisational conditions and similar professional roles, it is only when comparing the practical work of educators and therapists that differences emerged. Among these, the most significant was how they understood the value of art and of nature. For educators working across the gardens and the galleries, these domains had intrinsic value, and their professional responsibility was to promote visitors' appreciation of them. For instance, when I asked Cora, a senior CBG education staff member, to describe the mission of the education department, she responded: 'Well, we exist to use plant-based education to support science learning ... [but] also to promote the enjoyment of plants, because that is part of an educational mission, as well. And, we exist to interpret the garden, so that it enhances your enjoyment of it'. The means for accomplishing this goal further varied based on the visitors they worked with. For instance, while the AIC generally favoured inquiry-based teaching – open-ended questions to solicit visitors' contributions – they acknowledged the necessity of adaptation. According to one senior staff educator, Beth, more seasoned, self-selecting museum-goers often expected from their guides a certain degree of what Bourdieu (1984) has termed cultural capital (familiarity with, and appreciation of, high culture). As she stated, educators must work to meet halfway those visitors who want to 'know what the facts are' and tend to lament other people on the tour 'just yammering on about what everybody thinks'.

In contrast, the art and horticultural therapists I spoke with tended to discuss art and nature as instrumentally valuable: as the means to a specifically therapeutic end. Consider Art in the Moment. Research identifying the psychosocial benefits of The Museum of Modern Art's dementia programme, 'Meet Me at MoMA' – undertaken by the New York University Center of Excellence for Brain Aging and Dementia (Rosenberg *et al*. 2009) – had significantly influenced the development of the AIC programme (for general background on such programmes, see Rhoads 2009). Along with Lucas, Deb chose to extend MoMA's model by developing a programme predicated on evaluating specifically therapeutic benefits and (according to an initial grant proposal) using art to 'improve and enhance ... well-being'. Consider also how the art therapists and horticultural therapists I interviewed defined their professions (emphasis mine):

> [Art therapy] is *the use* of the creative process to basically deepen our understanding of ourselves, and try to use that process to create wanted change in a person's life.

> [Horticultural therapy] is a way in which a trained individual... *uses* plants and nature as a non-threatening medium to achieve a specific goal.

Thus, even while acknowledging the difficulty of ‘therapy’, therapists were intentional about realising therapeutic effects from their programmes (here contrasting with Beth’s emphasis on adaptation). Barb, for example, made this clear by contrasting for me on two occasions the concepts of ‘horticultural therapy’ and ‘therapeutic horticulture’, distinctions also made in a position paper published by the American Horticultural Therapy Association (AHTA 2012). As she acknowledged, even though ‘strict horticultural therapy’ required a client, an identified need, and a specific goal, ‘therapeutic horticulture’ still used nature toward a goal: ‘a positive experience for generalised well-being’. This therapeutic intention was further captured in Lucas’s description of Art in the Moment as the ‘most structured’ of all the gallery programmes he facilitated for older adults. This was in equal part due to its focus on evaluating therapeutic outcomes and its basis in a specific tour model developed by MoMA. ‘I suppose’, he acknowledged, ‘if [a programme] does have the end result goal of being a therapeutic experience, then we want to stick to the scientific method’.

Materials for therapeutic practice

Tracing the organisational context of museums’ therapeutic initiatives highlights how the things around which museum-going is organised – in this case, art and nature – come to be understood as therapeutic tools, even in an institution and within professions at best loosely committed to the standardisation of therapeutic practice. Left to explain in the following section is the content of these programmes, which reveals both differences in the material construction of therapeutic worth across the gardens and galleries and how such practices shape possibilities for visitor experience.

Art therapists: better for the making

Like many programmes at the AIC, Art in the Moment programmes presented visitors with themed, in-gallery tours featuring a selection of five to six of the museum’s approximately 300,000 artworks. Following MoMA’s questioning modules, conversations focused on fostering dialogue via open-ended inquiry (‘What do you see in this work?’ or ‘What does this make you think of?’). Through such questions, educators encouraged visitors’ personal associations and observations. For those participants unable to speak, facilitators acknowledged and engaged them directly, with professional or familial caregivers supplementing conversation.

If it is true that Art in the Moment was the ‘most structured’ of Lucas’s education programmes, it is equally true that the initiatives intended to structure self-expression through art. This emphasis was evident in the gallery portion of the programme but was particularly explicit in the art-making component that followed. Notably, to have art-making in a programme at all was somewhat of a departure from modal practice. At the AIC, art-making was most often incorporated into family programmes with young children (and to a lesser extent, school programmes). However, art-making was central to art therapy. In individual interviews, I asked Deb and Elisa if it would be possible to lead an art therapy programme without an art-making component. Both concluded that it would not be: ultimately, a person was better for the making. According to Elisa, art-making was an important mode of communication: it promoted unique expressive possibilities she considered central to therapeutic experience. She felt this was especially true for visitors with dementia: ‘You know, working with [people with] Alzheimer’s now: a lot of people have aphasia, and they don’t have as great access to verbal skills’. Deb phrased it even more directly, framing the import on ‘making’ as an important standard in an otherwise internally heterogeneous profession (emphasis mine):

> There will always be an art-making component [in an art therapy programme]... a person can't call themselves an art therapist, or can't graduate from an art therapy school without there being a consensus that that person really understands the art-making process and materials on top of the psychological and educational and all that stuff. *There are so many different pieces to the art therapy degree that that's what's central.*

Belief in 'the transformative potential of doing things' has a long legacy in the history of therapeutic work (Hocking 2008a: 149, see also Laws 2011). As Clare Hocking (2008a) has described, the earliest occupational therapists in the United Kingdom were guided by 'Romantic assumptions' of their time, principal among them the belief that patients should emotionally engage in the process of making beautiful objects. This conviction that patients could be transformed by the power of craft – emergent from the Arts and Crafts movement, and in direct response to the structural changes of the Industrial Revolution – were, notably, relatively eclipsed in occupational therapy following the Second World War. This resulted from the profession's efforts to align with biomedical standards and associated individualised (rather than environmental) models of impairment, as well as art therapists' growing interest in using art as a means for psychoanalytic diagnostics (Laws 2011, see also Hocking 2008b).

For art therapists working within the 'non-standard' world of the museum, however, many 'Romantic' elements of therapeutic making endured. They further expanded the museum's programme offerings. At the AIC, art-making was not simply a programme format but also a sensory modality, contrasting to museum-going programmes that otherwise privileged the eye (and the spoken word). The art-making component of Art in the Moment engaged multiple senses and endeavoured to work through, rather than upon, the body to acknowledge the significance of non-verbal behaviour (Kontos 2005). The tactile dimension of the experience further served participants who could not make projects on their own. During one Art in the Moment programme of the late spring, I sat with an older man, Alan. That day, programme participants had discussed Felix Gonzalez-Torres's *Untitled: portrait of Ross in L.A.* The piece, composed of a piled mass of colourfully-wrapped hard candies to which visitors can help themselves, sat as a glittering rainbow in a corner of the light-infused modern gallery. Having been reasonably talkative during the tour, Alan now appeared tired in the studio; the most he could do in response to a volunteer's questions was nod. Each time he ran his thumb over the silver wrapper from the candy he had chosen to incorporate into his collage, however, his face broke into a smile.

Given the innovative nature of its programme model, I asked Lucas at one point in our conversations if he would be interested in offering the Art in the Moment format to groups of adult visitors without dementia. Reflecting on this, he said that he might, but that the group would have to be advised in advance that the programme was 'very different'. I overheard a similar comment from one programme participant, Iris, one day during my fieldwork. Iris was particularly bothered by the warm-up discussion of Mary Cassatt's painting, *The child's bath*. In particular, she didn't want to hear what other people saw in the painting. As she made clear to Lucas, she knew all about Impressionism and wanted to learn more about it from an expert. As she flatly told him and later repeated to Deb: 'You don't have to dumb things down for us just because we're older'.

As Deb noted to me before the programme began, that day's theme, 'The Wonder Years', was meant to highlight the role of 'free association' in art. In the galleries, participants discussed gestural, abstract paintings by Joan Miró and Paul Klee; back in the studio, Deb encouraged them to think about why adults are so inhibited about doing what we once 'did so happily as a child: that period, you know, we call 'The Wonder Years'. To some appreciative laughs, she noted a person would likely encouragingly place on the refrigerator a drawing her young daughter might bring home from school, while embarrassedly stuffing her own (or her husband's) drawing in a drawer. In efforts to lower their inhibitions, the group would thus be working with 'some very simple materials, and people should just feel free to draw something that evokes a memory from a time when they allowed themselves to be free in that way'.

Throughout the programme, participants worked with freshly sharpened coloured pencils and markers on paper. Over the course of the hour, Iris had warmed up, and particularly so during the art-making portion of the programme; she diligently completed a three-dimensional line-drawing of a rectangular box with a child-like figure inside. She captioned it: 'Me in my playpen with *Good Housekeeping* magazine'. When I crossed over to her, we discussed the importance of having a space of one's own. As Iris said, with emphasis: 'Oh, I *loved* that playpen', asking me and her tablemate, Anne: 'Didn't you just have a space that you liked to go to, just you, where no one bothered you?' Later, she chatted with Anne about the 'dry pantry' in her childhood home, where her parents would hang salami and peppers.

Iris's experiences shed light on some effects of Art in the Moment's orientation toward therapeutic ends. On the one hand, she was exposed to an art-making opportunity she might not have otherwise expected, which she greatly enjoyed. As Silverman (2002: 76) has noted, 'locked within the framework of institutional history, museum workers tend to privilege a narrow range of visitor responses – typically, cognitive ones – and ignore the very personal and emotional responses that therapists value'. On the other hand, her tour experience was somewhat at odds with her self-concept and her level of cultural capital. Her interests were akin to visitors described by Beth, for whom questioning-based strategies were often adapted in favour of lectures. It is a notable irony that at the programme's end, I found out from a volunteer that this particular group was not, in fact, a group of older adults with dementia. Those in attendance that day were older adults who lived independently in a Chicago retirement community, not dissimilar from those visitors Lucas regularly served as part of his comparatively 'less structured' gallery tours for seniors.

Horticultural therapists and the creation of sensory asylums

Where therapeutic ideologies at the Art Institute tended to be localised to Art in the Moment, those at the CBG were more diffuse. With varying degrees of specificity, staff framed botanic gardens as 'therapeutic landscapes:' places with longstanding reputations as sites for healing (Gesler 1992, Smyth 2005). The CBG, for example, offered outdoor 'walking workouts', tai chi, and yoga courses that fell under the broader umbrella of 'wellness and fitness' programmes. As Cora acknowledged:

> 'the general public, they're coming here to be filled with the colour of the flowers in the garden beds. And, we'll [show them], you know, the huge swath of tulips. You can't help but feel like, 'Ah, that looks good. That's pretty. I feel good when I see that'.

Along similar lines, horticultural therapists often noted in conversation that gardens have a long and storied history as places of ameliorative asylum. Early in my fieldwork, for example, I attended staff members' presentation of independent research on horticultural therapy. Discussing her literature review, Alicia stated (Davis 1998) that HT had 'been around for ages', with Ancient Egypt serving as the 'first recorded use of horticulture in a treatment context'. Specifically, she noted, court physicians prescribed walks in palace gardens for royalty who were 'mentally disturbed'.

The notion of the garden as therapeutic was, perhaps unsurprisingly, prominent in the CBG's Buehler Enabling Garden, where horticultural therapy programmes took place. Buehler aimed to make gardening possible for people of varying abilities and capacities: in essence, again borrowing from Silverman (2002), it aimed to promote inclusion through therapeutic pathways. The garden included, for example, tactile beds organised into metal grids for blind or partially-sighted visitors who might garden by touch, and raised beds which had space underneath for people who might need to garden while sitting. Buehler also had a number of features intentionally designed for sensory engagement, a notable break with the somewhat loosely policed museum convention of ‘look, don’t touch’ that the CBG otherwise enforced (Mangione 2016b). When Barb and Alicia led a tour of Buehler for a group of teachers participating in the CBG’s annual School Gardening Conference, for instance, they highlighted the garden’s aural, olfactory, and visual plants and design elements. These included the thick sheets of water rushing playfully from a water wall tucked in a shaded corner of the diamond-shaped Buehler pavilion, and (depending on the season and year) hollyhocks for hummingbirds and bushes to attract butterflies; chocolate mint-scented geraniums and jasmine for visitors to touch and to smell; and nasturtium for them to eat.

The horticultural therapists consistently framed these sensory features as central to visitors’ therapeutic experience. When I asked Barb and Alicia why Buehler was an effective site for the practice of ‘therapeutic horticulture’, both agreed that being in a sensorially-stimulating outdoor environment was broadly ‘good’ for visitors. Barb, who had come to the CBG in 2010 with three decades of experience as an occupational therapist, was explicit on this point, stating without hesitation that HT’s biggest contribution to healthcare professionals was how it could get them to ‘think more systematically about the role of environment’. After a pause, she added that she’d worked in hospital basements, in bare conference rooms under fluorescent lights, and in windowless rooms the size of supply closets. Shaking her head, she asked me once over tea in the CBG’s cafeteria: ‘I mean, how can we imagine that surroundings mean no difference in the success of these [medical] programmes, these practices?’ adding later: ‘What would you rather be doing: having someone push on your shoulders in a hospital basement, or sitting in a bench in a garden?’

The majority of programmes led in Buehler – for veterans, people with visual impairments, those with dementia, on the autism spectrum, or in stroke rehabilitation support groups, among others I observed – were hands-on workshops that took place in a small outdoor classroom pavilion at the end of the garden. In this focus on making and doing, CBG’s horticultural therapy programmes thus had affinity with their art therapy counterpart and, notably, with early occupational therapist’s ‘Romantic’ emphasis on the uplifting pleasures of hands-on activities incorporating natural materials (Hocking 2008a). However, these workshops focused less on using these materials as a vehicle for expression and instead on environmental affordances: the idea that the curated plants and displays of the garden, even when ostensibly doing nothing, were understood to be doing something and were enrolled (Callon 1986) to the project of therapeutic work.

Throughout my fieldwork, I observed a broad range of gardening, craft, and culinary workshops which included coleus propagation activities; the preparation of vegetable dips and other dishes; people from a residential community for the blind and partially-sighted designing pebble-based dish gardens with thick, fleshy succulents; and a group of veterans create garden ‘memorial stones’ with brightly coloured glass marbles one day and flower arrangements with dahlias and sunflowers the next. A spirit of relaxed informality, focused on making and sensory engagements with nature, characterised these initiatives throughout. Alicia, for example, did not typically work with lesson plans, in contrast to the objectives and programme outlines specified for school and family programmes organised around a science curriculum. For the memorial stones project, she had printed out some background information from the Internet. When giving directions to the group, she emphasised her experimental approach by joking, with a smile, ‘remember guys: it’s amateur hour here’. I once asked Alicia if she felt education was the appropriate department for her programme. She began by stating: ‘I wouldn’t call us educators’, acknowledging, after a pause, ‘But… I do *teach*’. When asked to elaborate, she stated that while she hoped participants might ‘learn something being here’, most of her goals related to ‘enrichment:’ ‘mostly I hope they leave with some good memories’.

What of the participants themselves: the counterpoint to Iris? Notably, the horticultural therapy participants I spoke with all described Buehler's virtues and goals in ways aligned with the horticultural therapists. In particular, they spoke at great length and reverently about the beauty of the garden, as well as its sensory pleasures. When I asked Ellen, a young woman with developmental disabilities who participated in horticultural therapy programmes through her day programme, what she liked about trips to Buehler, she told me: 'It's gorgeous ... beautiful. Like, just, like, how natural everything is, and how beautiful nature can be'. This included both the view of the lake she liked to admire from the back of Buehler and 'the flowers and the plants: they smell good. They're very pleasant'. Opportunities to touch and handle the plants in Buehler, otherwise an institutional rarity, were welcomed by visitors like Renata, born blind, who spoke at length about the 'most softest' and 'sultry' plant she'd encountered in the garden that 'embod[ied] beautifulness' to her.

However, some participants spoke about what the CBG could do differently. Cameron, a partially-sighted middle-aged man who had previously worked in publishing, also described the horticultural therapy programmes quite favourably and the garden as lovely. Regardless, as he told me in our interview:

> Well, I've been [going to the CBG] for years now ... I'm at a level now that taking dirt and putting it into a pot and sticking flowers in it, that's not a challenge at all. So we need to expand our educational aspect of it. I don't know what there is if we're in a short-bus group or what. I would think that they would have more higher-level education there. And I'm sure there is. Right? Not everybody just goes there and starts clipping flowers off.

Cameron's discussion of the 'short-bus' – a pejorative reference to the kinds of public transportation associated with special education students – reveals his perception that the programmes offered to him differed from those offered to visitors without disabilities. This perception (like Iris's) was not entirely false. It resulted, in part, from the framing of art and nature as instrumental tools discussed in section one of my analysis, and the idea that therapists were less likely to adapt their programme formats due to their efforts to achieve 'therapeutic' outcomes, however defined. As Conrad (2005) has argued, most discussions of therapeutic landscapes have tended to take for granted their fixed or intrinsic therapeutic properties, bracketing how much of their therapeutic value is communicated through relational dynamics. For the CBG, this value was defined through engagement within carefully curated sensory gardens and, except for some more vocationally-focused volunteer garden work, 'enrichment' workshops. More broadly, Cameron's comments underscore that while visitors I spoke with and observed demonstrably enjoyed their visits to the garden, this did not preclude the finding that for some, variation in programme structure would have been an asset.

Concluding discussion

As Carmel (2013: 743) has argued, health practice straddles the world of science and art by functioning like craft: it encompasses both 'technical skills and manual dexterity' and 'insightful judgements and interpretation'; in its practice, 'the material world is generally altered, repaired or improved in some way'. In comparing the therapeutic initiatives of a major metropolitan art museum and botanic garden, I have argued that extending a 'medical sociology of practice' to new sites of inquiry can diversify medical sociologists' understanding of differences in the mechanisms of health 'craft' work, and their origins. This conclusion briefly outlines two main findings of the article to revisit existing debates about the effects of museums' health turn.

First, despite the educational mission of museum programmes – and despite the institutional challenges therapists face advancing a standardised protocol – I find established educational objectives are less prominent in therapeutic programmes otherwise concentrated on hands-on activities promoting expression and sensory stimulation. Studying how therapeutic practice changes museum work thus raises the important question of how museums' health turn – as a project of access – may reify social boundaries within these institutions by shaping who can do what. Studying the construction of therapeutic subjects in museums can thus further contribute to research on the 'local moral economies' negotiating responsibilities for what the medical anthropologist Vinh-Kim Nguyen (2005: 142) has termed 'therapeutic citizenship'. Ultimately, while the access to culture that museums promote may be a right, both the institutional histories and contemporary arrangements of museums suggest perceptions of social difference often shape what resources and opportunities are conferred in claim of those rights. Here we can begin to see how therapeutic interventions come to focus on people with disabilities (itself an internally diverse group), whose needs and interests are often viewed through a medical frame. For those designing and evaluating therapeutic programmes in the cultural sector, it may thus be valuable to take into account the relationship between participation and choice.

This noted, the programmes I have examined offer a novel choice for therapeutic engagement, not least for medical sociologists studying health and healing in an age of technoscientific intervention. Useful here is Hondagneu-Sotelo's (2010) recent observation that while gardens are of interest to scholars in various disciplines, sociologists have not typically seen them as legitimate topics of inquiry despite their functioning jointly as sites for the reproduction of social inequalities and for enchantment and meaning-making. Beyond its empirical relevance, her call for sociologists to reconsider their research preferences supports this article's broader suggestion that (medical) sociologists can benefit from revisiting old questions in new settings. In particular, the art and horticultural therapists I observed – working outside the evidentiary standards of contemporary biomedicine, and working with an unconventional set of therapeutic technologies – facilitate 'health' projects foregrounding the ameliorative power of aesthetic expression, sensory pleasures, and natural landscapes. Such programmes dovetail with studies addressing the convergence of accessibility, aging, and wellness interventions through, for example, communal gardening initiatives (Milligan *et al.* 2004) and in the use of fashion as a vehicle for personal narrative (Buse and Twigg 2016). Staff and participants' shared celebration of the therapeutic value of museums further aligns with research acknowledging that the strictures of contemporary Western biomedicine have overall minimised the role of sensory experience (Howes and Classen 2014) and pleasure (Klein 2010) in healing processes (a shift also acknowledged in Hocking's discussion of early occupational therapists). In studying how people account for their therapeutic understandings – and under what social conditions, in which unlikely contexts – sociologists can thus better address blind spots in the systems of health they study.

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Note

1 This article has rewritten any specific passages that appeared in the dissertation, though at times preserved them when rewriting would have distorted interpretation of the data or my argument.

References

American Alliance of Museums (AAM). (2000) Code of ethics for museums. Available at http://www.aam-us.org/resources/ethics-standards-and-best-practices/code-of-ethics (Last accessed 16 December 2016).

American Alliance of Museums (AAM). (2013) Museums on call: how museums are addressing health issues. Available at www.aam-us.org/docs/default-source/advocacy/museums-on-call.pdf?sfvrsen=8. (Last accessed 16 December 2016).

Americans for the Arts. (2015) The national initiative for arts & health in the military. Available at http://www.americansforthearts.org/by-programme/reports-and-data/legislation-policy/the-national-initiative-for-arts-health-in-the-military. (Last accessed 16 December 2016).

American Horticultural Therapy Association (AHTA). (2012) American Horticultural Therapy Association definitions and positions. Available at ahta.org/sites/default/files/DefinitionsandPositions.pdf. (Last accessed 30 June 2016).

Bennett, T. (1995) *The Birth of the Museum: History, Theory, Politics*. New York: Routledge.

Bourdieu, P. (1984) *Distinction: A Social Critique of the Judgment of Taste*. Cambridge: Harvard University Press.

Buse, C. and Twigg, J. (2016) Materializing memories: exploring the stories of people with dementia through dress, *Ageing and Society*, 36, 6, 1115–35.

Callon, M. (1986) Some elements of a sociology of translation: domestication of the scallops and the fishermen of St Brieux Bay. In Law, J. (ed) *Power, Action, and Belief: A New Sociology of Knowledge?* Abingdon-on-Thames: Routledge and Kegan Paul.

Carmel, S. (2013) The craft of intensive care medicine, *Sociology of Health & Illness*, 35, 5, 731–45.

Chatterjee, H.J. (ed) (2008) *Touch in Museums: Policy and Practice in Object Handling*. Oxford: Berg.

Chatterjee, H. and Noble, G. (2013) *Museums, Health and Well-being*. London: Routledge.

Classen, C. (2007) Museum manners: the sensory life of the early museum, *Journal of Social History*, 40, 4, 895–914.

Conrad, P. (1987) Wellness in the workplace: potentials and pitfalls of worksite health promotion, *Milbank Quarterly*, 65, 2, 255–75.

Conrad, P. (1992) Medicalization and social control, *Annual Review of Sociology*, 18, 209–32.

Conrad, P. and Schneider, J.W. (1992) *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple University Press.

Crawford, R. (1980) Healthism and the medicalization of everyday life, *International Journal of Health Services*, 10, 3, 365–88.

Davis, S. (1998) Development of the Profession of Horticultural Therapy. In Simson, S. and Straus, M. (eds.) *Horticulture as Therapy: Principles and Practice*. New York: The Haworth Press, pp. 3–20.

DiMaggio, P.J. (1982) Cultural entrepreneurship in nineteenth-century Boston. Part I: the creation of an organisational base for high culture in America, *Media, Culture and Society*, 4, 4, 33–50.

Gesler, W.M. (1992) Therapeutic landscapes: medical issues in light of the new cultural geography, *Social Science & Medicine*, 34, 7, 735–46.

Goode, G.B. (1896) On the classification of museums, *Science*, 3, 57, 154–61.

Hocking, C. (2008a) The way we were: romantic assumptions of pioneering occupational therapists in the United Kingdom, *British Journal of Occupational Therapy*, 71, 4, 146–54.

Hocking, C. (2008b) The way we were: thinking rationally, *British Journal of Occupational Therapy*, 71, 5, 185–95.

Hondagneu-Sotelo, P. (2010) Cultivating questions for a sociology of gardens, *Journal of Contemporary Ethnography*, 39, 5, 498–516.

Howes, D. and Classen, C. (2014) *Ways of Sensing: Understanding the Senses in Society*. London: Routledge.

Klein, R. (2010) What is health and how do you get it? In Metzl, J.M. and Kirkland, A. (eds) *Against Health: How Health Became the New Morality*. New York: New York University Press.

Kontos, P.C. (2005) Embodied selfhood in Alzheimer's disease: rethinking person-centred care, *Dementia*, 4, 4, 553–70.

Kreski, B. (2016) Healing and empowering veterans in a botanic garden. *Journal of Museum Education*, 41, 2, 110–5.

Laws, J. (2011) Crackpots and basket-cases: a history of therapeutic work and occupation, *History of the Human Sciences*, 24, 2, 65–81.

Levent, N. and Pascual-Leone, A. (eds) (2014) *The Multisensory Museum: Cross-Disciplinary Perspectives on Touch, Sound, Smell, Memory, and Space*. Lanham, MD: Rowman & Littlefield.

Livingston, L., Fiterman Persin, G. and Del Signore, D. (2016) Art in the moment: evaluating a therapeutic wellness program for people with dementia and their care partners, *Journal of Museum Education*, 41, 2, 100–9.

Lupton, D. (1995) *The Imperative of Health: Public Health and the Regulated Body*. Thousand Oaks: Sage.

Mangione, G. (2016a) Making sense of things: access and the therapeutic turn in museum gardens and galleries. Dissertation, Northwestern University.

Mangione, G. (2016b). Making sense of things: constructing aesthetic experience in museum gardens and galleries, *Museum & Society*, 14, 1, 33–51.

Metzl, J.M. and Kirkland, A. (eds) (2010) *Against Health: How Health Became the New Morality*. New York: New York University Press.

Milligan, C., Gatrell, A. and Bingley, A. (2004) 'Cultivating health': therapeutic landscapes and older people in northern England, Social *Science & Medicine*, 58, 1781–93.

National Endowment for the Arts (NEA). (2013) The arts and aging: building the science. Available at https://www.arts.gov/sites/default/files/Arts-and-Aging-Building-the-Science.pdf. (Last accessed 16 December 2016).

Nguyen, V. (2005) Antiretroviral globalism, biopolitics, and therapeutic citizenship. In Ong, A. and Collier, S.J. (eds) *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Oxford: Blackwell.

Rhoads, L. (2009) Museums, meaning making, and memories: the need for museum programmes for people with dementia and their caregivers, *Curator: The Museum Journal*, 52, 3, 229–40.

Rosenberg, F., Parsa, A., Humble, L. and McGee, C. (2009) *Meet Me: Making Art Accessible to People with Dementia*. New York: The Museum of Modern Art.

Scott, C. (2002) Measuring social value. In Sandell, R. (ed) *Museums, Society, Inequality*. London: Routledge.

Silverman, L.H. (2002) The therapeutic potential of museums as pathways to inclusion. In Sandell, R. (ed) *Museums, Society, Inequality*. London: Routledge.

Silverman, L.H. (2010) *The Social Work of Museums*. New York: Routledge.

Smyth, F. (2005) Medical geography: therapeutic places, spaces and networks, *Progress in Human Geography*, 29, 4, 488–95.

Timmermans, S. (2006) *Postmortem: How Medical Examiners Explain Suspicious Deaths*. Chicago: University of Chicago Press.

Timmermans, S. and Berg, M. (2003) *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.

Timmermans, S. and Epstein, S. (2010) A world of standards but not a standard world: toward a sociology of standards and standardization, *Annual Review of Sociology*, 36, 69–89

University College London (UCL). (2016) Museums on prescription. Available at https://www.ucl.ac.uk/museums/research/museumsonprescription. (Last accessed 16 December 2016).

Weil, S.E. (2004) Creampuffs and hardball: are you really worth what you cost or just merely worthwhile? In Anderson, G. (ed) *Reinventing the Museum: Historical and Contemporary Perspectives on the Paradigm Shift*. Lanham, MD: Altamira Press.

Zola, I.K. (1972) Medicine as an institution of social control, *Sociological Review*, 20, 4, 487–504.

Zola, I.K. (1991) Bringing our bodies and ourselves back in: reflections on a past, present, and future 'medical sociology', *Journal of Health and Social Behavior*, 32, 1, 1–16.

Zolberg, V. (1992) Barrier or leveler? The case of the art museum. In Lamont, M. and Fournier, M. (eds) *Cultivating Differences: Symbolic Boundaries and the Making of Inequality*. Chicago: University of Chicago Press.