Beyond the Frame: An Analysis of Museums as Therapeutic Spaces for Persons with Alzheimer’s Disease

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Abstract

The average lifespan of a person in the United States is increasing, along with population. This has a direct effect on the number of persons with Alzheimer’s disease and other dementias. Since Alzheimer’s disease currently has no cure, alternative therapy programs are more important than ever. This paper addresses the idea of museum therapy, particularly the success of museums as therapeutic spaces for persons with Alzheimer’s disease. Literature on museum programming provided a set of criteria for evaluation of these spaces. They are: layout, patient-care provider bonding, visual elements, interactive elements, and shared experiences. This paper uses those criteria to evaluate three art museums in Madison, WI: the Chazen Art Museum, Madison Museum of Contemporary Art, and Madison Children’s Museum. Interviews with program directors were also conducted, along with observations of a support group for persons with Alzheimer’s disease. The spatial analysis was enlightening and concluded that, while the two existing programs are housed at the Madison Children’s Museum, both the Chazen Art Museum and Madison Museum of Contemporary Art have a much higher potential as therapeutic spaces. In addition, this project found that museum staff is generally very interested in programming for persons with Alzheimer’s, but there is a lack of knowledge and training in how to create and implement these programs.

Introduction

As of 2012, 36 million people worldwide suffer from some form of dementia. By 2050, this amount is expected to triple (Chancellor 2013, 1). For a disease with no cure, this is a tragedy. Much research has been done on alternative therapies that give dementia patients, specifically those with Alzheimer’s disease, an improved quality of life. These therapies include art therapy: relief through creating art, and museum therapy: relief through viewing art. For our
research, we acknowledge the potential for success of art and museum therapies and attempt to understand what the missing links are between this research and implementation of programming.

**Key Concepts**

**Alzheimer’s Disease**

Alzheimer’s disease (AD) is a form of dementia in which there is progressive deterioration of brain function due to the death of brain cells. Alzheimer’s is a distressing disease for patients and their families. Although AD is known mainly as loss of memory, neuropsychiatric symptoms include apathy, depression, delusions, hallucinations, aggression, psychomotor agitation, inappropriate sexual behavior, and sleep impairment (Chancellor 2013, 2). These symptoms increase over time and worsen quality of life as the brain degenerates. There are no treatments to stop or reverse Alzheimer’s disease, so interventions to improve quality of life are of main interest. Three types of interventions are medication, lifestyle changes, and therapeutic activities.

In the area of medication, there has been limited success with cholinesterase inhibitors. These drugs work to boost levels of acetylcholine, a cell communication chemical depleted by AD. If the inhibitor works, patients’ symptoms can be delayed for 6 to 12 months. However, less than half of patients taking the drugs have any improvement (www.alz.org). Even if the drug does work, once the symptoms come back, it will not work again. For patients who are in the later stages of Alzheimer’s or those whom the drug does not work on (and in addition, for those it does), doctors prescribe lifestyle changes and therapeutic activities to improve quality of life.
Regular exercise and healthy eating are a good part of any person’s lifestyle, and Alzheimer’s patients are no exception. Walking and performing other light exercises daily can improve mood and promote restful sleep, as well as maintain general health. In addition, there has been a lot of research and success in various art therapies. Music, art creation, and museum therapies have all had marked success in improving quality of life for persons with Alzheimer’s disease (www.alz.org).

**Art as Therapy and Emotional Well-Being**

In this paper we focus on art therapy, specifically museum therapy and interactive programs. Art can be especially beneficial to persons with Alzheimer’s disease. Studies have showed an increased appreciation for art as well as increased artistic skill as the frontal lobe degenerates (Schott 2012, 1960-1961). Art has also been shown to improve the emotional well-being of persons with Alzheimer’s disease. Kinney and Rentz (2005, 221) define emotional well-being by 6 categories; interest, sustained attention, pleasure, negative affect, sadness, and self-esteem. In a study by these authors, they observed the well-being of individuals engaged in Memories in the Making, an art program, sponsored by the Alzheimer’s Association, for patients with Alzheimer’s that encourages self-expression through the visual arts. They then observed the same people participating in more traditional senior center activities including crafts. The results showed a more positive well-being during Memories in the Making (Kinney, Rentz, 2005, 221). This is especially interesting because it shows a difference between making crafts and creating art while encouraging self-expression. As the effects of Alzheimer’s disease include difficulty expressing oneself (Chancellor 2013, 2), any activity that encourages self-expression through alternate means has the potential to improve a patient’s well-being.

**Museum Therapy**
Much research has been done on making art as therapy, but recent research is now focusing on art appreciation as therapy. Alzheimer’s disease produces some dysfunction in emotional processing, but preserves basic emotional processing and expression until very late in the disease. For example, a study was done asking patients with Alzheimer’s disease to rank paintings according to their own preferences. Although they did not remember the paintings two weeks later, when shown them again, patients ranked them in the same way (Chancellor 2013, 9). This shows that persons with Alzheimer’s disease still have the capacity to enjoy and appreciate art. There are programs where museums use this appreciation to create a therapeutic experience for Alzheimer’s patients. One reason museums work so well is they are non-stigmatizing settings: they are not health institutions where diagnosis and treatment occurs. People experience no shame or criticism for attending a museum, and can be encouraged to learn about themselves and the world around them (Camic, 2013, 67-68). Another reason art therapy works, especially museum therapy, is the concept of reminiscence. As Gellis states, reminiscence assists people with dementia in connecting with and verbalizing the past through the use of memory aids like photos and personal objects (Rhoads, 2010, 230). Museums and the memories, feelings and emotions triggered by art allow persons with Alzheimer’s disease to more easily reflect on the past and present. These ideas both differentiate museums from many typical spaces for therapy.

One Alzheimer’s therapy program is called Meet me at MoMA. The largest program of its kind, Meet me at MoMA is housed at the Museum of Metropolitan Art in New York City. The program consists of 90 minute monthly sessions where groups of 7-8 patient/care provider pairs discuss four or five works of art (MoMA). A study of this program found that early stage dementia patients had improved mood and self-esteem. Improved mood lasted days
for 55% of patients, and improved self-esteem lasted days for 27% (Chancellor 2013, 9). The Meet me at MoMA program is part of a larger Alzheimer’s project at MoMA, sponsored by MetLife. Another part of the project is the guide MoMA has produced for other museums to start their own programs (MoMA). The Guide for Museums has instructions from designing to staffing to planning and executing a museum program. It has provided a wonderful base for us to evaluate museums upon.

The Meet Me at MoMA program is strictly about viewing art, but some programs have had success incorporating interactive elements as well. A program at the National Museum of Liverpool in the United Kingdom is doing just that. The House of Memories program incorporates guided tours of the museum along with a “memory suitcase”. This novel concept involves persons with Alzheimer’s being able to take museum items home with them for up to two months. Some past items have included Liverpool Railway posters, books, and memorabilia (National Museum of Liverpool, 2012). In this way, patients in the early and mid-stages of Alzheimer’s can exercise their memory with the aid of the objects they take home in the Memory Suitcase. As previously stated, any chance to form connections is an opportunity to increase a person’s well-being. The National Museum of Liverpool (NML) has said, “House of Memories is about joining the dots that link us through our life experiences, our dreams and our shared histories. The programme demonstrates how a museum can provide the health and social care sector with practical skills and knowledge to facilitate access to an untapped cultural resource; often within their locality (National Museum of Liverpool). In addition to providing evidence for the success of interactive activities, House of Memories also provides guidelines for a training program for caregivers. In an evaluation of their program, the NML discovered less than 45% of care providers believed they had the necessary skills to deliver memory activities in their care.
settings before the training program. After the training, 89% of care providers, almost double, reported confidence in their skills (National Museum of Liverpool, 2012, 29). By assisting the patient and care provider, House of Memories provides an example of a much more comprehensive museum therapy program.

These programs provide a glimpse into the future of museum programming. As more and more people develop dementia and Alzheimer’s disease, museum therapy programs will be more and more important. We will be focusing on Madison, WI as a case study for implementing these programs.

**Site Setting**

Our research is focused in on the museums and persons with Alzheimer’s disease in Madison, WI. There are more than 10 different museums in Madison, WI, but we focused in on the three art museums located in the city (See Figure 1). The first is the Chazen Art Museum, created to exhibit works of art and present educational programs in support of the teaching, research, and public service mission of the University of Wisconsin-Madison (www.chazen.wisc.edu). The second is the Madison Museum of Contemporary Art whose mission is to provide a forum for the exchange of ideas about art and offer programs to enhance the appreciation and understanding of art (www.mmoca.org). The final museum is the Madison Children’s Museum. Though not specifically an art museum, the Children’s Museum
encourages creativity and discovery through art, as well as provides a program for those with Alzheimer’s and Dementia. These museums, all within walking distance of each other, will provide a well-rounded look into different types of art and viewing experiences.

**Methods**

To attempt to further understand museum therapy and the struggles behind implementing such programs, we will be conducting observational research as well as interviews. We will be working with qualitative data. The observational research will be done at the three museums (Chazen, Madison Contemporary Art, and Madison Children’s), to evaluate their capacity to succeed as therapeutic spaces for persons with Alzheimer’s disease. The interviews will then be completed to gain a more holistic view of museum therapy from patient to care provider to museum staff.

**Observation**

To evaluate these museums, we have established a criteria based on previous research and the Museum of Modern Art (MoMA) Alzheimer’s project guide for museums. These are aspects that need to be in place for the ideal Alzheimer’s museum program to occur. We will be taking notes as well as photographs at each museum. By photographing museum layout and design, we will be able to step back from the experience and evaluate more critically (Johns, Phillips, 2012). See one example of a layout photograph taken at the Chazen Art Museum in Figure 2. We will also adopt Raymond Williams's philosophy that, “we learn to see a thing by learning to describe it” (Williams, 1961). In this way, by preparing to present our observations, we expect to refine them. We are observing these museums with the intent of evaluating them as
therapeutic spaces. Our criteria for evaluation falls into 5 categories: Layout, Relationship between patient and Care Provider, Visual Elements, Interactive Elements, and Ability to create shared experiences.

Layout

The layout of the museum is imperative to the success of a possible Alzheimer’s therapy program. When observing the layout of our three museums, we will be imagining possible routes for a tour, and how effective they would be. The area needs to be open and bright, and not loud or busy. The galleries should be easily accessible by ramps or elevators, and there should be comfort factors such as benches and bathrooms nearby (MoMA). This is all about making the museum a relaxing and comfortable place for persons with Alzheimer’s and their care providers. Again, the aim of a museum therapy program is to improve quality of life by promoting the well-being of the patient.

Other beneficial aspects of a museum’s layout have to do with people being able to interact with others, or communicate. Salom describes the different layouts that museums may contain, “Museums provide options: rooms can be explored individually or in unison, quickly or slowly, thoroughly or superficially. Members may attend wings alone or intermingled with the general public” (Salom 2010, 81). These options cause persons with Alzheimer’s disease to use their choice making abilities (Salom 2010, 83). These kinds of options are necessary for persons with Alzheimer’s. The reason for this is
because, with a lack of communication skills, someone with Alzheimer’s will be able to interact with others within these areas, if this is what they choose. Otherwise, if they are uncomfortable, they are able to be in a more secure or private area to reflect on the exhibits alone, or with their care provider.

Space and Patient-Caregiver Bonding

Going along with an easy, flowing layout, we will be looking more specifically at whether or not museum programs facilitate relationships between care providers and Alzheimer’s patients. Museum programs offer the opportunity for persons with Alzheimer’s disease to further bond with their care provider. These care providers can range from family members, in the early stages of Alzheimer’s, to formal care providers in later stages.

Programs within museums, along with the museum environment, facilitate stronger relationships between persons with Alzheimer’s disease and their formal caregiver. When discussing the potential benefits of programming for persons with dementia, Rhoads states, “Beyond joyful moments and enjoyable conversation, museum programs can also provide caregivers ‘a valuable respite—a chance to see their loved ones in a different light, and to socialize with others in the same situation’” (Gascoigne 2008, 234). Caregivers are normally only able to associate with their patients while taking care of them. This normally leads to the patient and caregiver not having a connection with one another, because they are not able to get to know one another outside of “work”. While these caregivers are monitoring their patients during these programs, they are able to see who these people really are. They are able to see these people express themselves, and they learn that these people have a true identity.
Along with bonding with formal caregivers, museum programs are also a way to bond with younger family members who may take care of their relative with Alzheimer’s disease, as well. As Rhoads discusses, there are over 1 million child caregivers, under the age of 18 (Rhoads 2010, 237). Many teens and children volunteer to help their families in taking care of their elders. When taking care of an elder, it is easy to fall into a work-like situation, even when these people are family members. The museum programs are beneficial for this because they give the family members an opportunity to bond, and do something fun together. As Rhoads further states, “Intergenerational programs for these young caregivers and their loved ones can provide a positive experience to share with their care recipient elder. Museums can and should play host to programs designed to nurture the youth-elder dynamic for young caregivers and their loved ones with dementia” (237). Intergenerational bonding is often difficult, due to a variety of different views on subjects. These programs are able to offer new forms of communication, through art and other interactive activities, which create closer bonds within families.

Visual Elements
Color and other different visual elements can be beneficial to museum therapy. Bright colors and dynamic elements engage persons with Alzheimer’s more effectively than muted tones and “static art” (Chancellor, 2013, 2). With paintings, we will be looking for bright images full of contrast to draw the eye in. With sculptures and other media, we will be looking for multiple visual elements to entertain the eye. See one example of a visually engaging painting taken at the Chazen Art Museum in Figure 3.

Interactive Elements

Interactive activities can be a useful companion to the viewing of art. Whether through art creation, like in the SPARK! program at the Chazen Museum, or more abstract interactions like in House of Memories, these extra activities provide more opportunities for a patient to connect to the art. This, again, is the goal of museum therapy programs. Persons with Alzheimer’s disease struggle to express themselves, so making connections and forming shared experiences can give them a relief that improves well-being and quality of life.

Shared Experiences
Perhaps one of the most crucial concepts, and the hardest to evaluate, is the ability to connect through shared experiences. Because museums cannot possibly tailor exhibits to each individual, one way they can do this is through cultural themes. For example, the Chazen Art Museum in Madison had a Midwestern themed exhibit in their gallery at the time of our initial observation. One can assume most people visiting this museum in Madison, Wisconsin have ties to the Midwest. See Figure 4 for an example from the Chazen Art Museum. Cultural themes such as this allow the patients to connect more to the pieces of art. Because a person with Alzheimer’s is struggling to express him or herself and their frustrations with memory loss (especially in the early and middle stages), feeling a familiarity with a piece of art can be beneficial to their emotional well-being. Another way to foster shared experiences is to select works of art around a broad theme such as identity and community, landscapes, or identity (MoMA). By using a broad and engaging theme, more people are likely to make connections as well. Ability to have discussion, whether facilitated by a docent or just between care provider and patient, is encouraged as well.

We note that two of the three museums do not currently have programs so our evaluations will be based upon the potential for different aspects of museum therapy.
By evaluating each museum based on the above criteria, we hope to have a better understanding of the challenges preventing museums from creating successful Alzheimer’s programs. We also will see where museums could succeed with these programs, and why existing ones are so effective. Observing these museums will inevitably create more questions as well as answers, so we plan on interviewing many different people involved to answer those questions.

Interviews

Our interviews will be a crucial part of tying the above-mentioned research together. We have already determined the validity of museum therapy and programming. By interviewing, however, we will gain first-hand, thus more personal, knowledge about the success or failure of these programs. In addition, we will have already evaluated several museums as therapeutic spaces, but the interviews will enlighten us as to why certain choices are made or not made. We expect, as well, that through our interviews, respondents will raise issues we have not addressed. (Valentine 1997, 199). This will provide for a more comprehensive conclusion.

We have identified 4 different actors involved in museum therapy programs. There are the Alzheimer’s patients, their care providers, museum directors, and healthcare professionals. We will be asking interviewees four to six questions based on which actor he or she is. To keep consistency in our research, all interviews will be semi-structured and asking mainly opinion and structural questions with leading tags (Dunn 2000, 104). These question sets will be tailored to fit each actor.

Persons with Alzheimer’s Disease:
For those with Alzheimer’s disease, we are asking questions that relate emotions to the museum experience.

1. Do you enjoy going to museums? Why or why not?

2. What kinds of museums typically interest you?

3. Do you find it relaxing to go to museums? Why? Or why not?

4. Do you create your own art? (If so) Could you tell us about that?

5. Would you enjoy museums more, or be more likely to go to them, if there were programs available for you to create your own art as well as view it?

Care Providers:

The care providers provide a unique perspective as participant and observer of museum therapy. Depending on the stage of the person with Alzheimer’s disease, the care provider can be anyone from a family member, to medical personnel. We will be asking about personal accounts of museum program experiences, and about the limiting factors holding back museum therapy.

1) Do you think museums are therapeutic to the person you care for? Why or why not?

2) What aspects of the museums, do you think, are most therapeutic, if any? In what ways are they therapeutic?

3) Have you participated in any museum programs or gone to a museum with (person’s name)?

4) Did you see any positive change afterward? How long did it last after the visit?

5) Has anything kept you from visiting a museum?

Museum Directors:
We will be specifically focusing on education curators, program leaders, and overall exhibit curators. This will lead us to possible factors that may affect why a museum may or may not be set up logically for the mind of someone with Alzheimer’s disease.

1) (Program Directors) What made you want to begin a program like this?
2) (Program Directors) Could you tell us more about your program?
3) Do you see your museum creating programs for people with Alzheimer’s/dementia in the future?
4) Why do you think most museums do not offer programs for these people? What kind of limiting factors are there?
5) Have you ever observed someone with Alzheimer’s, in your museum? Could you tell me about what you observed?
6) Do you see any potential for health and museum professionals to develop an Alzheimer’s therapy training program for museum tour guides and care providers?

Healthcare Professionals:

We will be focusing on two kinds of health care professionals. The first being neurologists, because they study disorders having to do with the brain. The second being psychologists, because they are able to explain more about the emotional well-being of a person with Alzheimer’s disease.

1) Do you see Alzheimer’s as becoming an epidemic?
2) Are you aware of the museum programs being provided for persons with Alzheimer’s disease and dementia?
3) What do you think of using museums as therapy/non-drug alternative for persons with Alzheimer’s disease/dementia? Do you believe they help with communication? Or help to keep the brain more active?

4) Would you recommend or have you recommended museum therapy to a patient?

5) Are you aware of any programs in the Madison area?

6) Do you see any potential for health and museum professionals to develop an Alzheimer’s therapy training program for museum tour guides and care providers?

By structuring these interviews with open-ended questions, we hope to have a good idea of what each actor’s role is in museum therapy programming, how they perceive their role, and how we might overcome the barriers to creating Alzheimer’s programs in museums across the country. In order to get the most out of the research, our interviews of patients, care providers, and museum staff will be done after or at the same time as our site visits. Once the interviews are completed we will perform latent content analysis, searching for recurring themes in the interviews (Dunn, 2000, 104). This will allow us to compare and contrast the various interviews, especially between our different actors. It will also allow us to succinctly summarize the interviews for presentation.

**Results**

**Interviews:**

We conducted four interviews, and have included the full transcripts below. We have created a word cloud from the interviews to more easily understand the commonalities all shared (See Figure 5 below). Words like “people”, “programs”, “time”, and “training” all stood out.
However, we found distinct differences between each interview, and between categories of interviewee. Richard Axsom and Sheri Castelnuovo are both curators at the Madison Museum of Contemporary Art (MMoCA) and their interviews could not be more different. Axsom is head curator at MMoCA, and doesn’t see a place for Alzheimer’s programs in his museum. He does not think Alzheimer’s programs are the business of an art museum, but better left to those with training in a more medical setting. Castelnuovo, curator of education also at MMoCA, feels very differently. She states that the museum is looking into programming and has already sent a staff member to a conference on Alzheimer’s and Dementia this year. She believes that an art therapy program for persons with Alzheimer’s could work very well at MMoCA given its minimalistic style and controlled elements. She believes enthusiasm is abounding for a program like this, and the only thing limiting its creation is a lack of time. This distinct difference between two curators at the same museum is important, and why we have decided to present the interviews separately as well as aggregated in the word cloud.

We also interviewed Angela Johnson, the head of the SPARK! program at the Madison Children’s Museum. She is the only program director we will be interviewing. In this interview, we were able to gain a more human perspective on these art therapy programs and why care providers and persons with Alzheimer’s disease attend them. Johnson believes the limiting factor to success of a program is simply that it is unknown. She believes that if museum staff knew how simple the training was, they would be very interested. This is a cause that many people can really get behind. “People who are vested are really vested.” Johnson’s interview will be an important link between the museum staff interviews and the care provider/PAD interviews and Meeting of the Minds observations.

The fourth interview we conducted was with Master’s candidate as the University of Wisconsin Madison, Angela Hronek, who previously worked at the Shelbourne Museum in Vermont with early to mid-stage Alzheimer’s patients from local memory care facilities. She designed and led tours based off of the MoMa model. When asked what the most important aspect of the museum layout is for their guests with Alzheimer’s diseases, she believes that it is accessibility, which tends to most often be an
issue. Having enough space, brightly lit rooms, and minimal distractions are all important factors to take into considerations as well for giving successful tours to persons with Alzheimer’s disease.

Because this data is qualitative and discrete, most of our analysis will be interview-by-interview in the body of our paper. We have assembled the word cloud, but other than that we will be mainly pulling direct quotes, summarizing interviews, and fitting them into the narrative from persons with Alzheimer’s to care providers, to medical staff, to program directors, to museum staff. We will attempt to tie all of these “characters” together in a compelling chain that shows cooperation is necessary to the success of art therapy programs and what role each one has in the process from training to implementation to ultimate success.

![Figure 5](image)

This word cloud has been created using the frequency of words from our interviews. (Source: wordle.net)

Observations:

To get a sense of how general programs for persons with Alzheimer’s disease are formatted, we attended multiple gatherings of Meeting of the Minds. We made observations on the spatial/setting component and also the content (topics of discussion, informal answers to our questions, attitudes of participants). To easily portray the setting of the two meetings, we drew a diagram of both spaces. For
the content, we have compiled our observations below. These will be incorporated into our paper to further illustrate how space and place play a part in emotional well-being, especially in those with Alzheimer’s disease. In addition, we will address our evaluation of the three Madison art museums by creating three unique schematic diagrams of each museum’s layout. These are currently in the very early, mostly conceptual stages so they are not included in this paper. These will be our “original graphics”, and will be our basis for analysis of each museum’s effectiveness or potential effectiveness as a space for Alzheimer’s therapy programs. For now, our data collection has focused on collecting data as to why and how museums are effective spaces for Alzheimer’s therapy. This will be compared and contrasted to the information we gathered in our literature review. At this moment, the data we have collected mostly reinforces the research, with a few exceptions and additions. For example, in our observation of one Meeting of the Minds gathering, we observed the attendees make the choice to critique the painting. This showed that they truly enjoyed talking about and viewing art. Though hardly an appropriate sample of an entire population, this is still important to note, and encouraging to see for the purposes of our research.

*The Alzheimer’s and Dementia Alliance’s Meeting of Minds*

The Setting

The Alzheimer’s and Dementia Alliance, gathers once a week for Meeting of Minds. This meeting consists of anywhere from 4 to 12 people, per gathering. The setting is explained in diagrams 1 and 2. The rooms in which these meetings are held are very basic, and similar to conference rooms. The way that the group members gather is the same in both rooms, because the people are seated around a large table for everyone to be heard, but there are also differences between the rooms.

The first meeting room is dull, with a gray color scheme, and with the people in the meeting as the focus. This room is much easier for the persons with Alzheimer’s disease, because the chairs are able to move more simply. This is beneficial to the elderly, because they
do not have to lift and move the chairs to sit down in them. There are no windows in this room, and there are around 6 framed pieces of art on the walls, none of which contain bright colors (Diagram 1).

The second meeting room contains much more color than the previous room. The room also resembles a person’s home, with larger chairs, old clocks, wooden cabinets, a mahogany table, and a large window (Diagram 2). Many of the group members commented on this meeting room. Most of the comments revolved around the scenery outside the window. The members enjoyed being able to look at something, like the trees outside, rather than being surrounded by blank walls. Although this room seemed to grab the attention of everyone, there are less seats within the room (10), and everyone is seated much closer than in the previous room. These people know each other well, which did not appear to make the closeness uncomfortable.
Group Member Observations

We sat in on a series of these meetings. There are things that we observed, along with questions that were asked to the group members. These observations included the members analyzing paintings, speaking about museums, and their thoughts on museum programs.

In the first session of Meeting of Minds, after a few other activities (trivia, discussing what they were thankful for, and some light tai chi), the group members critiqued a painting. They were given the choice between critiquing the painting and playing some word games, but the group unanimously decided on the critique. The painting being critiqued was *Washington Crossing the Delaware*, made in 1851, and painted by Emanuel Gottlieb Leutze. The members discussed their opinions of how the people in the painting probably felt. They each made their own stories involving the characters in the painting. Things that were discussed include: The ice
on the river, the uniforms, how cold the soldiers must have been, what the soldiers were thinking at the time, and the location.

The second session, the members discussed more about museums, and their thoughts on the programs. The discussions ranged from their enjoyment in going to museums, to the problems within the programs. These subjects were discussed among the group members, along with the group leaders who were able to add in suggestions they had received from past members.

When discussing if they enjoy going to museums, many members agreed that they do enjoy them. There were some group members who remain partial to the idea of museums, but generally, most of the member claimed to enjoy them. Out of the museums that interest them most, art museums appeared to be the top choice.

When speaking of the programs, like SPARK! and the Meeting of Minds art program, the group leaders and the group members discussed the positive and negative attributes, along with the necessary components in creating a successful program for these people.

Unfortunately there is not a great amount of positive feedback on the museum programs, themselves. The group members discussed how they enjoy critiquing art much more than creating art. They believe that looking at the artwork is “good cognitive stimulation.”

There are a great amount of negative attributes within the programs. As of now, the group feels that the Madison Children’s Museum is not the best place to have these programs. The amount of children overwhelms members, and is often very loud, making it difficult to concentrate. Another negative attribute is that the current studio is too small. The program can only be offered to around 10 people, which has caused them to have to narrow down their list. Along with this, the group leaders believe that persons with cognitive handicaps should not be in
smaller areas like this because they can feel closed in. The negative that is most agreed on involves accessibility. The parking is a large issue for the people involved in this program. Currently, they are not able to park for free, and they may need to walk a greater distance than they should have to. Another problem associated with this is that many caregivers are responsible for driving the group member to and from these areas. This cannot only disrupt the caregiver’s life, but this can also be difficult for the person with cognitive issues. The reason being is that their routine may be disrupted if their caregiver is not able to pick them back up in the same location every week.

For museums, there are many necessary components when developing programs that may be considered as limiting factors. These components include proper training, assessment of future group members, and time.

Instructors of the group meetings must be appropriately trained to provide a successful experience for the participants. They are trained to work with people who have cognitive disabilities with an emphasis on memory loss. Throughout this instruction they are taught how to work with person with Alzheimer’s disease and dementia and how to create a suitable learning environment for them. For instance, everything should be taught at a slower pace and directions should be separated into steps and these steps should be visually listed for them to see. Every meeting should be conducted similarly for the members to create a comfort level. By doing routine activities each meeting, persons with Alzheimer’s disease or dementia grows accustomed to performing these weekly tasks.

The group leader of Meeting of Minds often meets with the group member or the caretakers to assess whether or not the program is suitable for them, along with if the program is
something the person wants to commit to rather than the caregiver. This assessment evaluates if the person is right for the program.

The last major factor for these programs is time. The directors and instructors of these programs need a large amount of notice before beginning the programs. This time allows them to find members to join. Programs need time to contact the public, and advertise what their program is about.

**Findings**

From assessing our three museum sites, we have evaluated five elements of the museum: layout, space & patient-caregiver bonding, visual elements, interactive elements, and shared experiences. Based on our evaluations we have determined which of these categories are positives or negative attributes to each of the three museums for a persons with Alzheimer’s disease.
The Chazen Museum of Art provides for plenty of space for easy conversation with seating for guests to rest. Although there is a lack of interactive elements, the artwork is colorful and varied in subject, allowing for guests to engage in shared experiences.
Madison Museum of Contemporary Art is an open space for persons with Alzheimer’s disease to engage in interactive elements at a learning center, while still providing a partition for more private areas as well to enjoy the large, colorful exhibits. Although this space provides no benches or seating, it is wheelchair accessible for guests.
The Madison Children’s Museum art studio is just that: a studio. It is designed for
children mainly to create art in, and thus is not ideal for museum therapy programs. The walls
are covered in murals, not individual art pieces to view and discuss. In addition, it is crowded
with tables and chairs, and not easily navigable for the elderly. For these reasons we found the
Children’s Museum to have the least potential as a therapeutic space.
Although the Madison Children’s Museum houses both Alzheimer’s therapy programs in Madison WI, the Chazen Art Museum and Madison Museum of Contemporary Art have more potential as therapeutic spaces. Positive attributes to a therapeutic space include, adequate space and minimal stimuli, plenty of art to discuss, and the persons with Alzheimer’s disease must be willing to attend.

**Future Research**

Due to time and monetary constraints, our research results were fairly narrow in scope. Ideally we would have interviewed people in every step of the program implementation process. This would have included persons with Alzheimer’s disease, care providers, staff at the Chazen Art Museum, and health care professionals. Given additional time, we would expand the project to other types of museums as well as outside of Madison, WI.

**Conclusion**

Through the literature research we have done, and the observations and interviews we conducted, we have gained an understanding of what museum therapy can mean to a person with Alzheimer’s disease, and why programs like SPARK! and Meet Me at MoMA don’t exist in more museums. We have presented our museum evaluations along with our interviews and determined the potential for success of museum therapy programs as well as remaining obstacles. With a new perspective on these limiting factors, we hope to shed light on the existing programs and inspire and enable other museums to create programs of their own. Throughout our research we remembered this quote by Nelson Graburn about the museum. “It is a place of peace and
fantasy where the visitor can escape the mundane… world” (Fears, 2011, 11). Persons with Alzheimer’s disease deserve the same feeling of peace, and they can now achieve it through museum therapy programming.

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Appendix

Interview 1

Richard Axsom- Curator at Madison Museum of Contemporary Art (MMoCA)

Do you see your museum creating programs for people with Alzheimer’s in the future?

Not necessarily actually, probably not at all. It wouldn’t be our mission. Our mission is to present contemporary art.

Why do you think most museums do not offer programs for these people?

It’s not our business. It sounds like something a clinical would do. It’s comparable for doing a show for the blind. It sounds more medical and not historical. I have no direct experience, so I am not equipped to understand what an Alzheimer’s patient needs.

Limiting factors?

If we had money for additional programs, we still wouldn’t go in that direction. It is a role of different institutions, but still a role that could be played. Why not do it for the blind? Why not do it for attention deficit? Or tuberculosis?

Do you believe museums have the potential to benefit persons with Alzheimer’s disease?

No more so than the general public or people with other ailments. Art can soothe the human soul and is available to everybody. Not all the demographic can be an art going audience, but this can be a catch to get them to go to an art museum. Any art can trigger a memory. “GO ART!” Men
and women in the arts live longer, engage longer and live life on a more creative level. It keeps you engaged actively (I just take 2 aspirin and C in the morning).

Interview 2

Angela Johnson - Head of SPARK! Program at Madison Children’s Museum

What made you want to begin to train in this program (SPARK!)?

In WI and MN we received the Helen Bader grant, and it wasn’t called SPARK! before 2010. Usually there are no planning grants in museums. We got sent to train at MoMA and got to take that knowledge and tailor it to our own museum. We have to go through training to be a SPARK! museum. During training, we also visited the Metropolitan Museum of Art and American Folk Art Museum and used this knowledge to tailor it back to form SPARK! alliance. The 2nd annual conference is also in Madison next year. This will be a chance for caregivers to learn more.

Why do you think most museums do not offer programs for these people?

People don’t realize once you have the training, how easy it is to adapt. The thought to do one more thing can be overwhelming. The museums that are ‘SPARK! museums’ are very heavily vested. “People who are vested are really vested.” The unknown can be too much on their plate.

Do you believe museums have the potential to benefit persons with Alzheimer’s disease (or dementia)?

It can often be an opportunity for an outing after a diagnosis. Caretakers may not take them out much, or they don’t always know their resources. Their circle of people may narrow. It won’t obviously cure anybody. We make sure to shake their hand, look them in the eye, call them by name. This validates people. We don’t ask what color things are. We ask them how different things make them feel. Programs where caretakers come, they learn things about each other and help families come together.
Have you ever observed someone with Alzheimer’s, in your museum? 
Most volunteers are older and you can’t tell who is who, so sometimes you can’t tell. Different things engage people. Engaging the people’s home lives and past takes them back to a different time and place; not as much as reminding or remembering.

Interview 3

*Sheri Castelnuovo* - Curator of Education at Madison Museum of Contemporary Art (MMoCA)

What is your role as curator of education? What kinds of programs do you currently have at the museum?
I am responsible for educating and “bringing in” people from preschool age to older adults. I will email you a complete list of our many programs.

Do you see your museum creating programs for people with Alzheimer’s/dementia in the future?
Hopefully. I have been contacted by a local Alzheimer’s support organization about starting some sort of program, I think it was the Alzheimer’s Association of Madison. This is just in the early stages, it is only a conversation right now. One of our MMoCA staff members was just sent to Alzheimer’s/Dementia conference in Racine, WI to learn more. The Museum is currently working on a long range planning process for the next 3 years, and we are talking about how programs for Alzheimer’s/Dementia patients work into the future [of the museum].

Why do you think most museums do not offer programs for these people? What kind of limiting factors are there?
TIME!! This museum (and most other museums) already has a full schedule. How to fit that in, how to find staff time, how to find time to train docents and how to plan/create programs are all big issues. Outreach is also an issue, this is a difficult demographic to reach out to. We would have to reach out mainly to memory care facilities and organizations like the one that has already contacted [MMoCA]. It is definitely NOT for lack of knowledge and interest, I want to be very clear on that. There are so many people who would love to be involved and would be passionate about a program like this.

**Have you ever observed someone with Alzheimer’s, in your museum? Could you tell me about what you observed?**

No. I have seen several senior citizen groups, but not noticed any of those individuals with any apparent cognitive disorders.

**Do you see any potential for health and museum professionals to develop an Alzheimer’s therapy training program for museum tour guides and care providers?**

YES! So many people would be interested, and volunteers/docents would benefit from the experience as well. This is such an exciting time, there is a noticeable change in our thinking of Alzheimer’s disease as well as other mental illnesses. It is not as limiting, and we can still acknowledge and celebrate the individual.

**How well equipped do you think this museum is specifically for an Alzheimer’s therapy program?**

Contemporary art especially good for free association, spurring individual expression through those associations. This museum also caters to the needs of the guest… it is handicap accessible, has little stimulation besides the art, and is very open and spacious. We also can bring in other sensory experiences to the galleries, such as music! We also have a classroom here where
interactive art-making activities can occur and already do for some of the school-age and family programs. In addition, groups are able to come in during hours closed to public, we also already does this for some programs.

Interview 4

*Angela Hronek- MA Candidate in Art History, University of Wisconsin at Madison*

In your work, what aspects of a museum’s layout are beneficial/not beneficial to persons with Alzheimer’s disease while visiting a museum? Also, if there were any other experiences you would like to share.

Accessibility was a huge concern with our Alzheimer's groups. The museum I worked at (http://shelburnemuseum.org) is on a campus with about 40 different buildings, some historic (so with stairs, dim lighting, no bathrooms), that all house different parts of the collection. They are connected by gravel pathways. It was not ideal for these tours! Usually we did not allow vehicles besides our own shuttle on the museum grounds, but for these tours we allowed the facilities to drive their own shuttles right up to the building we would be touring. We began the tours before the museum opened to the public and often closed galleries for them so that noise and distractions would be minimal.

We usually had 3 or 4 pieces that we wanted to talk about during a one-hour tour. We only showed artwork that was large enough to see from a distance, and always set up chairs so that the people with Alzheimer's could sit. Actually, I always tried to have enough chairs so that we all
could sit so that it wasn't them sitting and us (museum and nursing home staff) all standing, staring at them, which I thought was really uncomfortable. One of the most frustrating things for Alzheimer's patients and, really, everyone who visits an art museum is that you can't touch the pieces. We always tried to have some tactile handouts.

In terms of the way the space was laid out, elements that are universally accessible (wide corridors, artwork at eye-level, good lighting, comfortable temperature) worked well for these tours. In addition to Alzheimer's, many of the participants had age-related vision or hearing loss so we needed to accommodate for that. We also learned that too much stimulation could be distracting. We had a fashion exhibition with a "runway" displaying dresses...there were mirrors all over the walls and probably 20 dresses on mannequins in the gallery. It was really difficult to focus on one piece at a time and, after that, we tried to visit more "low-key" galleries. As education staff, we really didn't have much control over the layout of exhibits. The curators chose how they were organized and we worked within those limitations for these tours.