Feeling at Home in the World through Art

Exploring possibilities for an intervention in a museum for depression

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"Art as only art is powerless in the real world."

-- Suzi Gablik

Summary

This research explores the possibilities for an intervention in a museum for people with a major depressive disorder (MDD). A literature review of relevant studies in cultural theory, philosophy, mental healthcare and cognitive neuroscience, combined with qualitative interviews with museum and mental healthcare professionals revealed that engaging with visual art in a multisensory way in a guided conversation has the potential to contribute to the participants' wellbeing. MDD symptoms such as a decreased interest or pleasure, social withdrawal, a feeling of emptiness, rationalisation and overthinking could be eased or decreased. This could be achieved by, firstly, providing an encouraging and inspiring safe space with the focus on personal significance, self-worth and empathy instead of proclaiming societal value, functionality or achievements – features that come from an ableist external pressure and impose a limited understanding of the self. Secondly, as people with MDD experience difficulty in finding meaning in life, a key aspect of the intervention should be meaning making. Not meaning in the sense of objectified, rational, factual knowledge, but of the personal significance and understanding that people experience in relation a situation, object, or others, which is directly related to their physical, sensory and emotional reactions. That is, meaning making is a dynamic sensorimotor process, and from the perspective of the embodied, embedded and enacted mind mental processes are intrinsically related to the specificity of the body, the environment, and acts from the body on that environment. Engaging with art could be a motivator for people with MDD, who are stuck in their heads through rationalisation and overthinking, to reconnect with their sense-experience and notice that to be a valuable source for meaning, or, for 'feeling at home in the world'. An intervention could stimulate identification, recognition, imagination and wonder, resulting in a feeling of care. On a broader scale, a specialised initiative regarding MDD could instigate a movement of implementing mental healthcare in the social agenda of museums as part of following the UN Convention on the Rights of Persons with Disabilities, and, vice versa, to starting an integration of the perception of art in a museological setting in mental healthcare.

Key Words: depression, mental healthcare, inclusive museum, meaning making, relational dynamics, sense-experience, empathic identification, disenchantment and reenchantment, neuroplasticity, 4E theory.

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CHAPTER 1 Introduction

§1.1 Introducing the topic

On 14 July 2016 the Convention on the Rights of Persons with Disabilities (CRPD) by the United Nations was ratified in the Netherlands. Due to this convention fundamental laws regarding human rights were modulated. The government now has more ground to improve and safeguard the position of people with disabilities, by strictly reprimanding discrimination and thoroughly ensuring the accessibility of public places and common goods and services.[1] As museums fall within this territory, the CRPD made sure that accessibility and inclusivity became a pressing point on the agenda of Dutch museums, in the form of policy, architectural adaptations and specialised programming. Institutions such as the Van Abbemuseum, Stedelijk Museum Amsterdam, Kröller Müller Museum, Van Gogh Museum, and Drents Museum – to name but a few – provide specialised programs for, for instance, people with visual or auditory impairments, Alzheimer's disease, or aphasia.[2] These are realisations of the purpose of the CRPD, which is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." [3] Studio-I, a platform for inclusive culture, is an important actor in accomplishing accessibility in museums, and is at the forefront of sustaining the contemporary movement towards inclusive museums.[4]

The CRPD target group is defined as follows: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[5] Despite the fact that mental impairments are included in the definition of persons with disabilities, the museums do not focus that much on mental health (yet). Meanwhile, in mental healthcare ideas on the therapeutic effects of art are present in the form of creative or art therapy. This form of therapy, in which visual art has a prominent role, has been developing since the beginning of the 20th century. Art fulfils the function of stimulating expression and creativity. It is about the *making* of art and reflecting on that process, not necessarily the *perception* of it. Nowadays there are upcoming museum projects that involve art therapy, particularly in the United Kingdom and United States, but these too mainly revolve around

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[1] Relevant Dutch laws that the CRPD concerns are: Article 1 of the Constitution, Equal Treatment on the Basis of Disability or Chronic Illness Act (WGBH/CZ), Societal Support Act (WMO 2015), Suitable Education and Participation Act. Source: Schelvis et al. (2017): 85.

[2] 'Special Guests', on: https://vanabbemuseum.nl/educatie/special-guests/blinden-en-slechtzienden/; 'Spraakmakend Van Abbe', on: https://vanabbemuseum.nl/educatie/special-guests/afasie-programma/; 'Doven en Slechthorenden', on: https://vanabbemuseum.nl/educatie/special-guests/doven-en-slechthorenden/; 'Prikkelarm Museumbezoek', on: https://vanabbemuseum.nl/educatie/inclusie/prikkelarm-museumbezoek/; 'Alzheimer Programma', on: https://vanabbemuseum.nl/educatie/inclusie/alzheimer-programma/; 'Onvergetelijk Stedelijk', on: https://www.stedelijk.nl/nl/museum/inclusieve-programmering/onvergetelijk-stedelijk-programma; 'Stedelijk in Gebaren', on: https://www.stedelijk.nl/nl/museum/inclusieve-programmering/stedelijk-in-gebaren; 'Toegankelijkheid', on: https://krollermuller.nl/toegankelijkheid; 'Van Gogh op gevoel', on: https://www.vangoghmuseum.nl/nl/zien-en-doen/van-gogh-op-gevoel; 'Gebarentolk', on: https://drentsmuseum.nl/nl/programmas-op-maat/gebarentolk; 'Onvergetelijk Drents Museum', on: https://drentsmuseum.nl/nl/programmas-op-maat/onvergetelijk-drents-museum.

[3] 'Convention on the Rights of Persons with Disabilities and Optional Protocol', on: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

[4] 'STUDIO-I. Platform voor inclusieve cultuur', on: https://www.studio-inclusie.nl/.

[5] 'Convention on the Rights of Persons with Disabilities and Optional Protocol', on: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

artistic creation.[6] Creative therapy can involve looking at each other's art but this still happens in a therapeutic context, whereas in this thesis I aim to see whether it would be possible to bring looking at art in favour of wellbeing into the museological context.

The absence of mental health in the practice of accessibility and inclusivity in museums on the one hand, and of looking at art in mental healthcare interventions on the other, made me figure whether it would be possible to change this. The objective of my research is to bridge these two lacunas in the form of an exploration of ways to design an effective intervention for people with depressive symptoms and the potential positive effects of perceiving visual art in a museum on their wellbeing. This leads to the main question of this research: *In which ways could perceiving visual art in a museum be an effective intervention for people with a major depressive disorder?* This is divided into two sub-questions: Which symptoms of depression could possibly be eased or decreased by perceiving visual art in a museum? What would be the key elements in order to achieve this? These are answered by firstly reviewing relevant literature from cultural theory, philosophy, mental healthcare and cognitive neuroscience, and secondly executing qualitative interviews with both museum employees specialised in accessibility and audience, and psychologists and psychiatrists.

§1.2 Project Framework: Societal Embedding and Relevance

To put integrating healthcare in museums into context, this section starts with a short description of the *Onvergetelijk* ('Unforgettable') project at the Stedelijk Museum Amsterdam and Van Abbemuseum, based on *Meet Me at MoMA*. In 2006 the Museum for Modern Art in New York launched the *Meet Me at MoMA* program, with the desire to make art accessible for people with Alzheimer's disease.[7] In especially developed tours the participants experience and discuss artworks in the museum with a guide. The New York University has extensively studied the project, which has proven to enhance the participants' quality of life, as it foregrounds mental stimulation, communication, and social engagement.[8] *Meet Me* realises, in their own words, "the great potential for self-awareness, expression, and empowerment through the arts".[9] Inspired by *Meet Me*, the Stedelijk Museum Amsterdam and the Van Abbemuseum in Eindhoven started the *Onvergetelijk* program in 2013. *Onvergetelijk* also provides an interactive tour around pieces from the collection for people with Alzheimer's and their caregivers. The aim is to share stories and create a meaningful conversation in a positive, safe, and inspiring environment. A guide takes the participants along a small number of artworks, so that there is sufficient time to elaborate on each one. Encountering each work consists of four steps, namely observing, describing, interpreting, and relating. These steps are not separate elements, but guidelines for the conversation that smoothly change into one another. Nonetheless, by distinguishing them the interaction appeals to multiple cognitive and emotional features, such as intellectual stimulation, empathising, communication, and association. In this process there are no wrong answers or faulty remarks, and it is the guide's task to provide a 'failure-free experience'. Subsequently, the overall visit should feel inclusive, encouraging and interactive, instead of overly didactic and condescending.[10]

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[6] Camic and Chatterjee (2013); Dodd and Jones (2014); Ioannides (2017).
[7] Rosenberg (2009); 'Meet Me', on: https://www.moma.org/meetme/index.
[8] Rosenberg (2009); 'Meet Me', on: https://www.moma.org/meetme/index.
[9] Rosenberg (2009).
[10] Rosenberg (2009); 'Onvergetelijk Stedelijk', on: http://www.stedelijk.nl/en/education/adults/onvergetelijk-stedelijk; 'Onvergetelijk Van Abbe', on: https://vanabbemuseum.nl/en/mediation/special-guests/alzheimer-programme/.

In the years after its launch, *Onvergetelijk* has expanded to ten other Dutch museums[11], and the Vrije Universiteit Amsterdam has extensively studied the impact on participants, the institute in question, and society.[12] The tour appeared not only beneficial for the patient, but also for the relationship with their carers. The reason for this was the revived enthusiasm of the person diagnosed with Alzheimer's regarding the discussed objects, stories and the other people involved, inducing feelings such as empathy, recognition and joy. The increased emotional and social engagement elevated the participants' direct personal relations and, hence, their quality of life.[13] Another outcome of the study was the importance of the pleasant setting of the tour. Stimulating dialogue, including everyone, attentive listening, and emphasising that there are no wrong answers added to this positive experience. The participants declared that they did not feel stigmatised, on the contrary, they felt heard, more self-confident, and motivated. The VU indicated that the project breaks stigmas on a micro as well as macro level. That is, it is not only effective within the involved group of one tour, but it also contributes to a more understanding attitude towards Alzheimer's disease in society. *Onvergetelijk* is a striking example of a dementia-friendly approach, regarding the execution of the tours, as well as the functioning of the museum as socially inclusive institute. Similar methods are now implemented in other facilities and institutes, even outside the cultural field, such as taxi services and the supermarket chain Albert Heijn. Making the subject of Alzheimer's more discussible and less designating, the program has proven to be of high individual and societal value.[14]

Meet Me and *Onvergetelijk* have confirmed to be favourable for all parties involved, and form a well-founded starting point as example of a successful museum project that overlaps with healthcare. It supports my belief that the perception of art has indeed great possibilities, and could be beneficial for mental disorders too, and depression in particular. As Alzheimer's is a different condition it is not just a matter of copying the format, but *Onvergetelijk* inspired me to think more thoroughly about the possibilities for a similar project, fitting the specific needs and manifestations of depression.

The reason this thesis is aimed at depression is the high prevalence as well as sociocultural pressure. In 2016 the Trimbos Institute released a publication that showed 18.7% of the Dutch population under the age of 65 nowadays has gone through a form of depression.[15] Prevalence this high makes it important to keep investigating ways to deal with depression – both on an individual and sociocultural level. Moreover, depression goes hand in hand with taboos, prejudices and stigmatisation, and there have been multiple campaigns that try to break these and make the subject discussable, such as *Hey! Het is oké*[16], *Samen Sterk Zonder Stigma*[17], *Grip Op Je Dip*[18] and, internationally, *I Don't Mind*[19] and *Pay It Forward Gear*.[20] These projects stimulate people to talk about their condition and how it affects their daily life. It needs to be

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[11] These being: Centraal Museum (Utrecht), CODA Museum (Apeldoorn), Drents Museum (Assen), Limburgs Museum (Venlo), Mauritshuis (Den Haag), Museum Boijmans van Beuningen (Rotterdam), Museum Dr8888 (Drachten), Natura Docent Wonderryck Twente (Denekamp), Singer Laren (Laren), Zeeuws Museum (Middelburg).

[12] The research that *Onvergetelijk* was built on has been done by the New York University for the *Meet Me at MoMA* project. See: https://www.moma.org/meetme/resources/index#evaluation. The VU study focused specifically on the impact of the project.

[13] Heesbeen (2017).

[14] Heesbeen (2017); 'Betekenisvolle activiteiten voor dementerenden van belang', on: https://www.vumc.nl/onderzoek/nieuws/betekenisvolle-activiteiten/.

[15] 'Depressie in Cijfers', on: https://www.omgaanmetdepressie.nl/over-depressie/depressie-in-cijfers (2016). See also: 'Prevalentie', on: https://www.depressie.nl/depressie/epidemiologie/prevalentie; Droës (2017).

[16] 'Depressie bespreekbaar maken', on: https://www.omgaanmetdepressie.nl/depressie-bespreekbaar-maken.

[17] 'Organisatie', on: https://www.samensterkzonderstigma.nl/over-ons/organisatie/.

[18] 'Grip op je Dip', on: https://gripopjedip.nl/nl/Home/.

[19] 'About IDONTMIND', on: https://idontmind.com/.

[20] 'Pay it Forward Gear', on: https://payitforwardgear.com/.

addressed that various newspapers and sites, such as *Trouw* en *Financieel Dagblad*, reported a reason for *Hey! Het is oké* is that depression costs society 1,5 billion euros a year.[21] Why this focus on economical pressure and societal responsibility is problematic will become clear in the next chapter. That being said, incorporating a specified program in museums can contribute to an open attitude as promoted by these initiatives, and be an opportunity to provide a safe space for people with depressive symptoms. By exploring the possibilities regarding this, I hope to make a valuable contribution to implementing mental healthcare in the social agenda of museums, and, vice versa, to starting an integration of the perception of art in mental healthcare.

§1.3 Research Methodology

This thesis concerns two umbrella topics: the experience of art and depression. Traditionally, the first is subject to the fields of cultural studies and art history, and the second to the fields of medical science and psychology. Up until today, the division between the humanities and natural sciences has grown to become a standard working method, coming with social, political, economical and prejudicial consequences. Classical humanities concern itself with the human spirit and its cultural production, interpreting these and aiming to put them into socio-historical context. On the other hand, classical natural science regards observing, describing, classifying and striving for objectivity and logic. These are two different worlds, with their own distinct language, habits and background.[22] However, for some researches, like this one, the division does not apply well. Nowadays an upcoming movement of researches explores how materiality, the world, and bodies and minds intertwine.[23] After all, we do have a body and a mind that work in a certain way, in an environment that triggers and influences them, all the while using materials to shape or enhance them. This cannot exclusively be investigated by one world; it needs the best of both – or all – worlds. It becomes increasingly apparent that they are not mutually exclusive, but can complement each other very well. In fact, there is no inherent opposition that keeps them apart.[24]

The questions that are dominantly asked – and have been asked for decades if not longer – regarding the experience of art and depression very much depend on this uphold dichotomy, namely something along the lines of: 'what is the message of the artwork, what was the artist's intention, and what is its function or place in society' and 'what are the causes of depression and how can it be treated'. Cultural studies and art history are fit to answer the first, medical science and psychology the second.[25] Instead of investigating *what* art expresses or means, or *how* depression starts and unfolds, my thesis asks what art could establish for people who suffer from manifestations of a depressive disorder. The research does not take place in either one or the other field, but spans views and strategies from multiple disciplines in order to answer the research questions. In doing so, this study is a theory-based exploration with a societal relevance and empirical evaluation, through an iterative process of collecting, analysing and

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[21] 'Overheidsrecept tegen depressie: praat erover', on: https://www.trouw.nl/samenleving/overheidsrecept-tegen-depressie-praat-erover~a728b9a9/; 'Depressieve Nederlander Kost Maatschappij €1.5 mrd', on: https://fd.nl/economie-politiek/1182260/depressieve-nederlander-kost-maatschappij-1-5mrd.

[22] See, amongst others: Snow (1959); Nagel (1961); Kuhn (1962); Chalmers (1972); Popper (1972); Latour (1987); Luyten et al. (2006); Leezenberg and De Vries (2010).

[23] This movement can be found by the name of Medical Humanities, Health Humanities, Neuro Humanities, Neuroaesthetics, Cognitive Cultural Studies and many other variations, all encompassing these intertwining disciplines.

[24] See, amongst others: Dooremalen et al. (2010); Zunshine (2010); Jones et al. (2014); Viney et al. (2015); Whitehead and Woods (2016).

[25] See, amongst others: Snow (1959); Popper (1972); Luyten et al. (2006); Deelman et al. (2007); Beck and Alford (2009); Comer (2010); Leezenberg and De Vries (2010).

reviewing valuable sources. It regards a method triangulation of literature review and qualitative interviews, with the benefit of refinement and forming a complete as possible picture.

The research follows a deductive reasoning, in the sense that it starts with general observations, shaping the topic of interest. The theoretical framework, Chapter 2, deduces tentative assumptions, which will be tested and evaluated through the collection and analysis of empirical data in Chapters 3 and 4. Guiding in the process are sensitizing concepts, which are concepts that function as direction of the research. At the start of the research they have a broad meaning, but become more defined during the process.[26] The sensitizing concepts define the arrangement of the topics of interest, namely: depression, meaning making, relational dynamics, neuroplasticity, and disenchantment and reenchantment. Each step of collecting, coding and analyzing the retrieved data narrows down the sensitizing concepts.

The literature review is an in-depth, goal-oriented review of existing scientific studies, using studies from cultural theory, philosophy, mental healthcare and cognitive neuroscience in order to collect insights. The results are presented in the theoretical framework. It is a case of theory triangulation, providing useful arguments concerning the impact of the perception of art on the body and mind, meaning making through relations, meaning making as dynamic sensorimotor activity, and the malleability of the self. The aim of the literature review is to explore the theoretical foundation for possibilities of the positive effects of perceiving art in a museum on the wellbeing of people with depression. A first cycle of open coding will result in a preliminary conclusion, forming the starting point for the qualitative interviews.

The objective of the interviews is to evaluate and test the assumptions that will culminate from the theoretical framework and to gather information and insights on the topic. Seven museum professionals and six mental healthcare experts are interviewed. The interviews have an intersubjective approach, offering the advantage to gain multifaceted observations from both fields, by incorporating museum staff, psychiatrists and clinical psychologists. The methodology of the second and final cycles of data collection and analysis is assessed in more detail in Chapter 3. Combining the theory with the interview data, the Chapter 5 concentrates on the confirmation or denial of the assumptions and on a specification of the sensitizing concepts, and leads to a final answer to the research questions.

[26] As explained in Verschuren and Doorewaard (2007) and Boeije (2014), following Glaser and Strauss (1967).

CHAPTER 2 Theoretical Framework

In order to answer the posed question of how perceiving visual art in a museum could be an effective intervention for people with depression, the first part of this theoretical framework goes into the sociocultural and medical discourse of depression. It will become clear that the difficulty of meaning making is a most present struggle, which is the subject of the second part. The *Onvergetelijk* method is used as starting point, adapting it into a more affective approach. The third part clarifies this affective relation and its importance, utilising the term 'relational dynamics'. From hereon the link is made with neuroplasticity. Thereafter, part four makes an analogy between depression and disenchantment, in order to demonstrate not only why, but also how an intervention in a museum could be of importance. The chapter culminates in assumptions that will be evaluated in the interviews.

§2.1 Depression

Symptoms associated with depression have been described and portrayed in texts and images for centuries, but the definition and implications of the concept are always developing. From Hippocrates in the fifth century BC until the seventeenth century severe and long-lasting fear and sadness combined with physical discomforts such as sleeplessness and restlessness have been defined as 'melancholia' or melancholy. From the seventeenth century onwards a distinction was made between melancholic or psychotic, and neurotic depressions. The first were seen as a mental instability, whereas the latter were attributed to brain lesions and disturbances in the nervous system.[27] From the turn of the twentieth century until the twenty-first century this dichotomy shifted and became defined as endogenous and exogenous forms of depression. Endogenous forms were caused by internal factors, primarily biological, physiological, or neurological anomalies, as opposed to exogenous or reactive forms that were caused by external factors, such as an impacting life-event.[28] It was not until 1980 that the term major depressive disorder, as we know it today, was coined.[29] This short overview shows that depression is not a fixed medical diagnosis, but a concept liable to change. As Michel Foucault explains in *History of Madness*, the position of madness and the mad in society drastically changed over the past few centuries. This development is of direct influence on how we perceive not only madness but also mental illnesses nowadays.

In the Middle Ages mad people were ritually and symbolically excluded from society, not as a judgement but as a kind of pilgrimage or cure. Madness was seen as a form of forbidden knowledge, partly due to the Christian Church that linked it to the reign of Satan. This belief in a 'madness wisdom' as critical yet tragic consciousness increased in the sixteenth century, after which madness slowly became appropriated by reason.[30] From the seventeenth century onwards hospitals for the mad originated, where the mad could be confined and tamed. The reason for this was to maintain order and morality in society (hence the term 'mental dis-order'). Confinement became not so much a treatment but a punishment. The mad ended up on the same level as the poor, prisoners, homosexuals and mentally ill patients; in other words, everyone who was deemed 'unethical' and a threat to the social order. Condemned people were put away in a house of confinement, prison or asylum, which appeared to be separate institutes

[27] Horwitz et al. (2017): 1-24.
[28] Beck and Alford (2009): 68-75.
[29] Horwitz et al. (2017): 16.
[30] Foucault (2009 [1961]): 3-35.

but functioned similarly in practice, treating all 'unethical' persons as equals.[31] For mental illnesses this meant that there was not a duality between healthy or sick, but between normal or abnormal, and good or not good. The nineteenth century recognised reason as a state of being anterior to madness, and madness as acquired sickness. Madness became a medically scientific issue instead of a social inconvenience. Here is when the asylums started to receive the function and status of psychiatric hospital. Confinement acquired a therapeutic purpose.[32] It becomes clear that the way madness is perceived comes with a great number of consequences. The correctional urge of the seventeenth and eighteenth century translated into repressive social practices. It constituted a self-defining truth, as the system put madness and mental illness together with unreason, sin and immorality. The idea of a 'normal' state pre-existing a mental disorder in the nineteenth century is, according to Foucault, an invention, as it is situated in a system instead of in nature.[33]

Accordingly, the understanding we have of depression nowadays is different from decades, or even centuries ago. Trudy Dehue also approaches the discourse of depression from a sociocultural perspective. She states that depression is not a fixed entity, and examines the transformation of its meaning throughout the years. With this in mind, she goes against the dominant idea that depression is an inherent neurobiological defect that can be 'discovered' and cured, or even prevented – an idea with its roots in the nineteenth century. This view severely regulates someone's identity, an issue discussed in more detail later on in this chapter. Dehue has studied the use and production of antidepressants, and found that there is a supposedly increased need, but one that is mostly promoted by companies that produce the medicine. The results of researches regarding antidepressants are often simplified or generalised for the sake of publicity or profit, which means they are not by definition objectively obtained. Nevertheless, these results set the qualifications of diagnoses and treatments, and the researches define and uphold the system in the sense Foucault established.[34]

Unfortunately it is beyond the scope of this thesis to fully go into the history, socio-political implications and power relations of depression, but for now it is important that the definition and understanding of madness, mental illness and depression have transformed over time. In this ongoing transformation the cultural and medical discourses are always intertwined. In Foucault's words: "Medical experience itself created concepts and measures in keeping with the indefinite movement of this consciousness [of madness]." [35] The researches on antidepressants by companies that benefit from a result that make a large amount of people use antidepressants are a striking illustration of Foucault's theory. With this in mind we can say that medical concepts are socially and culturally constructed.

Not only the concept, the criteria to diagnose depression are in flux as well. Since 1952 there have been five updated versions of the so-called *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The fact that five versions of the *DSM* exist, and the fifth will not be the last, demonstrates that the term and its applications are liable to change. Exemplary is that the manual grew from 106 diagnoses of mental disorders in the first *DSM* to more than 300 in the *DSM-5*.[36] As Dehue would argue, this is not a case of 'discovering' new disorders, but a matter of reclassification and redefinition. Over 160 medical experts worked on the manual and decided

[31] Foucault (2009 [1961]): 41-57, 109-121.
[32] Foucault (2009 [1961]): 79-81, 89-94, 128-131, 140-143.
[33] Foucault (2009 [1961]): 129, 155-159, 169-173.
[34] Dehue (2008): 14-26, 90-130, 255-265.
[35] Foucault (2009 [1961]): 169.
[36] Interestingly enough, a specific number for the *DSM-5* is not to be found. See, amongst others: Horwitz (2014); 'Alles wat je al wilde weten over de DSM-5', on: https://www.ggztotaal.nl/pg-29166-7-89824/pagina/dsm_5.html.

the categories and definitions of the conditions[37], proving Foucault's points of mental disorders being an invention and medical experience creating the concepts and measures. Nevertheless, the *DSM* functions as a guideline in mental healthcare, as it supplies tools in order to make diagnoses and propose treatments. For the sake of workability, I use the terminology as used in the *DSM-5.* The *DSM-5* distinguishes unipolar and bipolar depression, the first being one long-term episode, whereas in the latter the episodes alternate between depressive and manic. Unipolar disorders all have in common that there is a presence of a "sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function."[38] There are multiple subtypes that differ in duration and causation, one of them being the major depressive disorder (MDD), which this thesis is directed at.[39]

The diagnostic criteria for MDD in the *DSM-5* are as follows. The primary aspect is the presence of a depressed mood or loss of interest or pleasure (almost) every day for a continuing period of at least two weeks. The second is that the person in question experiences at least four of the following symptoms in these two weeks: significant changes in appetite, weight, sleep, or psychomotor activity, tiredness without a direct cause, extreme feelings of worthlessness or guilt, a difficulty in thinking, concentrating, or making decisions, or, lastly, recurrent thoughts of death or suicide. These symptoms can be divided into emotional, cognitive, and physical manifestations. Emotional consequences can be anxiety, self-dislike, carelessness, social withdrawal, loss of gratification, loss of attachments, and crying spells. Recurring cognitive ones are a low self-evaluation, negative expectations, self-blame and self-criticism, a distorted self-image, loss of motivation, and suicidal wishes. Lastly, physical signs can be indeterminate aches, irritability, fatigability, agitation, retardation, and loss of libido.[40] The third criterion is experiencing effort, suffering or impairment in everyday functioning, albeit professional or social, as a result of these symptoms and manifestations.[41]

No studies have found a conclusive biological or neurological cause for MDD yet, but anomalies in certain brain areas have been linked to it. In order to help us understand this, this paragraph makes a short detour to give a – rather simplified and selective, but no less important – outline of the brain's anatomy. The brain consists of two parts, the left and right hemisphere, each divided into four lobes that all have different main functions. These functions are not as isolated as they appear on paper, as the lobes are intricately interconnected. The frontal lobe is, among other things, responsible for executive functioning, such as thinking, reasoning, problem solving, emotional regulation, and planning. It also contains the primary motor cortex, which concerns movement. Behind the frontal lobe lays the parietal lobe, of which the areas are in charge of language and integrating certain sensory information, such as touch, temperature, pressure and pain. On the lateral side of the frontal lobe, the temporal lobe has areas that process other sensory information, such as hearing, as it contains the primary auditory cortex. It also helps making sense of complex visual information. The hippocampus lies close to this lobe, which is a structure that plays a major role in emotions, behaviour, learning, language, memory,

[37] These experts come from the fields of neuroscience, biology, genetics, statistics, epidemiology, social and behavioural sciences, nosology, and public health. See: 'DSM-5: Frequently Asked Questions', on: https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions.
[38] 'Depressive Disorders', on: http://dsm.psychiatryonline.org.ru.idm.oclc.org/doi/full/10.1176/appi.books.9780890425596.dsm04.
[39] From this point onwards, when I talk about depression or depressive symptoms I specifically mean MDD.
[40] 'Depressive Disorders', on: http://dsm.psychiatryonline.org.ru.idm.oclc.org/doi/full/10.1176/appi.books.9780890425596.dsm04. See also: Beck and Alford (2009): 12-43, 64-79.
[41] 'Depressive Disorders', on: http://dsm.psychiatryonline.org.ru.idm.oclc.org/doi/full/10.1176/appi.books.9780890425596.dsm04.

and spatial navigation. Finally, the occipital lobe is home to the primary visual cortex – also called striate cortex due to its striped appearance – that receives information from the eyes, which means in this lobe the major part of visual processing takes place.[42] Stimuli from the sensory systems in the lobes are sent to the amygdala. The amygdala, which is a small almond-shaped core in the medial temporal lobe, is crucial in the emotional taxation of perceived stimuli. Its cells create a representation of the perceived world, and then send connections to the brain stem and hypothalamus. The brain stem forms connections between the brain and the spinal cord, and so to the rest of the body. The hypothalamus is largely responsible for the body's hormonal production, working together with the pituitary gland. The hypothalamus is the regulating core of physiologic functions.[43] (See Fig. 1 and 2)

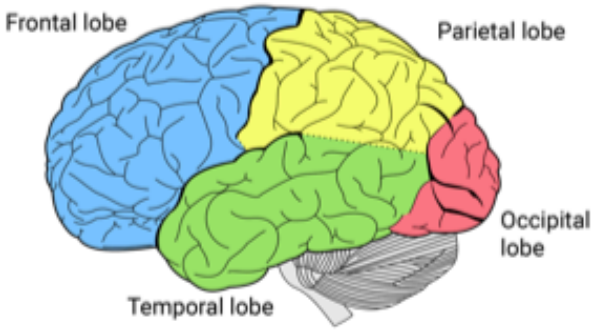

Fig. 1, as found on https://qbi.uq.edu.au/files/7887/QBI-brain-lobes-neuroscience.png

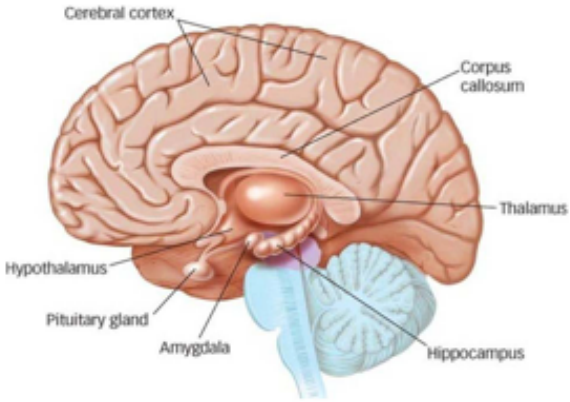

Fig. 2, as found on https://www.quora.com/What-are-the-most-important-parts-of-the-human-brain

With this framework we return to a selection of neurological indications that are concerned with depression nowadays. It is beyond the scope of this thesis to fully explore the workings of the brain, but it is relevant to give a review of some anomalies in the neurological processes. These are, for example, a smaller or damaged hippocampus, and smaller neurons and fewer glial cells in the prefrontal lobe.[44] A neuron is a cell in the brain that is specialised in processing information, and glial cells are supporting cells that do not conduct informational electrical impulses as neurons do. Other studies have confirmed functional abnormalities in specific brain areas that deal with emotions: Adults with MDD generally have a thinner cerebral cortex, being the outer surface of the two hemispheres, especially in parts that concern emotional processing, such as the orbitofrontal cortex, anterior and posterior cingulate cortex, insula, and temporal lobe.[45] Some regions show extremely low activity, like the thalamus, striatum, amygdala, hypothalamus, and prefrontal cortex – areas that regard either emotional or motor functions. Lastly, hyperactivity of the axis between the hypothalamus, pituitary gland and adrenal is being associated with major depressive episodes, causing abnormalities in the regulation of hormones, as this occurrence has proven to be linked to melancholia, psychotic features and suicidal risks.[46] However, the *DSM-5* emphasises, as does numerous other literature on depression, that up to this point studies have not been able to find results of 'sufficient

[42] 'Lobes of the brain', on: https://qbi.uq.edu.au/brain/brain-anatomy/lobes-brain.
[43] Kolb and Wishaw (2006): 410-412. See also: 'Hypothalamus Overview', on: https://www.healthline.com/human-body-maps/hypothalamus.
[44] Beck and Alford (2009): 135-168.
[45] Schmaal et al. (2016).
[46] Depressive Disorders', on: http://dsm.psychiatryonline.org.ru.idm.oclc.org/doi/full/10.1176/appi.books.9780890425596.dsm04. See also: Liotti and Mayberg (2001); Coryell et al. (2006); Stetler and Miller (2011).

sensitivity and specificity' to function as conclusive diagnostic tool. The complex structure of the brain and its even more complex relation to the rest of the body makes that scientists can estimate and show abnormalities, but not give decisive answers that match the delicacy and complexity of the neuroanatomical factors of depression.

Nevertheless, these findings resonate with the neurology of the experience of art, as there are noticeable correspondences. Studies have found that looking at art activates e.g. the orbitofrontal cortex and anterior cingulate cortex, areas that are critically related to the experience of pleasure and emotional regulation.[47] Findings like these show overlap in parts of the brain that are active in responding to art as well as to emotion and affect. In turn, these areas are generally smaller or less active in a major depressive disorder. The reason why engaging with art could workably be related to mental healthcare from a neurological point of view, is that it can stimulate this brain activity, as supported by NYU's and VU's research regarding respectively *Meet Me* and *Onvergetelijk*.

Up to this point we saw that criteria to diagnose depression have a cultural and social foundation, making it dangerous to assume that a symptom is a determined biological state of being. Nonetheless, multiple studies have examined physiological and neurological anomalies and processes that are being related to a state of depression. The medical world is in need of specified knowledge in order to provide help to those who need and want it. After all, something *does* happen in the body and brain. The demarcation of the physiological and neurological phenomena, and the terminology and meaning with which these phenomena are granted are socially and culturally constructed and liable to change.

Even though depression has physiological symptoms and underlying biological processes, nowadays depression is seen as a *mental* illness. The fact that it is determined as a mental disorder means that it is automatically related to ableism. 'Ableism' refers to the denigration of people with disabilities – albeit physical or mental – as being lesser than or subordinate to able-bodied people. It manifests itself in, for instance, belittling behaviour or disrespectful prejudices. This, in turn, has implications for how someone perceives him or herself and is perceived by others – in short, for his or her identity.[48] As David Mitchell and Sharon Snyder state, ableism is associated "with ideological formulas that equate devalued bodily conditions with decreased social value."[49] This value depends on someone's function in society: does someone contribute in a profitable way? If so, this means he or she is doing just fine, if not, then it is examined how he or she can recover as soon as possible in order to function 'well' again. The focus is on rehabilitation, but in terms of "functional capacities to the very activities that exist outside of a body's abilities"[50] instead of on the person's own feelings and experience. Precisely this is the reason why the reported economical interest and societal responsibility for *Hey! Het is oké* is problematic. Michelle Jarman criticizes this pressure on capability too. She describes how the traditional medical model constitutes a division between either being doomed to failure when suffering from a mental illness or being destined for success when being mentally healthy. This model imposes a limited understanding of the self, which is directly linked to stigmatisation and degrading someone's individual abilities and achievements.[51] This external pressure can increase certain manifestations of MDD, such as a

[47] Ishizu and Zeki (2011); Candidi and Aglioti (2015); Boccia et al. (2016); Heesbeen (2017).
[48] Mitchell and Snyder (2010): 6-8, 17-20.
[49] Mitchell and Snyder (2010): 18.
[50] Mitchell and Snyder (2010): 8.
[51] Jarman (2011): 14-17.

feeling of worthlessness or guilt, self-dislike and a distorted self-image, when the person in question feels he or she is not able to live up to the imposed standards, responsibilities and expectations. The external pressure turns into internal pressure.

This model leaves its traces in the therapies nowadays. Without extensively going into each of them, this paragraph gives an impression of psychotherapy and creative therapy, as they represent common treatments and lay bare possibilities for a new intervention. The general goal of psychotherapy is to reassure and to reorganise someone's thinking, by changing his or her thought patterns, behaviour and/or environment. Inducing a modified routine is difficult on one's own, so the therapist's task is to act as a catalyst and to guide and encourage the patient. Psychotherapy focuses either on behavioural, interpersonal or cognitive treatments. That is, in order to reorganise a person's thinking, it is important to break through habitual structures of relating to other people, to yourself, and to your actions. As the name suggests, the behavioural approach takes someone's actions as starting point. The therapist reintroduces pleasurable activities and social skills, which ideally will lead to a better mood. (Re)introducing positive experiences and their rewards could give reassurance. The relationship with people close to the patient is one of the key points.[52] Cognitive Behaviour Therapy (CBT) is based on the theory that a depressed person has "certain idiosyncratic cognitive patterns (schemas)"[53], which, when triggered, will dominate someone's thinking. Resulting in affective and motivational problems, schemas come with biases, unrealistic and illogical thinking, and a negative attitude. The therapist helps the person to distance him or herself from the schemas, so that he or she can counteract them instead of be trapped by them.[54] Psychodynamic therapy seeks to bring unconscious grief or trauma to the surface. In associative conversations it tries to uncover *why* someone feels or behaves the way he or she does. It is a long-term process, because it does not only try to replace dysfunctional patterns and routines, but also question them in terms of origin and course.[55] As the therapy is highly associative, the use of music, dance, or painting is common in order to express, bond, or communicate.[56] Creative therapies take psychodynamic therapy a step further. Or, rather, instead of starting from cognitive patterns and the unconscious, and then moving towards creative interventions, it has the creative disciplines, these being art, music, drama, dance and movement, and poetry or creative writing, as starting point. The general goal is to stimulate expression and, in doing so, to get in touch with one's feelings and to learn more about oneself. An understanding of the medium is needed, so the therapy integrates knowledge of the art discipline with the core principles of psychotherapy. It can help to identify and redirect negative thought patterns by expressing oneself through the making of art.[57] The creative process is believed to release chemicals in the brain that are beneficial in the recovery from depression.[58]

As we can see here, the main focus is either on cognitive patterns and rationalisation or on actively being creative. An approach that is yet missing in the arsenal of interventions for depressive disorders is one that revolves around perceiving art in a museological setting. I hypothesise that a perceiving art in a museum can help to shift the understanding of the self, by creating a safe and open space that does not proclaim societal value, functionality or achievements, but personal significance, self-worth and empathy. In other words, to regain

[52] Comer (2010): 275-297.
[53] Beck and Alford (2009): 298.
[54] Beck and Alford (2009): 293-310; Comer (2010): 275-297.
[55] Comer (2010): 275-297.
[56] 'Psychodynamic Therapy', on: http://www.goodtherapy.org/learn-about-therapy/types/psychodynamic.
[57] Malchiodi (2014).
[58] Illiades (2012).

authority over one's thoughts and feelings, instead of having these imposed by ableist views. The emphasis then lays on capacities and activities *inside* the body's abilities. An intervention in a museum would not be a treatment for depression, but a new approach to cope and to enhance someone's wellbeing. It is about caring, not curing.

As seen in this section, the sociocultural and neurological perspective on the benefits of the perception of art complement each other. Consequently, we can regard that an intervention in a museum for people with MDD might be able to contribute to the participants' wellbeing. That is, it would intend to provide a safe space, where there is no external pressure and the participants can fully focus on sharing their personal experiences, in order to shape a more understanding attitude on both an individual and sociocultural level. Now it is time to concretise how engaging with art has the potential to concern and ease certain MDD symptoms, such as a depressed mood, a loss of interest or pleasure, a feeling of worthlessness or guilt, self-dislike, self-blame, self-criticism, a distorted self-image, a low self-evaluation, social withdrawal, carelessness, and a loss of gratification.

§2.2 Meaning Making

After having delved into the cultural, medical and neurobiological matters of depression, it appeared that a crucial underlying problem in MDD is the difficulty of finding meaning in life. People with MDD experience difficulties in establishing personal significance and connection to others. Redirecting the awareness to meaning making would then be of great importance. An intervention might help to do so, and in order to investigate how we now return to *Onvergetelijk*, or, rather, its underlying method. After all, it has been proven that this project has positive effects on the participants, in the form of e.g. increased self-confidence, being able to express oneself better, feeling fulfilled, and being less agitated or lonely.[59] *Onvergetelijk* follows an inquiry-based method, which is a variation on the Visual Thinking Strategies (VTS). In VTS the viewer actively verbalises what he or she sees and thinks. To put the procedure and impact of VTS into context, this section starts with explaining its background. VTS is a teaching method developed by museum educator Philip Yenawine and cognitive psychologist Abigail Housen, and has proven to be an effective way of engaging with art. By guiding the participants in a certain way, focusing on particular details, and making them participate, the perception of art acts on different levels of cognition and increases activity in specific brain areas as addressed in §2.1.[60]

VTS came into being because Philip Yenawine felt there was a gap in museum education that needed to be filled. As Director of Education at the Museum of Modern Art in New York between 1983 and 1993, he was involved with the educational programs there. This included their content as well as their impact and effect. As he was not satisfied with the latter, he wanted to develop a new strategy. Where the original programs had the traditional design of a teacher giving background information about an artwork to a listening audience, Yenawine wanted to aim for a more active involvement. He declares: "What MoMA visitors really needed was what Wyla [his young, curious granddaughter] needs: not answers but permission to be puzzled and to think."[61] His vision stems from the belief that personal growth comes from curiosity, and from the drive to question and solve problems. After all, being provided with answers does not have the same satisfactory effect as finding out for oneself.

In Abigail Housen's work Yenawine found what he missed: the benefits of active thinking. Her psychological research played an important part in the realisation of VTS. Since the

[59] Heesbeen (2017): 13.
[60] Yenawine (1997).
[61] Yenawine (2013).

1970s she extensively studied how viewers think when they look at art. Her research consisted of searching for behavioural patterns while the participant was looking at an image. In this process it was essential to have them act naturally and think out loud, and to avoid suggestive questions or comments. Housen analysed and coded these observations, of 4000 subject interviews in total, culminating in the Theory of Aesthetic Development (TAD). The results lay bare five distinct patterns of looking at art, so-called developmental stages, based on the characteristic way the viewers responded. The stages signify different types of making sense of an image. It would be superfluous to cover all stages in detail, but in summary, a beginning art viewer relates what he or she sees directly to what it reminds him or her of, a somewhat more experienced art viewer rather discusses the making of the artwork, and a proficient art viewer combines personal contemplation with a vast contextual knowledge.[62] How the elements of interpretation and appreciation are balanced depends on which developmental stage someone is in.[63]

The outline of VTS consists of three main questions: What is going on in the picture? What do you see that makes you say that? What more can we find?[64] By asking these, the viewer is triggered to make sense of the image they see, instead of being told what is portrayed and why. It is the role of the guide to mediate the conversation in the group. In doing so, the structure of the 'teacher' performing a one-way educational monologue to a 'listener' is undermined. Rather, everyone's vision and ideas matter in a dialogical structure. When fitting, the guide gives information about the work or the artist, or confirms an accurate contribution from one of the participants. It is proven that information sticks better this way, as someone can impossibly remember a whole talk, whereas if he or she discovers answers or thinks critically for themselves, the information that comes up in the conversation is more thoroughly remembered.[65]

We must keep in mind that VTS, with TAD as underlying fundament, is an educational framework with educative guidelines. Housen's studies have shown that after someone is repeatedly being exposed to art with the VTS method, he or she evolves into a next TAD stage. VTS aims for this to happen, as it intends participants to learn a new skill and new way of looking, to improve certain cognitive functions, such as critical thinking and comprehension, and to develop subjective and emotional perception.[66] Entering a new stage is an achievement, something that implies linearity and a certain hierarchy. VTS has instigated a turn in museum education that acknowledges the position of the audience, in the sense that interaction and personal interpretation are leading in a tour, instead of an informational monologue. My thesis does not concern education or achieving skills, but VTS is based on extensive research and so makes a well-founded point of departure. *Meet Me* and *Onvergetelijk* are striking examples of redesigning VTS for the purpose of improving the wellbeing of participants. These projects suggest it should be possible to shift the functionality and focal points of VTS, from educative learning towards a more affective approach. With 'affective approach' I mean a strategy that highlights affect, in other words, how people affect the world around them and how the world affects people.

[62] Housen (2007); 'Overview of Aesthetic Development', on: https://vtshome.org/aesthetic-development/.
[63] Housen (1987): 42-43; Housen (2007): 173-180.
[64] Murawski (2014).
[65] Yenawine (2013); Leeuwen, van (S.d.).
[66] Yenawine (2013); Leeuwen, van (S.d.).

Artist and art critic Suzi Gablik states that creating meaning is essential in life. With this, she means that people need a feeling of getting a grip, of significance, wonder, and a personal connection to the world; features that are weakened when someone suffers from depression. The three questions in VTS regarding the portrayed image are inadequate to pursue this kind of meaning. An important question is, then, what 'meaning' means here. After all, it can have a great number of interpretations. In museums 'meaning' traditionally refers to the background information, underlying story and essence of an artwork. The meaning I propose has a different focus, being defined as the significance and understanding that people experience regarding a situation, object or image, directly related to their personal feelings and emotional associations, and to the particular time and place they are in.

As we have seen, the three questions asked in VTS still revolve around the work, as the goal is to make sense of the *image*. Instead, I propose the *self* to be the focal point of engaging with art, or, more specifically, someone's physical, sensory and emotional experience. 'Physical' from hereon refers to sensation in the body, such as heartbeat, breathing, tension, and so forth. 'Sensory', on the other hand, refers to the input from the senses, such as seeing, hearing, touching, smelling, or tasting. 'Emotion' is defined as a mental reaction with a value judgement, which, in most of the cases, comes with a physical reaction in the form of e.g. a quickening pulse, tightened muscles or tears.[67]

The way the questions of VTS are framed make that it fundamentally still deals with making sense of what is seen and not otherwise felt or sensed, and with discovering the work's meaning in the traditional sense of the word. Emotional associations and feelings are utilised in order to shape this meaning. When physical, sensory and emotional reactions become the centre of the experience of art, they are not mobilised for another – that is to say, narrative or educational – purpose. Knowledge, for instance about the artist or art historical context, can strengthen or weaken how someone relates to an image, but it is not the leading aspect and it does not have an educational purpose. I do not mean to say that information and stories should be discarded. There is no strict dichotomy between knowledge and affect that calls for a choice; they go hand in hand, but it is about the balance between the two and the direction of attention.

Maurice Merleau-Ponty's notion of 'sense-experience' clarifies why this emphasis on the physical, sensory and emotional reaction is convincing. Sense-experience encompasses the relation between the body and the environment. Merleau-Ponty argues that all senses are unique in their function, as only the ear hears, the eye sees, and so forth. However, they are not unique in determining a bodily sensation; that consists of all sensory input together. In other words, all senses take in the world in their own way, together forming a synthesis that defines an experience.[68] Everything that the senses pick up, so, every colour, form, taste, sound, touch, smell, et cetera, not only has a different neurological reaction in the sense that different brain areas are activated, but also a distinct physical reaction in the body. That is, some colours and sounds are soothing whereas others are compelling, and some tastes and smells are pleasant whereas others are repulsive. Multiple studies have confirmed that sensory perception is interlinked with the motor cortex, so all sensory input intrinsically influences someone's movements.[69] Subsequently, when we approach this from Merleau-Ponty's theory, it means that perception does not only take place locally in the ear, eye, mouth, skin, or nose, but echoes

[67] Deelman et al. (2007): 239-241.
[68] Merleau-Ponty (1958 [1945]): 243-247, 257-261, 270-272.
[69] See, amongst others: Berrol (2006); Buk (2006); Freedberg and Gallese (2007); Gallese (2009); Candidi and Aglioti (2015); Boccia (2016); Palmer et al. (2016); Fassihi et al. (2017).

throughout the whole body.[70] Following this theory, if feeling, hearing, smelling, and other sensory input are triggered when engaging with visual art, it would stimulate an enrichment of the sense-experience.

Merleau-Ponty states that the sensation of a colour, sound, or another object characteristic is not *knowing* what it looks or sounds like, but *experiencing* it, a thought also expressed by Suzi Gablik.[71] Merleau-Ponty clarifies this by saying that the senses are distinct from the intellect, as sensations can never be fully rationally explained or reduced to a fact. Consequently, it is the body that gives significance.[72] Particular characteristics of an object, image or the environment cause the body to react in a certain way, which is directly interlinked with an emotional reaction. In short, the sense-experience is the continuous interplay between sensory, physical and emotional factors, which is how we signify and connect to the world around us. It illuminates why merely observing the formal elements or knowing the background information – or, the way VTS works – is insufficient for meaning making: paying attention to the bodily and emotional reactions tells so much more. When we link sense-experience to the new working definition of meaning, we see that it revolves around signifying and connecting, being shaped by the particularity of time and place. Feelings, both emotional and physical, are leading in the process. The affective relation to an artwork is now the source for meaning making: What an image means for someone is a direct result of their experience of it, instead of what they know about it. Furthermore, the meaning is not just based on what is seen, but on what is sensed with the whole body.

In light of this argumentation an intervention for MDD would revolve around meaning making through directing awareness towards someone's sensory, physical and emotional reactions regarding an artwork. This process would make someone realise his or her own personal responses – or, sense-experience – are a valid source for signification and connection. It would require drawing the attention back to the self and one's position in the world. Moreover, it would encourage the individual in regaining a sense of trust, comfort, appreciation and confidence, because 'meaning' is an individual experience that is never wrong and always valid, instead of externally determined and based on facts and knowledge. Or, to continue Mitchell and Snyder's and Jarman's argument, an intervention in this fashion would accentuate someone's value on their own account instead of having it imposed. Crucial aspects in this process are responsibility, affinity, and compassion. The next part goes more deeply into these elements, by exploring the causes and effects of such a caring approach.

§2.3 Relational Dynamics

To introduce this section I briefly explain the transition Suzi Gablik describes from the traditional dominator model towards an alternative partnership model, to put her thoughts into context. The dominator model originated in dualistic Cartesian thinking, and glorifies the ideal of the powerful, independent individual with a rational approach. It is characterised by pursuing one's own ends without any regard to others or the environment, aiming to compete and dominate: "The parts function without regard for the interests of the whole."[73] The partnership model, on the other hand, revolves around relationships. Nothing is isolated; everything is interconnected. This system values participative interactions, cooperation and compassion, and the self is embedded in a larger whole.[74] The partnership model is defined by something Gablik

[70] Merleau-Ponty (1958 [1945]): 241-249, 264-277.
[71] Gablik (1999): 29-48.
[72] Merleau-Ponty (1958 [1945]): 248, 261-266, 270-281.
[73] Gablik (1999): 81.
[74] Gablik (1999): 62-64, 150.

calls 'relational dynamics'. Relational dynamics go against objectification, detachment and generalisation – traits that are still present in the medical model as portrayed by Foucault and Jarman. Alternatively, Gablik argues for a feeling of responsibility and affinity towards the world and each other, highlighting the importance of compassion and the capacity of sharing experiences.[75] As we have seen, these are main points in the *Onvergetelijk* program.

A phenomenon called neuroplasticity acknowledges the importance of relational dynamics on a neurological level, as it means that the brain is malleable. External stimuli can change the structure of neurons, which means that the brain changes as a result of environmental or social experiences. Increased sensory processing in a complex and stimulating environment can cause a heightened number of synapses. A synapse is a junction between two neurons, which allows the cells to 'communicate'. Consequently, this means that our brain does not determine our being, as our body and engagement with the world and other people makes that is always in flux.[76] This ties in with the cultural model on two levels: It recognises that the state of our brain is not a given fact, and that our identity or state of being is not merely dependent on our brain. In other words, that both are heavily influenced by individual acts and sociocultural discourse. This confirms how the physical condition and cultural views are intertwined, as discussed in the first part of the theoretical framework. This view stands in contrast with the Cartesian tradition of cognitive neuroscience, which, in short, assumes that all cognitive processes exclusively take place inside the brain, that they are all neural. It adheres to the belief that 'you are your brain'. It dualistically separates mind from matter, mental from physical. Alternatively, the so-called 4E-theory – the E's standing for embedded, extended, enacted and embodied, which will be explained in the following paragraphs – embraces neuroplasticity, and advocates that cognition and mental processes are not limited to neural activity in the brain.[77]

As addressed in the previous section, in meaning making the attention needs to move away from the object. Gablik pleads for a similar movement. She declares that in the dominator system "art is organised around the primacy of objects rather than relationships".[78] In a traditional museum tour, and even in VTS, there might be a risk that by having the emphasis on the object, its story and information might come between the viewer and the artwork. This thought is supported by Jay Bernstein's idea that the "grasping of the meaning remains sensory, remains bound to the acts which accomplish it".[79] Merely *knowing* background information is insufficient in order to achieve a sense of meaning as I propose. We saw this statement made before by Merleau-Ponty and Gablik, and now Bernstein's theory can help to delve more deeply into the underlying reason.

According to Bernstein it is impossible to fully explain and rationalise an artwork by the use of facts or concepts. To some extent these facts and concepts always deduce and generalise the particularity of not only the object, but also of the moment and experience of it: "classification and explanation negate immediacy and thereby objectify experience."[80] He goes so far as to say that the result of deduction and generalisation is that people, objects, and events lose their individual significance, which detaches them from direct impact – albeit physical, sensory, or emotional.[81][82] If we think about this, it could feel paradoxical that focusing on the

[75] Gablik (1999): 7, 98-114, 123, 149-151.
[76] Kolb and Whishaw (2006): 208-212; Fitzgerald and Roepstorff (2014).
[77] Varela et al. (1993); Rowlands (2010); Choudhury and Slaby (2012).
[78] Gablik (1999): 62.
[79] Bernstein (2001): 311.
[80] Bernstein (2001): 87, 88.
[81] Bernstein (2001): 87-89, 187-234, 263-329.

object precisely creates a distance to it. Nonetheless, this results from the fact that, in this view, what the individual actually experiences is subordinate to the material form and factual information of the object or image. In VTS this is still the case, as the object is still the prime focus when it comes to making sense of the image.

Gablik does not agree with the traditional view, situated in the dominator model, in which only the object or image counts, as she believes the so-called 'disembodied eye' represses someone's lived reality. With this she means, similar to Bernstein, that the traditional view objectifies and reduces, resulting in a detached observer.[83] It isolates both the person and the object, whereas in the partnership model the interaction would be central. Then the person and object are not two separate entities, but interconnected. We recognise Merleau-Ponty's theory on sense-experience, which accentuates that the perception of an object, in this case an artwork, is not limited to just the eye. Gablik's partnership model is a realisation of how the self is embedded in a larger whole. In cognitive neuroscience this applies to the embedded mind, meaning that mental processes are contingent with the environment.[84] This approach states that mind and environment are inextricably connected, as environmental structures heavily impact cognitive processes.[85] Or, in Gablik's and Merleau-Ponty's words, they are a continuum.

These insights clarify why it matters to put the affective relation to an artwork in the centre of the perception of art, and why the object – the artwork – cannot be completely discarded in order to do so. Gablik's partnership model characterises itself by acknowledging a continuum between inner and outer world. Following Merleau-Ponty's thoughts, there is a direct connection between people, objects and space. Objects are not "entirely self-identical"[86], and the body is "organically connected"[87] with the space it is in and the objects that surrounds it. No less than the fact that light touches the retina, sound waves touch the eardrum, or food the taste buds on the tongue. The synthesis of these unique contacts makes that someone senses and feels something, both physically and mentally. Our experience of the world relies on our bodily experience and vice versa; there is a mutual dependence of self and world. The enacted mind ties in with relational dynamics and sense-experience, as the engagement with others and the world is not a one-way relation from a person to an 'outside reality', but a multilateral interaction. The enacted mind is not limited to the biological brain; it is not just neural but constructed by how someone acts.[88] In Alva Noë's words: "Perception is not a process in the brain, but a kind of skillful activity of the body as a whole. We enact our perceptual experience."[89] Our perception of an object or space depends on what we do with our body and how we move – on our actions. Earlier we saw Bernstein pose how not only perceptual experience, but also meaning making is sensory and bound to someone's acts.[90] Mark Rowlands explicates that the enacted mind acknowledges sensorimotor information as a form of knowing. Someone's actions shift his or

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[82] Bernstein reacts against Theodor Adorno's notion of identity thinking, a system that expresses similar characteristics as Gablik's dominator model.
[83] Gablik (1999): 99.
[84] The embedded mind is a matter of dependence, because mental processes depend on the environment, whereas the extended mind is a matter of constitution. It asks where the mind ends and the world begins, and advocates an 'active externalism'. That is to say, it adheres to the belief of extending functional cognitive processes, such as orientation, problem solving and memory, to outside the brain and body, for instance to computers, notebooks, telephones, or smartwatches. Mental processes are delegated to external structures for the sake of functionality through manipulation, exploitation, or transformation. As this functionalism goes in a different direction than my thesis, I will leave it at that.
[85] Rowlands (2010): 3, 67-70.
[86] Merleau-Ponty (2004 [1948]): 51.
[87] Merleau-Ponty (2004 [1948]): 54.
[88] Rowlands (2010): 70-82; Choudhury and Slaby (2012); Wilson and Foglia (2015).
[89] 'Action in Perception', on: http://www.alvanoe.com/action-in-perception/.
[90] Bernstein (2001): 311.

her sensory input. Whereas traditionally this sensory input was believed to cause internal neural processes in order to cognitively know something, in the enacted mind that what the senses pick up – touch, sound, taste, vision, et cetera – *is* knowledge. We saw that Merleau-Ponty assumes the same, in saying that the synthesis of all sensory input together shapes an experience. In his words, the body can "attach to the notion of 'significance' a value which intellectualism withholds from it."[91] We can argue, following Rowlands and Noë, that this sensory synthesis is influenced and shaped by enactment. Knowledge and meaning emerge from bodily engagement with one's surroundings.[92] This resonates with Merleau-Ponty's idea that it is the body that gives significance. Mental processes are composed of actions not only in, but also on the world, and relate to how the world acts back. In other words, it is about the encounter.

Consequently, each object provokes, consciously or subconsciously, a specific personal emotional and physical reaction.[93] Any reaction is meaningful and valid, as demonstrated in *Meet Me* and *Onvergetelijk*, because, as Merleau-Ponty's says: "I am brought into relation with an external being, whether it be in order to open myself to it or to shut myself off from it."[94] Relational dynamics enlighten, supported by Gablik's and Merleau-Ponty's idea that everything is inevitably connected, the relevance of redirecting the attention to one's sense-experience and to the interaction with both one's environment and the other people involved. It also clarifies why the bodily and emotional reactions are so telling in the process of meaning making. As Rowlands explains, in the embodied mind mental processes are to a more or less extent formed by bodily structures and physical processes. The brain and mind depend on the nature of the body they are in, and mental processes cannot be complete without sensory input, which is different and specific for every body.[95] For example, the brain structure of someone in a wheelchair is different from someone who can walk, and that of a blind person differs from someone who can see. This body-specificity influences the experience and perception of the world. Citing Antonio Damasio, Rowlands states, "psychological processes are *incomplete* without the body's contributions".[96] If we include Merleau-Ponty's notion of sense-experience, we could say these processes are not incomplete but even impossible without the body.

As Merleau-Ponty profoundly puts it, through the body "we can consequently 'be at home in' that world, 'understand' it and find significance in it."[97] As one does not feel at home in the world when suffering from MDD, because it is difficult to understand it and one's place in it due to a lack of significance, an intervention could help to refocus on this. By highlighting the sense-experience the attention can gravitate towards what someone physically and emotionally feels. In other words, gravitate towards the capacities and activities inside the body's abilities. It allows for the possibility to shift someone's cognitive patterns (or, schemas), mood, self-awareness and self-image.

Meaning making and relational dynamics appear to be the first key elements in order to possibly contribute to the wellbeing of people with MDD. In order to give these concepts some more ground, the next section makes an analogy between depression and disenchantment, and the necessity for reenchantment, as a way to demonstrate more clearly from a cultural theory point of view why and how a museum initiative for people with MDD could be beneficial and essential. It makes the concepts of meaning making and relational dynamics more workable,

[91] Merleau-Ponty (1958 [1945]): 246.
[92] Rowlands (2010): 71-73; Wilson and Foglia (2015).
[93] Merleau-Ponty (2004 [1948]): 49-62.
[94] Merleau-Ponty (2004 [1948]): 248.
[95] Rowlands, M. (2010): 3, 52-58. See also: Damasio (1994); Shapiro (2004).
[96] Damasio in Rowlands (2010): 53.
[97] Merleau-Ponty (1958 [1945]): 275.

because it concerns the need for finding meaning, and reflects on how the self is not isolated but has a relation to and position in the world.

§2.4 Disenchantment and Reenchantment

The term 'disenchantment' has been broadly interpreted, so I start with explicating its origin. In 1919 the German sociologist Max Weber stated: "The fate of our times is characterized by rationalization and intellectualization and, above all, by the 'disenchantment of the world.'"[98] The reason for this disenchantment he argued to be the scientific revolution of the nineteenth century, which caused the process of intellectualisation. With this he meant that the explosive scientific developments had caused a change in how people give meaning to their lives. A shift happened towards a belief in science instead of a higher supernatural, spiritual or religious power; a belief that mankind could control and solve anything through calculations and rational argumentation.[99] Weber cites Tolstoy in saying that science cannot answer *all* questions in life, and especially not the most important ones: 'what shall we do and how shall we live?'[100] As inclined before and as Weber assures, the provided calculations and scientific facts are not sufficient in order to give meaning in life.[101]

Bas Heijne continues this line of thought, by stating that people need to be able to signify, connect and interpret, and it is up to themselves to do this – not to science. He paints a picture of a disenchanted world in which measuring and calculation becomes the only way of giving meaning to the world.[102] The danger is, then, that science not only teaches us to explain the *world*, but also *ourselves*. Heijne gives the example of medical science being able to extend people's lives, but not providing answers as to *why* lives should be extended. It other words, it does not consider what it would mean for individuals as well as in general.[103] Bernstein's ideas on how classification and explanations deduct and generalise individual significance relates to this. That is to say, the explanation of how someone's life can be extended and the generalisation that all lives should be extended does not equal the individual significance for someone in a particular situation. If anything, it causes a detachment from the person in question. To quote Heijne, who refers to Weber when saying: "science supplies facts in its best way possible, […] but it is up to humans to interpret these facts."[104] If everything in life would be signified and explained by scientific facts without interpreting these facts, there would be no place for a deeper sense or value. As a result, a discomfort and fear can befall for a world in which everything becomes static, empty and meaningless.[105] Heijne claims that people need to dream, interpret, signify and find meaning, and this does not happen with scientific input alone; it comes from oneself in relation to one's surrounding world.[106] Here we recognise the enacted and embedded mind too. The aforementioned ideas from Gablik and Merleau-Ponty resonate with this line of thought, and as we will see in the following paragraphs, the resonance grows stronger.

This thesis is not the place to go further into the history or societal impact of disenchantment, nor into the collective need for a reenchantment of the world. Instead, it makes an analogy between disenchantment and depression. Emptiness and meaninglessness sound

[98] Weber (1919): 133.
[99] Weber (1919): 116-122, 129-133.
[100] Weber (1919): 117-122.
[101] Weber (1919): 131-133.
[102] Heijne (2014): 12-15, 24-27, 30.
[103] Heijne (2014): 18-28.
[104] Heijne (2014): 24.
[105] Heijne (2014): 15-29.
[106] Heijne (2014): 38.

familiar, as do feeling discomforted in the world, and lacking sense or value. These are signs of disenchantment, but also significant manifestations of MDD. When Lawrence Kimmel describes disenchantment, he might as well describe depression: "When the world indeed is not so much with us, when the work which usually occupies our consciousness falls away and we are left alone, the default of individual consciousness, confronted with the empty fact of itself, is often fear."[107] When we proceed with this analogy, reenchantment would mean easing depressive symptoms, by means of concentrating on meaning, sense, and value. An intervention in a museum could intend to be a stimulus for this. In order to explore how this would take shape, we need a working definition of reenchantment.

Kimmel defines reenchantment in the most common sense. He states that when one feels enchanted, one's imagination is fully engaged in another, often fictive, world. The experience is that of make-belief, and is creatively empowering. Kimmel compares enchantment to, for instance, fantasy, myth, fairy tales and ecstasy, as the mind and imagination are in a heightened state. Comparable to Weber, Heijne and Gablik, he sees that the everyday world requires factual knowledge in order to function, control and dominate. What *people* need, on the other hand, is meaning, constituted through feeling – similar as to what Merleau-Ponty suggests.[108] Kimmel too states that the world "is not the totality of things or facts, but the totality of meaning."[109] This includes e.g. dreams, hopes, memories and significances, which are nourished by enchantment in the fictional or magical sense.[110]

Gary Backhaus approaches reenchantment differently. He does not equal enchantment to imagination and fiction. Kimmel argues that fantasy and make-belief are separate from the everyday life-world, whereas for Backhaus enchantment is part of it. One does not have to enter another world, either fictional or magical, in order to be enchanted.[111] He states that we function cognitively in our daily lives, when it comes to executing tasks and finding solutions. Enchantment characterises itself by this cognitive approach being transformed into something Backhaus calls hyper-awareness. This means the awareness of being confronted with normalities or habits in a way they are emphasised, considered, appreciated or accepted, instead of taking them for granted.[112] In this view, enchantment gives the ordinary – the habitual – a "new vitality of significance."[113] Linking this to the previous sections, this means that meaning making happens out of relational dynamics, feelings and experiences, instead of rationality, cognition and routine. And rationality, cognition and routine are precisely the features in MDD that need to be counteracted.

The working definition of reenchantment for my thesis is achieving a new way of looking, especially at oneself and one's place in the world, making space for wonder and connecting. This does not mean a complete existential transformation or transcendence, but appreciation, signification and wonder, also – or, perhaps even especially – of the small and ordinary things in life. The experience is of oneself, instead of distancing oneself from a situation, story or object by dismissing it as magic or fiction. I see it as a reemphasis on the self. This means that reenchantment is not 'out there', but something that is personal. After all, it is very difficult to be enchanted by something that is not of one's interest or not close to one's heart.

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[107] Kimmel in Kronegger and Tymieniecka (2000): 192, 193.
[108] Kimmel in Kronegger and Tymieniecka (2000): 192-197, 200, 201.
[109] Kimmel in Kronegger and Tymieniecka (2000): 206.
[110] Kimmel in Kronegger and Tymieniecka (2000): 202-205.
[111] Backhaus in Kronegger and Tymieniecka (2000): 25.
[112] Backhaus in Kronegger and Tymieniecka (2000): 26-35.
[113] Backhaus in Kronegger and Tymieniecka (2000): 35.

According to Backhaus, something that might otherwise be insignificant can be a motivator for reenchantment.[114] But if anything can trigger enchantment, why choose *art* as this motivator? The reason for this is twofold, namely that it appeals to identification and to reflection. Looking at art involves perceiving feelings of others, which can create a feeling of relatedness or recognition, or, contrarily, of repulsion or estrangement. This can occur on the level of the artwork and of the other participants. Seeing portrayed scenes or emotions and discussing them can make someone aware that he or she is not alone or abnormal, and it can create more understanding and awareness of one's own as well as someone else's position and situation. Ideally, this makes space for sensibility and connection. Moreover, by considering one's opinion and physical, sensory and emotional reaction towards the artwork by actively reflecting on it in a guided conversation with others, the individual can reflect on his or her own personal being, relation to others, and place in the world. Kimmel states that art activates imagination and wonder, as it portrays another world than one's own.[115] For me, art does precisely that, but instead, in Backhaus' words, the "horizon of the everyday life-world remains available."[116]

In MDD one of the symptoms is the difficulty to consider, appreciate or accept the ordinary, manifesting in a long-lasting loss of interest or pleasure. When it is hard to be enchanted by the everyday life-world, as is the case in MDD, engaging with art could function as stimulus. Earlier we saw that looking at and talking about an artwork inherently invokes reaction, both physically and emotionally. Emphasising this, for instance by asking questions that direct attention towards the individual's physical, sensory and emotional experience, could be an efficient motivator for a state of hyper-awareness, in the sense Backhaus proposes. By pointing out details and connecting them to life, it directly relates the person in question to his or her surroundings, and intensifies consciousness of the body and feelings in relation to the space and material, instead of taking them for granted. This experience can be a trigger to consider and reflect on situations, sensations or emotions. Neurological studies support this assumption, as they have shown that the perception of art can be stimulating for sensory-motor, emotion-valuation and meaning-knowledge processes.[117]

A crucial element of reenchantment according to Gablik is emphatic identification, in which art plays an essential role. With empathic identification she means the "ability to enter into another's emotions, or to share another's plight"[118]; this is the essence of the partnership mode, and defines relational dynamics. Through this process we can be more compassionate and empathetic, and feel more responsible for each other. Gablik mentions that the act of empathic identification is healing. 'Healing' does not equal 'treating' here, but signifies something more along the lines of 'caring' and 'easing'. The setting for this healing, Gablik says, is putting the capacity to understand, trust, respect and help in the forefront.[119] These are precisely the outcomes of the *Meet Me* and *Onvergetelijk* projects; the participants feel understood, accepted and respected, and the museum creates a safe environment. Some of the projects' objectives are to be open and inclusive, to bring people together, and to contribute to a dementia-friendly

[114] Backhaus in Kronegger and Tymieniecka (2000): 31, 32.
[115] Kimmel in Kronegger and Tymieniecka (2000): 202.
[116] Backhaus in Kronegger and Tymieniecka (2000): 33.
[117] See, amongst others: Kawabata and Zeki (2004); Silvia (2005); Di Dio and Gallese (2009); Zaidel (2013); Chatterjee and Vartanian (2014); Kirsch et al. (2015); Boccia et al. (2016); Pearce et al. (2016).
[118] Gablik (1999): 106.
[119] Gablik (1999): 71-75, 112, 157, 178.

society. For Gablik, these are all elements of the empathic mode of thinking[120], "in which the polarizing, objectifying tendency has been neutralized and replaced by a belief in the restorative action of care."[121] With 'care' she means a 'quality of attention', which involves committing to looking and listening together – the methodological centre of *Meet Me* and *Onvergetelijk*.

The neurological version of empathic identification, so to say, could be embodied simulation as described by Vittorio Gallese. Embodied simulation generates, to a more or less extent, the capacity of empathy and of sharing the meaning of actions, intentions, feelings and emotions. Because of this we can identify ourselves with and feel connected to others.[122] Gallese hypothesises that social identification is underpinned by the activation of shared neural circuits that establish an interpersonal link – or, a 'we-centric space'.[123] Comparable to Merleau-Ponty's theory, this means that there is no distance between the people involved, and that they are momentarily interconnected. The neurological fundament for embodied simulation is Gallese's extensive research on mirror neurons. Mirror neurons are "premotor neurons that fire both when an action is executed and when it is observed being performed by someone else."[124] In other words, perceiving an action done by someone else activates the same neural mechanism as when executing that same action for oneself. It needs to be said, however, that Gallese's conclusions have been heavily criticised as the initial research has been done in macaque monkeys, and up to this point no unambiguous proof can be detected in humans. Research is ongoing, and so far Gallese's findings suggest that perceiving not only actions but also someone's emotion activates the same brain areas as subjectively experiencing that same emotion for oneself. This process could not exclusively be triggered by other persons, but also by static images.[125] Similar to the arguments regarding empathic identification, embodied simulation would be responsible for our feeling of compassion, responsibility, understanding, trust, respect and help.

Merleau-Ponty's notion of sense-experience sheds a light on why emphatic identification and relational dynamics would form an effective fundament for an intervention. Earlier we saw that for him the relation to the objects, people and world around us is intrinsic, and that the body functions and behaves accordingly. From this point of view it is no wonder that emotional and social engagements are the strongpoints of *Meet Me* and *Onvergetelijk*. These are inherent to relational dynamics and empathic identification, and receive an impulse in programs such as these. Through becoming conscious of one's physical, sensory and emotional state of being – or, one's sense-experience – and of one's place in the world and relation to others, it is a logical step to emphatic identification; more so than from a detached, 'disembodied eye' that explains or rationalises what it sees and knows.

When we relate this to MDD, we saw that one of the difficulties is that the person endures certain cognitive patterns, or, schemas, that dominate his or her thinking and behaviour, determining their everyday life. In MDD reenchantment could contribute to shifting these cognitive patterns, by encouraging hyper-awareness and redirecting the attention toward the self and one's place in the world, on one's own account. Schemas also determine someone's process of meaning making, which particularly takes place in one's head through rationalisation and overthinking. The isolation of the mind results in a detachment from one's physical, sensory and affective experiences, resulting in a disembodied eye as Gablik describes. In other words, for

[120] Gablik (1999): 71-75, 112.
[121] Gablik (1999): 71.
[122] Gallese (2009): 521-532.
[123] Kolb and Wishaw (2006): 410-412.
[124] Gallese (2009): 520. See also Rizzolatti and Craighero (2004).
[125] Gallese (2009).

someone with MDD meaning originates from overruling – mainly negative – thought patterns instead of from the actual interaction from the body and mind with the world. As the enacted mind theory specifies, mental processes are defined by actions in and on the world, but in the case of MDD there is a lack of these encounters. Moreover, if the cognitive processes are so disconnected from the body, it not only influences someone's lived reality and mind, from the theory of the embodied mind, but also the structure of the brain, as seen in §2.1. Reenchantment would then mean moving away from rationalising schemas towards a reconnection with the sensorimotor system in the process of meaning making, and in doing so change someone's thought patterns as well as the neurological patterns.

We can now safely say that the key to reenchantment is meaning making: not through external, rational, factual knowledge, but through bodily sensations, internal feelings and relational encounters – with the artworks as well as with each other. This does not mean that the artwork itself is unimportant. The formal aspects and background information of an artwork can contribute to the experience and signification of it, but those are not the end goal of meaning making. Instead, meaning is, following Backhaus and Heijne, constituted by the interpretation, consideration and appreciation of these facts. What Backhaus calls hyper-awareness can generate, according to Bernstein, a move away from routinely applying concepts and from normative thought patterns[126] – or, from schemas that are present in MDD. Gablik and Merleau-Ponty show that this does not happen in isolation, but in relation to others, being time and place-specific. Meaning is not intrinsic to the object, but neither to the subject. It arises in the encounter and that is where the importance of the guided conversation comes in. The dialogue can connect and open up the possibility to wonder and relate. Gablik states that disenchantment is fully fixated on the *isolated* individual and dismisses conversation. She relates this to the modern perspective on art that the audience cannot talk back; it rejected dialogue and interaction.[127] Reenchantment, on the other hand, exists in actively relating art to life through interaction – or, in embodiment, embeddedness and enactment. To her, and we see this in *Meet Me* and *Onvergetelijk* as well, art realises its purpose in relationships, because it creates a sense of compassion, responsibility and community. This is what makes the act of engaging with art healing.[128] These points are exactly what the NYU and VU have found to be the strongpoints of respectively the *Meet Me* and *Onvergetelijk* programs. Bernstein states that a disenchanted life is experienced through destruction, loss, fragmentation, or disintegration.[129] To pick up the analogy, these too are manifestations of MDD. The person becomes not only disconnected from the sense-experience but also from his or her sense of self and place in the world. In order to move beyond this an intervention could help to refocus on this, as it can – theoretically – evoke a form of reenchantment, for which I borrow Gablik's criteria of "participative, empathetic and relational modalities of engagement."[130] This way, sense-experience and empathic identification have become the other two key elements for the intervention in order to contribute to the wellbeing of people with MDD.

§2.5 Preliminary conclusion

As the literature review in this chapter has shown an intervention in a museum could theoretically be availing when it comes to certain symptoms and manifestations of MDD. These are, as defined in the *DSM-5*, a depressed mood, a loss of interest or pleasure, a feeling of

[126] Bernstein (2001): 310-317.
[127] Gablik (1999): 150.
[128] Gablik (1999): 143, 150-158, 173.
[129] Bernstein (2001): 342.
[130] Gablik (1999): 131.

worthlessness or guilt, self-dislike, self-blame, self-criticism, a distorted self-image, a low self-evaluation, social withdrawal, carelessness, and a loss of gratification. This chapter also explored what, in theory, the key elements would be of an intervention in a museum that would achieve easing or decreasing of these manifestations.

First of all, Foucault and Dehue demonstrated depression is not a fixed concept, nor a determined neurobiological state of being. The diagnosis changes over time and comes with different sociocultural implications. Nowadays depression is oftentimes associated with ableism, in the form of prejudices and expectations, imposing limitations on someone's identity. With this in mind, based on the ideas of Jarman and Mitchell and Snyder regarding the problematic concept of ableism, it appeared an intervention would need to gravitate towards the self and one's position in the world. It is fundamental to emphasise someone's own capabilities, instead of having thoughts and feelings imposed in terms of functionality. The intervention should be an open and safe space, without the external pressure of societal value.

Secondly, following the thoughts of Gablik, Heijne and Backhaus, the intention of the intervention would be meaning making, as a crucial underlying problem in MDD is the difficulty of finding meaning. Meaning – in the sense of experiencing significance and understanding regarding a situation, object or image, directly related to personal feelings and emotional associations, and to the particular time and place – occurs through three processes. Through relational dynamics meaning arises in the encounter with the surroundings and people, as seen in Gablik's theory. This idea is situated in the partnership model, in which the self is embedded in a larger whole instead of isolated. This embeddedness highlights responsibility, affinity, compassion and the capacity of sharing experiences – features that need encouragement in MDD. Relational dynamics ties in with the embedded and enacted mind, which advocates that mental processes are defined by someone's environment and the way he or she acts on that environment. An intervention would function as a motivator for this enactment. Through sense-experience the body constitutes meaning, explained by Merleau-Ponty as a continuous interplay between the body and its surroundings. The sensory input and physical sensations that follow from this interplay cause emotional associations. The notion of sense-experience is supported by the idea of the embodied mind, signifying the body-specificity of the experience and perception of the world. Through empathic identification meaning is generated through interaction leaning towards empathy and compassion, as is demonstrated in *Meet Me* and *Onvergetelijk*. Empathic identification in Gablik's sense, with the capacity to understand, trust, respect and help in the foreground, has proven to have a healing effect in these programs, and would also form an effective foundation for an intervention for MDD.

Highlighting meaning making and the self and one's position in the world are important, because they could cause or stimulate care, comfort, hope, compassion, joy, recognition, understanding, signification and connection. An intervention in a museum could contribute to the wellbeing of the participants, as it could be a motivator for a realisation of these features. From the concept of reenchantment, engaging with art could appeal to identification, recognition, imagination and wonder. With Backhaus' point of view in mind, this emphasis could bring about a consideration and appreciation of the everyday life-world, also called a hyper-awareness, which could help people with MDD to consider, appreciate or accept the ordinary again. Based on the theories regarding sense-experience and empathic identification a conversational approach needs to highlight bodily sensations and emotional associations. Schemas dominate thoughts and actions for someone with MDD, resulting in a detachment from one's affective, sensory and physical experience. An intervention that gravitates towards meaning making through relational dynamics, sense-experience and empathic identification

could instigate moving away from these schemas and reconnect with the sensorimotor system in the process of meaning making. It would then be essential that every reaction, both bodily and emotionally, is achieved as valid and meaningful, and potentially contributes to an understanding about oneself and one's place in the world.

The idea of neuroplasticity supports the critical importance of relational dynamics and recognises the theory of sense-experience, as it recognises that the brain and our state of being are malleable. The embedded, extended, enacted and embodied mind acknowledge that mental processes are not exclusively neural, but depend on or are constituted by someone's relations and surroundings. Traditionally, the dualist approach separates mind from body. Meaning making was detached from the sensorimotor system, in the sense that meaning was synonymous to intellectualisation and rationalisation – as explained by the notion of disenchantment. The 4E-theory, on the other hand, integrates the body's systems and functions as well as the body's relation to and acts on the world as playing an active part in meaning making. In MDD a detachment occurs as cognitive patterns, so, rationalisation and overthinking, define how someone finds meaning. The perception of art in a museum could be a stimulus to acknowledge that one's mind is embedded, enacted and embodied. In other words, that the mind is not separated from the body. The next step of this research is to see how professionals from the practices of museums and mental healthcare regard the assumptions as formed this theoretical framework.

CHAPTER 3 Methodology Collecting and Analysing Empirical Data

§3.1 Methodology qualitative interviews

The literature review has provided a theoretical framework that formed the starting point for the qualitative interviews. The purpose of the interviews is to evaluate and test the assumptions that culminated from the theoretical framework and to gather information and insights on the hypothetical possibilities and effects of the perception of art in a museum for people with depressive symptoms.

The interviewees function as informants, as they provide opinions, attitudes, evaluations, knowledge and insights on their practice and experience. Selecting them was a combination of theoretical, convenience and snowball sampling. That is to say, it was a purposive selection based on their potentially valuable contribution, but, as it proved difficult to meet with some people and as some responses remained forthcoming, the final selection was a result of convenient accessibility too, in which some were referred to by initial contacts. The reason for speaking with museum staff is that they are experts who work in the field of accessibility, inclusivity and education in museums, and are involved in the development and implementation of programs for specialised audiences. Psychiatrists and clinical psychologists were asked because of their expertise in the field of depression, albeit as therapist or researcher. They have experience with researching and executing workable interventions and therapies regarding depression.

The interviews are recorded, all except one conversation that takes place by phone. All interviews are semi-structured, in the sense that they have the form of an open conversation following a topic list. The topic lists are based on the preliminary conclusion from the theoretical framework. The themes for museum professionals are:

- Inclusivity and accessibility of the museum.
- In which ways specialised programs contribute to openness and to breaking stigmatization.
- The purpose and content of the specialised programs in the museum.
- The way the artworks are approached: through knowledge or personal experience.
- The effect on the participants of the specialised programs.
- Thoughts on the setting and target audience of a possible intervention for people with MDD.

Those for mental healthcare professionals are:

- Art as a possibly effective stimulus for people with MDD.
- The relevance of empathic identification for people with MDD.
- The effectiveness of a multisensory approach when engaging with art.
- The symptoms and manifestations of MDD that engagement with art could appeal to.
- Thoughts on the setting and target audience of a possible intervention for people with MDD.

In one interview, a specialist in museum inclusivity joined the conversation with the educator who was contacted in the first place. By the end of the thirteen interviews saturation occurred, as not any more brand-new information was received, so the amount of conversations appears sufficient.

§3.2 Methodology data analysis

For analysing the interview data a slight adaptation of the Grounded Theory Approach (GTA) is used. GTA was developed by Barney Glaser and Ansel Strauss in 1967 as a new sociological method. Their innovative addition of discovering theory from data instead of vice versa and generating instead of exclusively verifying theory became a widely used strategy in social studies. GTA is based on constant comparative analysis.[131] As my research is not about analysing social phenomena, it does not strictly follow the GTA. What is used from the GTA is the explorative collection and analysis of the data, being concentrated on the formulation of a theoretical conclusion. In each step a constant comparing of theoretical concepts and empirical data is applied. Throughout all stages memos are made. The guiding sensitizing concepts, as explained in §1.3, also come from the GTA.[132]

What is slightly different from the initial GTA are the three cycles of collecting, coding and analysing data; originally, with newly retrieved insights a new round happens, three times over.[133] My study started with the data collection in the form of a literature review, with the aim to collect theoretical insights on the sensitizing concepts. Analysing these resulted in a theoretical framework, presenting the key theoretical concepts and concluding with assumptions. Here the first round of coding happened with pre-set codes, being the theoretical concepts – ableism and stigmatisation, sense-experience, empathic identification, hyper-awareness, signification, and affective relation – forming the starting point for the topic lists of the interviews. The second cycle of data collection are the qualitative interviews, concentrated on collecting insights from the practices of museum and mental healthcare. The first analysis of the transcripts happens through axial coding with emergent codes, in order to arrange the data into general categories for a first overview. Themes and patterns are identified, as are useless fragments (or, 'dross'). The axial categories are: accessibility and inclusivity, MDD symptoms, art as motivator or stimulus, multisensory approach, conversational approach, effects from specialised museum programs and therapeutic interventions, Visual Thinking Strategies, neurological elements, and organisational aspects. Each category is exemplified by a symbol, which is written on the printed transcripts. From this step onwards it deviates from the original GTA, as the there is no third stage of data collection. The third analysis is the link between the theoretical framework and the interview data, connecting the theoretical and practical insights. The final step of selective coding exists of emergent codes, which are four umbrella categories – MDD symptoms, approach and effect, risks, and practical points of interest – subdivided in specific topics. Each umbrella category is assigned a colour, these being blue for MDD symptoms, green for approach and affect, red for risks, and purple for practical points of interest. Each sub-category is numbered. The combinations of colour and number are also marked on the printed transcripts (e.g. Rumination is Blue-4, and Activation Green-8). The results, as assessed next, will form the foundation for answering the research questions. The cycles demonstrate the constant assessment of theoretical sampling and empirical data, and the results from each step form the starting point for the next.[134]

In the analysis of the interview data, informants are anonymised and called by their profession or expertise. When it says 'informants' in general, it means people from both fields shared their insights on the matter. For the sake of readability assenting 'yes' or 'no' and confusing slips of the tongue are left out in the translations. The original quotes can be found in

[131] Glaser and Strauss (1967): 1-21.
[132] As explained in Verschuren and Doorewaard (2007) and Boeije (2014), following Glaser and Strauss (1967).
[133] As explained in Verschuren and Doorewaard (2007) and Boeije (2014), following Glaser and Strauss (1967).
[134] For a schematic overview of the methodology see Attachment 1.

Attachment 2. Some statements are supported by documents. This source triangulation functions as reinforcement of the informants' argumentation. The first version of the data analysis results (Chapter 4) was sent to the informants so that they could see if their words were translated aptly and could correct unforeseen inaccuracies. No extensive remarks were made.

CHAPTER 4 Results Qualitative Interviews

§4.1 MDD symptoms

The first umbrella category is major depressive disorder symptoms, and this section presents the informants' ideas and clarifications on which ones would be concerned with an intervention in a museum. Five emerged from the interviews, namely decreased interest or pleasure, social withdrawal, negativity bias, rumination, and emptiness.

Almost half of the informants address that people with MDD experience a decreased interest or pleasure. In the words of a psychiatrist: "People with depression can have more difficulties experiencing and enjoying things." Consequently, they raise the question of how they will be motivated to participate in a museum program. They all say something similar to this museum employee: "Of course you have to get someone to come with you, that is as hard as it is." This does not mean an intervention in a museum cannot work, on the contrary. Another psychiatrist says: "People with a depression experience very little pleasure, so if you could add something to that it would be good."

In line with not feeling motivated to do things, is social withdrawal. Four mental healthcare professionals describe how depressed people experience difficulties with empathising with and caring about others. Or, as one of them specifically states: "People with depression have the tendency to retreat from their social contacts. To stay at home, to stay on the couch, or to stay in bed. So they close themselves off from all environmental stimuli and retreat with all kinds of ideas about this." Someone else specifies: "[Depression] gives a kind of cocoon view, and [people] also have less interest in others, even in others who are very close to them." Another psychiatrist describes how it is not easy for depressed people to engage with others, but that social engagement is a useful activity and that a museum intervention could function as such: "They often think it to be a little threatening, but usually the experience is rather favourable, and this is of course an accessible way, because you do not demand too much."

An important issue that several mental healthcare professionals mention is the so-called negativity bias. This means unpleasant experiences and negative input stick longer. Multiple studies have shown the neurological and psychological effects of the negativity bias, and show correlations with anxiety and depressive disorders.[135] A psychologist indicates: "the fundamental emotion is so negative in depression, and people cannot get out of that. […] That such a negative network [in the brain] is activated, that is extremely dominant", and "a depressive person is just more inclined to save negative things." She, as well as the others, estimates that this negativity bias will also be effective when looking at art. As one of them states: "They always interpret more gloomily than we think, so that will probably be the case with art too." In someone else's words: "within the image […] they focus on all sorts of negative cues." Nevertheless, two experts propose that looking at art can train the patients to focus on the neutral or positive again. As a psychiatrist clarifies:

> People with a depression have a bias and they have a preference towards the negative, both images and interpretations, as well as selecting their objective of attention. And indeed you could do something by, for instance, replacing negative images by neutral ones, or teach people to

[135] Marano (2003).

> observe positive things more. […] Then you are working on shifting that focus very specifically, what in itself could be a really good strategy.

A recurring response from mental healthcare professionals is this shifting of focus, not just regarding the negativity bias, but also in reaction to so-called rumination.

Rumination means getting stuck in one's stream of thought, by repeating generally negative thoughts over and over again. This too has strong links with anxiety and depressive disorders, as it deepens a downward spiral.[136] Most of the mental healthcare professionals name this to be a dominant difficulty in MDD. As a psychiatrist explains:

> They continually repeat [negative thoughts], such as 'why do I have this and that', comparing to others, or comparing to yourself and what is not possible anymore. So, a lot of their time is consumed by staying trapped in negative spirals, and that is a crucial maintaining factor in depression.

Another psychiatrist adds:

> They are often really distracted by their internal thoughts, so they concentrate very badly. […] And people often believe that cognitive functions stopped working altogether, […] but in fact, they are so involved in their own thoughts that they lose their attention to anything else.

The last manifestation of MDD that a couple of informants present is a feeling of emptiness or apathy. One of them urges: "Do not underestimate the affect, which is completely flattened out in people with a depression. That is actually one of the larger problems, that they do not feel anything." Or, as another psychiatrist puts it: "What you often see in people with depression is nihilism, so that means […] that you do not believe anything to be worthwhile, and nothing has any meaning left for you."

§4.2 Key elements approach and effect

Now that we have five dominant symptoms of MDD that an intervention in a museum could be concerned with, this section shows the informants' responses regarding key elements when it comes to the approach and effects of such an intervention. Eight sub-categories surfaced: An open and welcome attitude, recognition and identification, shifting attention and focus on the moment, continuation in everyday life, impact on the brain, signification and connection, the role of information, and activation.

The ratification of the Convention on the Rights of Persons with Disabilities by the United Nations made sure that museums pay more attention to their accessibility. All interviewed museum professionals report that they aim to make their institute as inclusive as possible, meaning that everyone would feel welcome. Achieving this lies in the programming as well as in the ambiance. One of them declares: "By acknowledging this audience [Alzheimer's patients and their caregivers] exists and inviting them for a special program, they can now return." Another educator affirms:

> For someone who is blind and perhaps always thought, a museum is not for me, then you perhaps have an additional objective to demonstrate, look, we can add something. […] That is, if you can make that connection and someone feels touched, then you automatically show: the museum has something to offer you.

[136] Wehrenberg (2016).

An ideal to pursue for most museums is to be able to have a toolkit for the tour guides in order to welcome anyone at any time, and meet every visitor's wishes. This means the medical category is not leading anymore: "In the enrolment [for a slow tour] I will not [ask], 'do you really have something', because I assume that people who do this really wish for this calmness. But that makes it inclusive, that you have everyone mingled." In some cases this might not work, however, so one museum educator reckons: "As often as possible together, separate when needed." But an inclusive museum contains more than programming: "It is the whole entourage of entering." This means that the whole institution must collaborate, in order to provide a pleasant visit for everyone. The same educator illustrates: "If a museum really does not feel like it, and the security does not feel like it and the catering does not feel like it, then you are flogging a dead horse because the people will not have a pleasant visit. Because they will not feel welcome." On her program for Alzheimer's patients, another educator says: "It should be light-hearted, it should be nice, it should be super delightful, and the museum needs to sustain that." In line with this, a kind and fostering ambiance seems essential. She also declares: "Sometimes people enter quite afraid, anxious, but we just know that they mirror, so we are always really cheerful and inviting, and very kind, and then, like that, they mirror and go along." Offering hospitality is one thing, but the methodology of the tour is another. When it comes to creating a welcoming atmosphere the *Onvergetelijk* methodology is a setting example. The tour is not about 'right' or 'wrong' answers, but any response is valid and valuable. One of the museum employees working with *Onvergetelijk* states:

> Acknowledging thoughts is important in the methodology of *Onvergetelijk*, and I can imagine that you would develop a similar method for people with depressive symptoms, [...] but whether or not you can steer it in such a way that you just arrive at positive notes... the whole method is positive.

A number of mental healthcare professionals also believe this to be relevant. Feeling acknowledged is crucial, so that "you feel part of a whole." One psychiatrist claims that the focus should be on "what is already there and whether or not you can utilize that." She pleads for an approach as normal as possible, by not treating the participants as 'patients' but as ordinary people "just looking at art."

Both museum and mental healthcare professionals share their ideas on recognition and identification when collectively engaging with artworks. This process could take place on three different levels: identifying with the artwork, the artist, and the other participants. One educator describes how participants from her Alzheimer's program often recognise themselves in the portrayed scenes, which brings about great stories, for instance that they recognise their birthplace in paintings – whether that is the Northern countryside or Surinam rice fields. This identification is not necessarily tied to depictions of depression. Those too could have their effect, as another museum worker says: "Recognition is always good. [...] We have an enormous collection [...], so many prints and old library books that probably contain things about depression, which could be quite interesting [...] to work with." The first strategy is about pulling the perception into ordinary life, stories or memories and so create a feeling of identification, whereas depression is the binding aspect in the other. Nevertheless, the key point is, as a psychiatrist highlights: "I think that you could recognise a whole lot in art of what you see, and that it expresses something that you cannot express yourself." He adds recognising oneself in the artist: "Of course many artists have struggled with or struggle with severe depressions, but who

manage to make really beautiful art. Well, that story, if you hear that story as a patient, I think, it could be very encouraging." Identification revolving around depression, whether with the work or the artist, can, according to another psychiatrist, achieve "that you feel, 'this is a universal human experience', or, 'there are more people who suffered from this or experienced that, and I am not the only one in this'." This process could take place not only on the level of perception, but also of sharing thoughts and feelings. The majority of the informants announce the importance of talking and sharing, of which they see direct benefits in their practices. Educators experience the positive effects of interaction during regular tours, special programs for the elderly, and *Onvergetelijk*. Or, from the point of view from a psychiatrist:

> You only have to tell what you think of something, or which impressions you get. So, that could have an effect in itself I believe, doing an activity in a group, directing it not too intensely towards exposing yourself but towards talking with each other about something you saw and experienced. I think that could be quite good.

The artworks then function as mediator or stimulator for the unfolding of recognition and identification. A psychiatrist sums up:

> Depression is also a relational problem. […] So, if it works out to engage in a conversation with others by means of art and perhaps tell something about yourself, about what you feel and for instance be able to explain something in a more indirect way… […] That would work, yes.

The previous section discussed the experts' thoughts on rumination. In order to counteract rumination, to interrupt negative spirals and to get out of one's head, four psychiatrists suppose that directing awareness to one's physical sensations should be effective. From the perspective of mindfulness, according to one of them, this means being more present in the here and now: "All sensory observations are by definition in the here and now. And by directing your attention towards that, you almost by definition let go of the streams of thought, negative streams of thought in your head." Art can then function as external point for this direction of awareness. She also describes a mindfulness exercise, which trains to mindfully look at something. This means paying full attention to what you see, and if you get distracted you kindly bring your attention back to the act of looking. She reckons that visual art could facilitate this. It also includes "becoming conscious that the perception is something different than the interpretation of that perception." Another psychiatrist agrees with the idea that practising to concentrate could be favourable. He raises the question why the object the attention is directed at should be art, instead of, for example, looking out the window, but answers himself by saying: "Art can probably more easily capture that attention, so that you wonder, 'what do I see, what is it…' so in that sense, I think that could work, […] focusing, and then really on something external instead of internal." That is, people with depression already focus too much on internal struggles, as is the case with rumination. This is closely related to overthinking and rationalisation, and another psychiatrist reckons that "perhaps it is an idea that they could feel something. So, literally touch. Because then you do not have to think about it for awhile." A museum professional sees this happening in *Onvergetelijk*, where each tour has an interactive element, such as smelling samples or making a clay sculpture. She describes:

> It really is about experiencing the art in the moment, and by integrating such a multisensory aspect this can be triggered even more. […] To get out of your head, but experience it in the moment in multiple ways, and the sensory aspect is, I think, really positive.

However, another museum educator stresses that these multisensory elements could also be counterproductive. He indicates that it takes experimentation to see when it works or "when you cross the line towards: 'why would I, I am smelling perfume and should I think that woman is wearing that perfume now?' It should make sense, and people are very sensitive about that." Directing attention not just encompasses being aware of physical sensations. It could, according to some educators, also be about providing people with another mind-set. Both of them doubt just the act of looking at art being inherently therapeutic or healing, but both believe it could give the participants a "more positive feeling, inspiration, [or] a new insight." From a psychologist's point of view: "every psychological intervention […] is inherently about an emotionally corrective experience." In line with this, various mental healthcare experts suggest looking at art could add to practicing paying more attention to positive things. One of them considers: "by means of art investigating which positive experiences or feelings can trigger associations, and to explicitly experience these." A psychiatrist mentions bias modification, which entails increasingly showing positive images instead of negative ones in order to shift the person's attention, and he believes artworks could also have such a function.

Earlier on one psychiatrist emphasised the importance of approaching the participants as normal people looking at art. This is directly related to the following aspect. Most of the informants address that the act of looking at art can be continued in everyday life, instead of purely being part of therapy or recovery. As the same psychiatrist puts it: "It would be a shame if it is just related to the depression." A museum educator considers that it could regard "practicing how to look, in order to be able to engage with art without a tour as well." Two other museum professionals agree with this. A few mental healthcare experts propose to not completely detach it from therapy, however, but combine it with themes dealt with in the treatment. One of them states that in her practice she gives small assignments to her clients, so that they can work on something at home. A museum educator has a similar experience with *Onvergetelijk*, where participants receive a postcard with which they extend the experience into their home. Another reason to encourage continuation in everyday life is, as addressed by two medical experts, the high relapse rates. A museum intervention could function as support: "There are not many things to do to prevent a relapse, and I do not know if you will really prevent relapses with this, but it might serve as something to hold on to, or as something that could be pleasant for some people." One museum notices the benefits of something similar regarding a project in nursing homes. It received feedback that participants and carers wished to acquire something they could work with after the particular workshop, as they felt it was a shame it was a single and momentarily event. The first-mentioned psychiatrist summarises: "In that sense art is much more than just a means to get out of your house and then get back into that depression." In other words, it is not about escaping or defining the depression, but about coping and connecting to what there is in everyday life.

Perceiving art in a multisensory approach and extending this into ordinary life not only defines the participant's experience, but has impact on the structure of the brain too. One educator refers to the study that demonstrates how looking at art activates the same brain areas as looking at a loved one.[137] A psychiatrist agrees with this but critically states that the choice of artworks would matter. Almost half of the informants talk about how the structure of the brain changes as a result of depression, but point out how engaging with art – especially in a multisensory way – might stimulate new areas. A psychologist relates it to her own research on

[137] Heesbeen (2017): 13, referring to Ishizu and Zeki (2011).

memory: "You activate the brain more globally instead of merely visually, so I definitely think this can invoke more. Memory based on the olfactory system, smell, is really strong." A psychiatrist talks about how depression is damaging the hippocampus, and that studies have shown it to be favourable for the hippocampus to offer many rich stimuli. He also points out the role of different networks in the brain.[138] Two that play a part in depression are the default mode network and central executive network. The first is activated when someone is not doing anything specifically. The latter becomes active when someone has to execute a task. He explains:

> What happens with people with a depression is that they have a way too active default mode network, which means they remain to themselves, working on those self-reflective processes, and they do not manage to get out of that and make contact with the outside world. […] Furthermore, this default mode network is not just reflecting neutrally, but negatively […]. A way to get out of that is just to stimulate you, by doing something else and just offering *something*. In that sense, neurologically, if you offer certain stimuli that cause the default mode network to retreat into the background for a while, that would definitely be good.

Three other mental healthcare professionals also reckon that activating other patterns in the brain could be beneficial, because "you carve out that path in the brain."

Almost all informants consider in various ways how a tour contributes to establishing a personal connection with an artwork, and to forming opinions and significance. One museum educator states that the aim of a tour is to "feel touched and to feel a connection with Van Gogh or his artworks." Two others add that this includes linking it to your own life, and to see what an artwork means for you specifically. A psychiatrist affirms: "When you are looking at art, that is something between you and the object." Multiple people refer to forming opinions as a valuable prospect of a tour. One educator speaks for all of them when he says: "you learn to define yourself and you learn to develop your own opinion, and I think in the end art is meant for that. Not as independent unit, but as carrier of emotions." Various experts gather that it is useful to observe why we think something to be beautiful or ugly, as that says a lot about ourselves. Looking at art can help to practise this reflection. This is not just about forming opinions but also making meaning, which six people believe to be a part of perceiving art. Meaning making can encompass multiple aspects. A psychologist mentions training to notice what gives rise to a positive feeling, and how someone can select their choices and actions on that – not just during the tour but also in ordinary life. Another psychologist reckons meaning can be adjusted, so if someone is repeatedly exposed to a specific image with a specific sound, the relation forms a new association. She also brings up so-called cognitive restructuring. This means rearranging thinking patterns (schemas). She says that in psychology cognition is equal to meaning: "You experience all sorts of things, but what meaning do you give to that, what are your thoughts about that, what are your thinking patterns about that?" Hence, in order to change these schemas, someone's way of meaning making has to change. And merely being exposed to a stimulus, such as an artwork, is not sufficient to do so; one actively has to work on this, for instance in the form of a conversation. This is in line with one museum's educational method, in which philosophising is leading. The educator states: "We notice you need a vehicle in order to help people with letting [art] personally touch you." He stresses that Visual Thinking Strategies is particularly rational, as it is merely about looking and describing what the beholder sees, whereas with a philosophical conversation the participants can connect that which they see to

[138] Networks in the brain connect areas or structures in order to execute certain functions.

what they feel and think about it. When it comes to signification a psychiatrist recommends involving the space in the conversation, as the arrangement, in terms of e.g. object placement, colouring, size and architecture, influences someone's perception and interpretation. Not only is this crucial in the experience of art, but it can explicate the lived reality of the participants. This explication is also articulated by another psychiatrist: "Someone has to internalise in a way what it means to be depressive and find expression therein, search for metaphors. Well, I think that is what art can do." He believes art can give meaning to what happens on different levels. On the other hand, a psychiatrist indicates that from a mindfulness point of view it is rather about letting go of meaning: "People with depression tend to attach negative meaning to themselves and others. […] People are particularly encouraged to notice that, also as a memory or association, […] and then to let go and return to what you see and feel."

In line with what has been said previously, the focal point of most museum tours appears to be the visitors' personal experience instead of knowledge. As one educator declares: "I am convinced that art is for everyone. And everyone looks in a certain way, but in the end it is about perceiving art with your heart. And not with the knowledge in your head." From their practice, most museums notice that visitors appreciate it if they have input. Two museums, on the other hand, conclude that the general visitor wishes to just see the masterpieces and listen to a story. Consequently, a coherent narrative is their approach for most tours, in which there is little space for interaction and personal interpretation, as passing on information is the central objective. Another museum explicitly states that is *not* their objective. Rather, this is social engagement. One educator tells how in her museum there is a combination between the two:

> Questions are asked, to which [the participants] can give their opinion. So, we partly tell the art-historical story too, but that is not the focal point. That is particularly on 'what do you see, what do you notice, which feeling do you get with this painting, what kind of person is this, what sort of character would it have…' and that works really well.

In the words of another museum employee: "I think sometimes information can give just the right hook […] for someone in order to see the connection with that work." This corresponds with a psychiatrist's view, who believes information about an artist and context can contribute to the appreciation and recognition, as we saw before, but that the participants should not be flooded with information.

The previous paragraphs mainly revolved around the possible approach and effect of a program in a museum for people with depression. The last point appears to be a critical one, as almost all professionals confirm engaging in any activity would be valuable for someone in a depression. It corresponds to a decreased interest or pleasure, social withdrawal and emptiness, because participating in such a program could be an impulse for coming out of that – albeit temporarily. A psychiatrist reckons:

> Everything is a stimulus if you get them out of their cocoon. What they do with it and if they can do something with it that is absolutely the question, but anything can add. And the good thing about art is […] that it is different. […] It is difficult to immediately have a standardised story about it.

Art could thus be an effective motivator, in the sense that it stimulates the participants in a different way than they are used to – affectively, cognitively and neurologically. All informants in the museum practice underline the positive effects of activation, particularly concerning *Onvergetelijk* and similar programs for elderly people. One of them illustrates: "Just the fact that

they get out, have to make a step, get here, be here… with that you have already won everything." Four of them observe that participants appear to be able to do much more than thought of in the first place, for instance talk, draw or walk more then they usually do. They flourish because of this activation and social engagement, and this occurs due to the methodology of the program. Merely listening to a stream of information appears to not be the right approach. Instead, as most museums have great experience with, the tour should include interaction but also small assignments – although not with right or wrong choices. This can include, for example, sketching, writing down associative words, drawing, or imagining the story of portrayed characters. The ultimate result for the participants would be, as an educator describes: "It would be so good if you feel like, 'yes, I *do* have that energy, I *can* do that, I can get out, I can get a hold of myself and I can make that decision.' And you can achieve that here very well."

§4.3 Risks

Now that we have an idea of the informants' thoughts on specific MDD symptoms and possible effects to ease or decrease these, this section announces some risks that they notice. These are: stigmatisation or labelling, negative spiralling, and overstimulation.

One caution that some museum professionals indicate is the definition of the target group. On the one hand *Onvergetelijk* claims to break taboos around Alzheimer's[139], but on the other it defines the participants as people with Alzheimer's. The same would go for a program for people with depressive symptoms. One educator says: "what kind of name would you use, […] as if there is a flag waving with 'look these people have depression'." And as the other puts it: "Would they have the need to be defined in the museum as someone with a depression?" However, precisely this point is the reason one psychiatrist stresses the importance of "ordinarily ordinary", as we saw in the above, and why an open and welcome attitude is so critical. Apart from that, an educator emphasises that *Onvergetelijk* does work anti-stigmatising, in the sense that it "spreads knowledge in a positive way about people with dementia, and doesn't show their disabilities but capacities. […] So, not the wallflower in the nursing home, but someone who can live in an active way with loved ones in the museum in the moment." This could count for a program for people with depressive symptoms as well.

A negative spiral is the second risk, which half of the informants address. This negative spiral can occur due to several aspects. Most of the mental healthcare professionals speculate that certain negative associations could be affirmed or boosted, by either looking at an artwork or talking about it. One of them explains: "If people identify too much with what they see, or with the feeling it evokes, […] if people cannot look at it with some distance and lose themselves in it or identify themselves with it, then the depression perhaps only increases." Another psychiatrist considers the opposite, namely that people experience too much distance, in the sense that they do not feel anything at all or do not know what to answer. This could be really frustrating and counter-effective. The last element is, as a third psychiatrist regards, a barrier that some people might experience, especially if they are not too familiar with art. That is, they might feel that they do not understand the art, which only induces resistance or aversion: "Of course it depends on which art you show. […] Because I think, if you do not have experience with it, that particularly modern art can evoke something like, 'this is such nonsense, I'm not even considering it'." In order to prevent such a negative spiral, a good preparation is essential because, as a museum educator notices in her practice: "It *does* hurt to try."

[139] Heesbeen (2017): 66.

The last risk is overstimulation. Too many stimuli can be counter-effective too. This manifests in, for instance, having trouble with vocalising thoughts, making choices, processing information, or concentrating. Overstimulation can be extremely tiring or oppressing, or invoke anxiety. A museum educator gives the example of an experience he had with a manic depressive visitor: "He wanted to see a Van Gogh by all means, and walked to the exit like this [with his hands before his eyes], because he just received too many stimuli. […] He wanted nothing else on his mind, except for the work that he saw."

§4.4 Practical points of interest

In order to reduce these risks, most informants say that testing is needed in order to have enough ground in order to decide what works best. Six points of interest came up that they share their thoughts on: the choice of artworks, the discussed topics, the questions asked, the target audience, the setting, and the appropriate guide.

As implied in some of the previous parts, the choice of artworks depends on the tour. Some audiences just want to see the masterpieces, but others prefer to engage with or philosophise about the artworks. In the *Onvergetelijk* program the guide chooses the artworks, revolving around a theme. In theory, the methodology can work with any piece, but multiple informants state this is a bit more difficult with MDD, because of the aforementioned risks. In the selection process there is always the practical issue of walking distance and spatial planning. A psychiatrist and a psychologist propose, in line with the latter's idea that such a program can help to practise making choices, to let the participants choose which artworks they would like to engage with, based on a good or bad feeling about it. An educator argues that people will be disappointed if they do not see Van Gogh's *Sunflowers* or *Almond Blossom*, "which goes for deaf visitors as well as hearing visitors." A psychiatrist reckons, as stated before, that the story of the artist matters. Another prefers using not-so-famous artists, as the beholder would then not be preoccupied with expectations and dispositions – which might not come true and be disappointing and counter-effective. She supposes that striking contrasts, bright colours, large objects or a spatial room would be most effective, as "it seems they are always under a black blanket, which removes a great amount of nuance." Another choice would be classical or modern art. A psychiatrist believes the first to be better, in terms of recognisability and preventing alienation, whereas a museum educator claims that people react better to abstract art. A psychologist describes psychological studies that found patterns in which kind of images inherently evoke positive reactions, such as a smiling baby, a naked lady (particularly without lingerie), or landscapes: "From biology there are certain patterns that are instinctively reacted to really quickly." This stands in sharp contrast with what *Onvergetelijk* shows, namely that landscapes invoke the least reaction.[140]

When the artworks are selected, there is still much to adjust. The discussed topics are sensitive, as there is the aforementioned risk of a negative spiral or overstimulation. From a mindfulness perspective, one psychiatrist suggests paying attention to the beholders' response regarding the artwork, the space, and the other people. Mindfully observing sensations, thoughts and urges can make someone reflect. Various informants indicate that it would be better not to discuss too heavy subjects, but rather focus on everyday topics or the momentary experience. That being said, they stress that avoidance is not desired either; acknowledging certain difficult themes can be liberating as well. One museum adopts a balance in their practice, by combining both larger and more specific subjects, which they experience to be effective. Another educator highlights the open methodology of *Onvergetelijk*, which offers a possible solution to this. That is,

[140] Heesbeen (2017): 66.

the overall theme of the tour is often something ordinary, such as food, hobbies, nature or work,[141] but whenever someone comes up with a grave story or association, this is being integrated in the conversation and not avoided. She illustrates: "You can have a bouquet of flowers and a four-year-old boy can be reminded of his grandmother's funeral." What needs to become clear from testing is which subjects trigger coping, or which create a discrepancy. As one psychiatrist points out, if the outer experience is so different from how you feel inside, this only lays bare the distance between yourself and the world around you, whereas in fact the aim of the intervention should be to decrease this distance.

Not only does this distance depend on the topics, but also on how these topics are approached. With the wrong question someone can become completely secluded, so the right phrasing is essential. The first step for multiple informants is just asking the participants to describe what they see, without judgement or interpretation. Two educators believe this is not enough, which is why they do not use the Visual Thinking Strategies method. They direct their questions to the participants' memories, everyday life, opinions, or feelings. Direction and concretisation appears to be critical, as general questions such as 'do you like it' or 'is this art' are, as an educator states, unanswerable. Large questions such as these imply they have a correct answer, and, as he specifies, "traditionally people experience a barrier to think something of art, because the dominant thought still is that there is always someone who knows more about it, and that you can say really stupid things about it." Additionally, as we saw previously, people with a depression experience an even higher barrier. The questions in this museum are always concretely covering a situation or position, so that everyone can have a response. Furthermore, two psychiatrists reckon that the focus should neither be on a generalising question such as 'what do you feel': "You tease them immensely when you ask what they feel. […] The word 'feeling'… be careful with it. […] Because they do not feel anything." However, comparable to the choice of subjects, here too an educator wonders "if you can prevent an artwork from triggering something negative."

An essential issue is defining whom the program is targeted at. 'People with depressive symptoms' is still quite broad, but only pilots can tell in which phase or for which specific group it would work best. Almost all informants share their ideas about this. Four of them recommend inviting existing therapy groups instead of having an open registration, to lower the threshold. One museum collaborates with regional healthcare institutions for the Alzheimer's program, and advises to have a similar concept for people with depression. A couple of mental healthcare professionals would invite anyone, no matter how severe the depression. Three others estimate a program in a museum would be most feasible for people in the first or last phase of MDD, and not so much for those who are in the most severe stage, nor people who are suicidal. The reason for this is that it is extremely difficult for these last two groups to do something *within* the clinic or hospital, let alone outside of it. As a psychiatrist explains:

> Nowadays we really focus on prevention. Or, for people with a light depression what we call first-step-interventions. This means there are things such as looking on the Internet if there is a course on depression or reading a book on depression, and this [intervention] would fit there.

Secondly, he argues:

[141] Heesbeen (2017): 23.

> There are of course people who have been depressive for a long time, who concluded the treatment and have improved but are not fully recovered. […] They are searching for 'how am I going to shape my life again.' And here too this [program] would fit.

Other issues that determine the target group are affection with art, age, and with or without caregivers and loved ones. A number of informants believe it would be beneficial to involve the latter in the experience too, because of the aforementioned reason to extend it into everyday life, but also being able to do something together and create positive experiences together. Two museum professionals base this belief on the fact that *Onvergetelijk* shows the great effects on the caregivers and loved ones. Regarding a psychiatrist including them would enhance the effect of 'ordinarily ordinary', and would encourage them to keep going to museums after the treatment.

Several factors of the setting would define an agreeable experience for the participants, but these too will have to be found out through testing. For instance, what would be a pleasant duration of the tour, in order to have enough time to deal with sufficient material but not cause overstimulation? It was not before pilots that a museum found out the tour in sign language needed to be one-and-a-half hours instead of an hour. Secondly, what is the best group size? There need to be enough people to maintain a conversation, but it needs to be a safe space and everyone needs to feel heard. Moreover, the guide needs to be able to oversee everyone. Half of the informants agree that such a program needs to take place on a quiet timeslot in the museum. Whereas *Onvergetelijk* sometimes takes place in a closed museum, a psychiatrist, again for the sake of treating the participants as ordinary people instead of outsiders, pleads during opening hours. She also mentions the so-called diurnal mood variation, which means depressive symptoms are more evidently present in the morning. Because of this, the person needs time to start up. Therefore she suggests doing a program in the afternoon. The last element is not something that individual museums can adjust easily, because it regards the rooms where the tour would go. A few mental healthcare professionals specify that dark rooms can work oppressing, whereas a light and spatial one can feel welcoming and open.

The last aspect that needs testing is the appropriate guide. This involves not only what feels most comfortable for the participants, but also for the guides themselves. For *Onvergetelijk* the museum tour guides have had a specific training for engaging with people who have Alzheimer's. A couple of informants propose a therapist should accompany the tour guide from the museum. As a museum professional explicates: "Because you can bring up stuff that you need to be able to adequately react to in order to pull people out of that. […] Imagine someone going overboard, then [a psychologist] could provide support in an appropriate way." He and the two others state that it could be too much of a responsibility for a museum guide. A psychiatrist recommends not necessarily a therapist, but an experienced expert. That is, someone "who can hit the right tones in how you approach and engage with people with a depression in the best way." She adds: "not with a fragile 'o help' attitude, but just [having a conversation] together."

CHAPTER 5 Conclusion

§5.1 Outcomes

The data analysis of the interviews revealed that some assumptions formed in the theoretical framework were plausible, and others needed revision. This final chapter goes into the evaluation of the assumptions by setting the theoretical and empirical insights alongside each other, and, in doing so, provides answers to the research questions. It lays bare in which ways perceiving visual art in a museum could, in theory, be an effective intervention for people with depression.

Starting with the first sub-question, which symptoms of depression could possibly be eased or decreased by perceiving visual art in a museum, we see that the informants specified the symptoms for which an intervention in a museum would be feasible. The concerned MDD manifestations as formulated in the *DSM-5* were a depressed mood, a loss of interest or pleasure, a feeling of worthlessness or guilt, self-dislike, self-blame, self-criticism, a distorted self-image, a low self-evaluation, social withdrawal, carelessness, and a loss of gratification. The informants also named decreased interest or pleasure and social withdrawal, and specified the negativity bias, rumination and emptiness, which correspond to various manifestations above. For instance, feelings of worthlessness or guilt are upheld because of negative biases, and a distorted self-image is maintained because of rumination. Another difficulty that arose from both the theory and the interviews were dominant cognitive patterns, causing rationalisation and overthinking, generally in a negative way, determining someone's thoughts and behaviour. Activation and shifting focus could be an effective resolution in order to break these patterns.

Some neurological effects from the perception of art on MDD as hypothesised from the theory turned out to be plausible. As multiple brain areas are underactive in MDD, it appeared indeed beneficial to activate the brain in a global way. The hippocampus is smaller or damaged in MDD and needs to be triggered by rich stimuli, for instance by visual art. A new insight was the overly active default mode network in the brain, and that the perception of art can be a way to activate the central executive network. This can in a sense be paralleled to Backhaus' idea that the cognitive approach with which we generally function in our daily life needs to be transformed into hyper-awareness in order to experience a 'new vitality of significance'. The fact that not only MDD but also engaging with art can change the structure of the brain upholds the notion of neuroplasticity.

The second sub-question, what would the key elements of an intervention be in order to achieve a decreasing or easing of these symptoms, requires a more extensive answer. The umbrella elements are the self and the position in the world, and meaning making through relational dynamics, sense-experience and empathic identification.

The theoretical framework delved into the sociocultural side of depression from the perspective of the cultural model, which touched various responses from the informants. Horwitz, Foucault and Dehue made clear that depression is not a determined neurobiological state of being that can be discovered, and that the diagnoses and implications have changed drastically over time. The same goes for the approach and purpose of the treatments. Jarman and Mitchell and Snyder argue that the aim of curing someone so that he or she can function well in society again is problematic, as it implies that someone's value and self-worth lies outside of him- or herself. Moreover, ableism imposes external pressure and expectations, and neglects

someone's own lived reality and capabilities. A museum intervention would provide a safe space where it revolves around 'feeling at home in the world', where people are acknowledged and heard, being disjointed from the external pressure and being given the opportunity to consider their own experience. Museum employees working with *Onvergetelijk* confirmed the advantages of emphasising someone's capabilities, an open conversation in which all responses are valid, and a kind and fostering ambiance – features as clarified by Gablik's notion of empathic identification. The professionals see that most participants noticeably flourish during *Onvergetelijk* or similar specialised programs. In order to enhance these features of empathic identification, the approach of the intervention should be 'ordinarily ordinary', where the participants are not treated as patients – in other words, not in an ableist sense – but as any other people 'just looking at art'. An addition on the theory from the interviews was the potential discrepancy someone can experience between themselves and the world around them. Ableist external pressure can increase this, when someone feels incapable of living up to imposed standards, responsibilities or expectations. In this case external pressure becomes internal pressure. Hence, it is crucial to consider someone's lived reality well.

The way to reconsider one's own capability and position in the world is to give meaning to it again. Or, in the theoretical analogy, move from a disenchanted to a reenchanted state of being. This would, firstly, happen in the partnership model that Gablik describes, which is defined by relational dynamics. Elements from this model, such as sharing, caring, compassion, connecting and being a part of a whole (so, the mind being embedded) were affirmed in the interviews. That is to say, precisely these elements appeared to be crucial in effective specialised museum projects as well as in therapeutic interventions. The enacted mind, as explained by Rowlands and Noë that the perception of an object or space depends on how someone acts on it, materialised in the observation of professionals that the meaning of an artwork arises in the encounter between the person and the object, being influenced by the outlook and arrangement of the space. Questions and small assignments could guide this enactment, as confirmed by multiple informants, as these encourage participants to perceive the works in a new way. The ideas on knowledge distribution were mixed, but the overall view approved that some formal or art-historical information can be a hook for recognition and connection, as long as it does not stand in the way of someone's individual experience. This idea is a slight adaptation of Bernstein's theory that facts and concepts deduce and generalise the individual experience of a particular moment. That is to say, the facts and concepts should not gain the upper hand. Rather, they can function as a boost to keep the enactment going. We also recognise Heijne's belief that scientific facts are not sufficient in order to give meaning in life, but that it is up to people to interpret these facts. To bring Gablik and Merleau-Ponty in, it is a continuum between the inner and outer world.

As relational dynamics implies, the body plays an essential part in the encounter between the person, other people, the artwork and the space. The interviews supported Merleau-Ponty's idea that it is the body that gives significance, through the continuous interplay between sensory, physical and emotional elements together forming the sense-experience. The positive workings of multisensory aspects when engaging with art, as seen in museum practices, echo this theory. They show that the mind is embodied, in the sense that someone's experience depends on all physical and sensory input, and not on merely what is seen or on the knowledge in one's head. A new perspective from the interviews was that of mindfulness, in which the focus on bodily sensations does not necessarily give meaning but neutralises meaning by taking attention away from streams of thought. The remark from a museum professional that multisensory assignments that are too artificial may be counter-effective was insightful. It

proves that the encounter should not be forced upon, but enacted from the point of view of the individual. Exclusively emphasising emotions and feelings is not favourable, for instance by asking 'what do you feel', as people with MDD are detached from the input of their bodily sensations in the sense that their way of meaning making purely happens in their head. Oppositely, the same goes for questions that are too cognitive, in the sense that it would not be beneficial if someone thoroughly has to think about the response or would feel that it expects a correct answer. The aim instead would be to let someone slowly but surely reconnect with his or her sense-experience on one's own account, and refocus from capacities outside to inside the body's abilities. As clarified by Merleau-Ponty, Rowlands and Noë, the bodily engagement with the world shapes someone's mental processes. Encouraging this bodily engagement could create a confirmation that one's own sense-experience can be a valid source for personal signification. This too is a matter of a continuum, as there is a constant oscillation between someone's inner lived reality and the relation of the bodily sensations to the outer world.

As the partnership model emphasises, it is not about the isolated individual but about relations with others. An important part of this is empathic identification. The theoretical framework addressed that in engaging with art together with others the process of identifying is twofold, namely with the artwork and the other participants. Various informants added the artist to this, especially if the artist also has or had a mental disorder and yet makes beautiful art. However, from the cultural model point of view, this 'making something beautiful *despite* your mental illness' is problematic. It represents Jarman's remark on the unjustified pressure on abilities and achievements, and, subsequently, the near surprise if someone with a mental illness 'succeeds'. There is a fine line between the comfort and hope of recognising one's own story in the artist's on the one hand, and emphasising that something is (or needs to be, even) 'wrong' in order to make good art on the other. Nevertheless, the social engagement of an intervention in a museum proved to be a positive aspect with both theoretical and empirical ground, and acknowledging others and oneself could achieve a feeling of compassion, responsibility and care. Altogether this process of empathic identification would be healing, as suggested in theory by Gablik and experienced in practice in both mental healthcare interventions and existing specialised museum tours.

An issue raised in the theoretical framework as well as in the interviews was why art, of all options, should be an effective stimulus. From the theory it appeared that art motivates identification and reflection, as well as imagination and wonder. Especially the last two appeared to be crucial in the notion of reenchantment, as argued by Gablik and Heijne, and were brought up in the interviews too. It became clear that art has its impact on both body and mind; it catches attention, it portrays another world that can still be pulled into one's own lived reality, it offers a new mind-set, it provides rich sensory stimuli, and it triggers specific brain areas. From the point of view of psychologists art can help to modify someone's bias and choices. All in all art is seen as a means to an end, namely to engage in conversation and as carrier of emotions. This stands in sharp contrast to the modern view that art is an end in itself.

When we return to the *Meet Me* and *Onvergetelijk* programs as variation on the Visual Thinking Strategies, we learned that VTS was an important factor in changing museum education. It instigated a turn towards a more active visitor, but now that it has fully landed it appears not sufficient for meaning making. For this reason all museums visited for the interviews do not use the method. Rather, they have their own adaptation of it, with more extensive questions and additional assignments. Similar to the theoretical framework, they said it is a well-founded starting point, but not enough to really engage with an artwork.

Interestingly, VTS shows great similarities with a mindfulness exercise in which full attention goes to what is going on in the picture – the first question of VTS. The objective of the exercise is to detach observations from interpretations and judgements, but precisely this is what museums feel to be deficient. One educator indicated VTS only takes place rationally in the mind. In other words, the experience is not embodied, and what misses is enactment.

§5.2 Practical implications and recommendations

Having explored the possibilities for perceiving art in a museum as effective intervention in MDD with both theoretical and empirical data, and from the point of view of museums and mental healthcare, it is safe to say it has the potential to contribute to the wellbeing of the participants. The objective of such an intervention would be, firstly, to become more aware of one's emotional, sensory and physical experience, and notice this to be a valid source for 'feeling at home in the world'. Secondly, it would encourage the participants to open up to compassion, empathy, affinity, sense, significance, understanding and appreciation, by engaging with artworks in a guided conversation. This comes with practical implications for both museums and mental healthcare, as discussed here, after which future research suggestions are made.

For implementing mental healthcare in the social agenda of museums and organising a program like this, it means the entire organisation needs to comply. Not just the tour guides will need a workshop in how to give a specialised tour, but all employees will have to be up to date. That is, a pleasant experience for the participants starts at the entrance and depends on the welcoming attitude from everyone who is encountered in the museum, such as the cashier, security, catering and shop workers. In other words, all employees should have agreeing standards, which could be provided by, for instance, the publications *Museum Open U* by Studio-I[142] or *Hoe doe ik gewoon normaal* ('How do I act ordinarily normal') by MEE[143]. These demonstrate manners for proper interaction, but also offer suggestions for designing the rooms in terms of e.g. arrangement, furniture, use of light, and appropriate colouring and fonts. Another point of interest is financing. Some museums work with funds when it comes to specialised projects, whereas others prefer to finance independently or cooperate with other institutions. Lastly, the interviews made clear that the institutional norms and the audience's wishes and expectations determine the objective of the tour, which, in turn, determines its form and content. It appeared that some people come to a museum to see the highlights and are calling for a more traditional informational tour, whereas others come for food for thought and appreciate a more open-ended and interactive tour. These aspects will need to be taken in consideration when designing a new initiative for a new target group.

When it comes to starting an integration of the perception of visual art in mental healthcare it was interesting to see that all interviewed professionals connected it to their own background and profession. This might make obvious sense, but it lays bare that there is not *one* exclusive option for an intervention revolving around perceiving visual art. We saw multiple heterogeneous ideas and suggestions. For instance, where some recommended a mindfulness sensory approach, others rooted for a more cognitive modification of bias or memory. And where some believed such a program to be potentially beneficial for all people with MDD, others were more specific in their definition of the target group. Lastly, on the one hand it was suggested to detach the program from the depression, and on the other hand to link it to the treatment. This variability shows that multiple interventions would be possible. All in all, every mental healthcare professional agreed on the idea that a museum program could be beneficial in

[142] Schelvis et al. (2017).
[143] MEE (2018).

order to activate people with MDD and stimulate them in a new way, and to shift their way of meaning making.

These implications lead to suggestions for further research, which is needed in order to fine-tune what the most effective approach would be for an intervention revolving around the perception of visual art. Studies are needed in both the development of theory and the potential executing of the intervention in practice. Relevant theoretical subjects would be, for example, reviewing the purpose and responsibility of art institutes when it comes to mental health and wellbeing, a renewed way to look at depression from the point of view of the embodied, enacted and embedded mind instead of cognition, the neurological effects of perceiving visual art on people with a form of depression, and discussing depression, its diagnoses and treatments with the cultural model in mind. When it comes to the practical side it is, firstly, important to talk with the target audience or people with a past in depression to find out the needs and wishes, and to minimise the risks that came up in the interviews. Questions need to be raised, such as: In which phase of the depression could you have wished for such a program? Would it be nice to have a loved one or caregiver with you? What would your personal purpose and expectation be for such a program? What would be a favourable time slot and amount of fellow participants? Which themes would you like to discuss? After having collected the answers, a pilot can be arranged and executed. For the pilots the most pressing matter that needs studying is the choice of artworks. That is to say, which artworks would have the most effect and, moreover, whether this effect is established by the conversation or also occurs when looking by oneself. The pilots need to be reviewed with the participants, for instance with surveys and open discussions. Matters that will be manifested in the pilots are, for instance, which (multisensory) assignments work well, which themes are most interesting, the length of the tour, the amount of participants, the selected artworks and rooms, and the ambiance. As there are numerous aspects involved, it is a matter of repeating this process and constantly adjusting the experience so that it becomes as agreeable and effective as possible.

§5.3 Reflection

This research aimed to combine the fields of cultural theory, philosophy, mental healthcare and cognitive neuroscience, and this came with some difficulties. It proved not only a challenge to incorporate multiple perspectives without losing sight of the specific focus of the topic, but also to find a methodology that would serve the purpose aptly. Coming from a cultural studies background, the thesis gravitated towards the cultural model. A present intrinsic paradox is the idea that depression does not have a determined definition, while at the same time having the need to define depression in terms of a workable concept. Nevertheless, I aimed to integrate the medical and (neuro)psychological side of depression as thoroughly and fittingly as possible, while also taking the sociocultural changeability of the concept into account.

The traditional difference between the two disciplines of humanities and natural sciences, as defined in §1.3, became most evident during the interviews. Museum professionals work on a regular basis with specialised audiences and continually experience the great benefits of the according programs. Every tour or workshop is a renewed evidence for them that the program benefits the wellbeing of the participants, because of the behavioural and verbal responses. The projects are improved by tests and evaluations, but the 'proof' is the direct impact on the participants that is visible and noticeable – not measurable. Contrarily, multiple mental healthcare professionals wished for hard evidence in terms of measurable proof that such a program or workshop works. 'Just' the fact that the participants have a pleasant experience that is positively continued in their daily lives is not enough. It is true that this

experience is extremely difficult to measure. Partly because it is impossible to express someone's wellbeing objectively (even a supposedly objective numeric or symbolic grading system is a subjective interpretation of someone's state of being), let alone measure whether or not it has multiplied by a certain number or percentage, and partly because there is an innumerable amount of variables. In the above some of these variables have been discussed, such as the chosen artworks and subjects, overall ambiance, the personal and professional connection with the tour guide, but also trivial factors such as someone's mood of the day and quality of the previous night's rest play their part. Not all of these are as controllable and measurable as some scientists might wish for, let alone the causal interrelationship that would be extremely complex, if not impossible, to analyse.

Method-wise, the topic suited a triangulation of sources and methodologies. The literature review formed a polyphonic theoretical framework and the interviews supplied interdisciplinary observations and recommendations. An adaptation of the Grounded Theory Approach was used for analysing the data, but it felt incorrect to strictly follow the original steps. That is, the GTA was developed as a methodology for social sciences, hence the three cycles of collecting, coding and analysing the data that would specify the final results. In this research the steps were adapted, because the aim of the research was not to analyse, compare or specify a social phenomenon, but to develop theoretical insights with empirical support. What was appealing to the GTA were the cycles of coding in particular. The separate processes of open, axial and selective coding proved useful for various reasons. Firstly, the open codes from the literature review gave direction and focus for the interviews. In the next phase the axial codes helped in making sense of the chaos that was more than a hundred pages of conversations, by finding categories and patterns. Finally, the selective coding was crucial in order to make the link between the theoretical and empirical data and, in doing so, be able to conclusively answer the research questions.

All in all, I hope to have demonstrated that an intervention in a museum where people with MDD perceive art in a multisensory way and in a guided conversation could be beneficial to their wellbeing. As one psychiatrist explicitly pointed out, a new paradigm is needed if the physical and sensory experience is to be integrated in the way depression is dealt with. People with depression are stuck in their heads as it is, and then the treatments often take place in the mind too. Perhaps an intervention in a museum, in which the emphasis lays on offering a safe space in which people are encouraged and supported to feel at home in the world based on their own sense-experience, could instigate a movement towards a more embodied, enacted and embedded way to deal with depression. *Meet Me at MoMA* articulated the great potentiality of art, and my thesis has demonstrated what this potentiality can offer for people with MDD. Art used to be separated from life, whereas nowadays it is starting to be reintegrated in life and conversation is encouraged. The ratification of the CRPD has been an incentive to integrate art in the lives of people with disabilities too, instigating a movement towards inclusive museums. Art is not a goal in itself anymore, but it is acknowledged that it can move people – in a literal and metaphorical sense. Because, in Suzi Gablik's words: "Art as only art is powerless in the real world."[144]

[144] Gablik (1991): 98.

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Attachment 1: Schematic Methodology Outline

Original GTA steps, as explained in Boeije (2007)

Step	Data	Activity	Result
1.		Choosing a subject and approach Reading literature Formulating research questions and objective Sampling Ethical reflection	
2.		Data collection	
3.	Data		
4.		Open coding	
5.			Code list
6.		Data collection	
7.	Data that fill in the categories		
8.		Axial coding	
9.			Code list
10.		Data collection	
11.	Data that support the interrelations of the categories		
12.		Selective coding	
13.			Results
14.		Report Discussion Quality reflection Conclusion (Answering research questions)	

Adaptation for this data analysis

Stage	Result	Aim	Codes
Data collection #1	Literature review	Collecting theoretical insights on sensitizing concepts.	
Data analysis #2	Theoretical framework	Presenting the key theoretical concepts, culminating in assumptions.	
Open coding	Pre-set codes; theoretical concepts	Forming the starting point for the interviews	• Ableism and stigmatisation • Sense-experience • Empathic identification • Hyper-awareness • Signification • Affective relation
Data collection #2	Qualitative interviews	Collecting insights from museum and mental healthcare practices.	
Data analysis #2	Transcripts of recordings	Collecting all empirical data	
Axial coding	Emergent codes; general categories	Arranging interview data into general categories for a first overview, identifying themes and patterns, leaving out dross (useless fragments)	• Accessibility and inclusivity • MDD symptoms • Art as motivator or stimulus • Multisensory approach • Conversational approach • Effects from specialised museum programs and therapeutic interventions • Visual Thinking Strategies • Neurological elements • Organisational aspects
Data analysis #3	Link between theoretical framework and	Connecting the theoretical and practical insights.	

	interview data		
Selective coding	Emergent codes; four umbrella categories, subdivided in specific topics	Forming the foundation for answering the research questions	<u>MDD symptoms</u> 1. Decreased interest or pleasure 2. Social withdrawal 3. Negativity bias 4. Rumination 5. Emptiness or apathy <u>Approach and effect</u> 1. Open and welcome attitude 2. Recognition and identification 3. Shifting attention and focus on the moment 4. Continuation in everyday life 5. Impact on the brain 6. Signification and connection 7. Role of information 8. Activation <u>Risks</u> 1. Stigmatisation and labelling 2. Negative spiral 3. Overstimulation <u>Pilot material</u> 1. Choice of artworks 2. Discussed subjects 3. Asked questions 4. Target group 5. Setting 6. Guide

Attachment 2: Quotes and Translations

In order of appearance:

Original quote	Translation
mensen met een depressie kunnen natuurlijk ook wel veel meer moeite hebben om dingen te ervaren en om eh plezier te hebben	People with a depression can have more difficulties to experience things and to enjoy
je moet ze natuurlijk al zover krijgen dat ze al met je meegaan, dat is al heel zwaar.	Of course you have to get someone to come with you, that is as hard as it is.
mensen met een depressie hebben dus heel weinig, ervaren heel weinig plezier, dus als je daar iets aan toe zou kunnen voegen is het prima.	People with a depression experience very little pleasure, so if you could add something to that it would be good.
mensen met een depressie een neiging hebben om ehm zich terug te trekken uit sociale contacten. Eh thuis te blijven, op de bank te blijven, of eh in bed blijven liggen, dus ze sluiten zich eigenlijk af van alle prikkels uit de omgeving en trekken zich terug met allerlei ideeën daarover.	People with depression have the tendency to retreat from their social contacts. To stay at home, to stay on the couch, or to stay in bed. So they close themselves off from all environmental stimuli and retreat with all kinds of ideas about it.
het geeft toch een soort cocon visie, en met mensen, ja, hebben ook minder belangstelling voor anderen, zelfs minder belangstelling voor anderen die ze heel erg na staan	[Depression] gives a kind of cocoon view, and [people] also have less interest in others, even less interest in others who are very close to them.
Die vinden het ook wel vaak vaak een beetje bedreigend, maar meestal is toch de ervaring wel gunstig en dit is natuurlijk een vrij laagdrempelige manier want je hoeft niet te veel, ja je kan je kan nog een nagesprek zijn misschien.	They often think it to be a little threatening, but usually the experience is rather favourable, and this is of course an accessible way, because you do not demand too much.
de basis emotie is zo negatief bij depressie, en mensen kunnen daar echt niet uitkomen. […] Dat zo'n negatief netwerk geactiveerd wordt, dat is echt heel dominant.	the fundamental emotion is so negative in depression, and people cannot get out of that. […] That such a negative network [in the brain] is activated, that is extremely dominant
een depressief iemand is gewoon geneigd om negatieve dingen beter op te slaan.	a depressive person is just more inclined to save negative things better.
zij interpreteren het toch altijd somberder dan wij denken, *ja ja*, dus dat zal met die kunst ook zo zijn.	They always interpret more gloomily than we think, so that will probably be the case with art too.
richten binnen dat beeld op allerlei negatieve cues.	within the image […] they focus on all sorts of negative cues.
mensen met een depressie hebben een bias en die hebben een hun voorkeurs naar de negatieve, zowel beelden, interpretaties, maar	People with a depression have a bias and they have a preference towards the negative, both images, interpretations, as well as selecting

ook het selecteren van hun aandacht richten op, en dat je inderdaad ook iets kunnen doen door een eh, bijvoorbeeld een een eh negatieve plaatjes te vervangen door neutrale, of mensen te leren dat ze meer naar positieve dingen leren kijken, daar zou dit ook en dan ben, dan ben je heel gericht bezig om ja, iets van die aandacht te verschuiven. *Ja.* Wat natuurlijk op zich ook een hele goeie strategie kan zijn.	their objective of attention. And indeed you could do something by, for instance, replacing negative images by neutral ones, or teach people to observe positive things more. […] Then you are working on shifting that focus very specifically, what in itself could be a really good strategy.
dat ze dat voortdurend eigenlijk blijven herhalen, van waarom heb ik dit en dat en zus en, vergelijken met andere mensen, of vergelijken met jezelf en wat allemaal niet meer kan, en eh, dus dat heel veel van hun tijd wordt opgeslokt door het verstrikt blijven in negatieve spiralen, en ehm dat dat een belangrijke onderhoudende factor is bij depressie.	They continually repeat [negative thoughts], such as why do I have this and that, comparing to others, or comparing to yourself and what is not possible anymore. So, a lot of their time is consumed by staying trapped in negative spirals, and that is a crucial maintaining factor in depression.
Worden vaak erg afgeleid door hun interne gedachtes, door ze kunnen zich eigenlijk heel slecht concentreren, dat is, ze zullen altijd, ze zeggen ook heel vaak he, ik kan me, ik kan niks onthouden, ik kan niet naar tv kijken, en dat lijkt een beetje men, men denkt dan vaak dat de cognitieve functies helemaal uitgevallen zijn, dat ze dus niet meer kunnen.. maar dat is waarschijnlijk niet eens zozeer het geval, maar het is vooral.. ze zijn zo met hun eigen gedachtes bezig waardoor ze de aandacht dus verliezen voor iets anders.	They are often really distracted by their internal thoughts, so they can concentrate very badly. […] And people often believe that cognitive functions stopped working altogether, […] but in fact, they are so involved in their own thoughts that they lose their attention to anything else.
Maar onderschat het affect niet he, dat is volstrekt afgevlakt bij mensen met een depressie, dus ze hebb.. dat is eigenlijk een van de grote problemen, dat ze niks voelen.	"Do not underestimate the affect, which is completely flattened out in people with a depression. That is actually one of the larger problems, that they do not feel anything."
wat je veel ziet bij mensen met depressie, is nihilisme he, dus dat betekent eigenlijk dat je eigenlijk eh niks meer de moeite waard vind en eh niks heeft nog betekenis voor je.	"What you often see in people with depression is nihilism, so that means […] that you do not believe anything to be worthwhile, and nothing has any meaning left for you.
En door te erkennen dat ja die doelgroep bestaat en door ze uit te nodigen voor een speciaal programma, kunnen ze nu ook terugkomen.	By acknowledging this audience [Alzheimer patients and their caregivers] exists and inviting them for a special program, they can now return.
voor iemand die blind is en misschien altijd heeft gedacht een museum is niks voor mij, dan heb je misschien nog wel een extra doel	For someone who is blind and perhaps always thought, a museum is not for me, then you perhaps have an additional objective to

om te laten zien kijk, we kunnen wel iets toevoeggen. […] als je namelijk die verbinding weet te leggen en iemand voelt zich eh geraakt of, dan heb je automatisch al dat je aantoont, het museum heeft iets te bieden voor jou.	demonstrate, look, we can add something. […] That is, if you can make that connection and someone feels touched, then you automatically show, the museum has something to offer for you.
ik ga niet heel ster, eh zeg maar aan de, bij de inschrijving van heb jij wel echt iets, want dat dat, *nee*, gaat er gewoon van uit dat dat mensen dat doen die echt behoefte hebben aan die rust. Maar dat daardoor maakt het inclusief dat je dus alles door elkaar hebt.	In the enrolment [for a slow tour] I will not [ask], do you really have something, because I assume that people who do this really wish this calmness. But that makes it inclusive, that you have everyone mingled.
zoveel mogelijk samen, apart als het nodig is.	As often as possible together, separate when needed.
Het is de hele entourage van het binnenkomen.	It is the whole entourage of entering.
He want als een museum er echt geen trek in heeft, en de bewaking heeft er geen trek in en de horeca heeft er geen trek in, dan trek je aan een dood paard want dan krijgen die mensen uiteindelijk geen fijne beleving. *Nee, da's waar.* Want dan gaan ze zich niet welkom voelen.	If a museum really does not feel like it, and the security does not feel like it and the catering does not feel like it, then you are flogging a dead horse because the people will not have a pleasant visit. Because they will not feel welcome
het moet heel luchtig, het moet leuk, en het moet supergezellig, en ehh het museum moet dat dragen.	It should be light-hearted, it should be nice, it should be super delightful, and the museum needs to sustain that.
En je hebt ook wel eens mensen die bang binnenkomen, bangig, maar we weten gewoon, ze spiegelen, dus wij zij altijd heel vrolijk en heel uitnodigend en heel vriendelijk en dan hup, spiegelen ze, gaan ze mee	Sometimes people enter quite afraid, anxious, but we just know that they mirror, so we are always really cheerful and inviting, and very kind, and then, like that, they mirror and go along.
het erkennen van gedachten is, is belangrijk in de methodiek van Onvergetelijk en ik kan me voorstellen dat je zo'n vergelijkbare methodiek bij mensen met depressieve klachten ontwikkelt, mogelijk ook met hun partners of met hun dierbaren, ehm dat kan ik me heel goed voorstellen, maar of je dat zo kunt sturen dat je alleen maar op positieve noten komt.. de hele methodiek is positief.	Acknowledging thoughts is important in the methodology of *Onvergetelijk*, and I can imagine that you would develop a similar method for people with depressive symptoms, […] but whether or not you can steer it in such a way that you just arrive at positive notes… the whole method is positive.
je deel voelen uitmaken van een geheel	you feel part of a whole.
wat er al is en of je dat kan benutten	what is already there and whether or not you can utilize that
gewóón naar kunst kijken	just looking at art
herkenning is altijd wel goed, dat je daar iets mee doet. Wij hebben […] best wel een enorme collectie, dus ook heel veel prenten en	Recognition is always good. […] We have an enormous collection […], so many prints and old library books that probably contain things

oude bibliotheekboeken waar vast wel ook dingen in staan over depressie, wat misschien wel heel interessant is om, wat je zegt, 300 jaar geleden al eh *ja* ja, zou je daar iets mee kunnen doen.	about depression, which could be quite interesting […] to work with.
En eh ik denk dat eh dat je ook zoiets kunt hebben dat dat je in kunst heel veel herkent van wat je ziet, en dat het iets uitdrukt *ja* wat je zelf niet kan uitdrukken	I think that you could recognise a whole lot in art of what you see, and that it expresses something that you cannot express yourself.
kijk er zijn natuurlijk ook best wel veel kunstenaars die zelf eh eh hebben gekampt of kampen met een ehm ernstige depressies, he en eh maar die het toch lukt om heel mooie kunst te maken. Nou dat verhaal, als je dat verhaal als patiënt denk ik hoort, kan het ook wel heel erg bemoedigend zijn he	There are of course many artists who have struggled with or struggle with severe depressions, but who manage to make really beautiful art. Well, that story, if you hear that story as a patient, I think, it could be very encouraging.
Dus dat je, dat je voelt van eh dit is een universeel menselijk.. menselijke ervaring, of eh er zijn meer mensen die daar, ja, daaraan hebben geleden, of dat hebben ervaren, en eh ik ben niet de enige daarin.	that you feel like, this is a universal human experience, or, there are more people who suffered from that, or experienced that, and I am not the only one in this.
Maar je hoeft alleen maar te vertellen wat.. wat je van iets vindt of wat wat voor indrukken je krijgt. Dus dat zou ook al een een mooi, zou een effect kunnen hebben denk ik, dus een activiteit in een groep doen met de richting wat niet te intensief gaat over jezelf blootleggen maar wel praten met elkaar over iets wat je hebt gezien en meegemaakt, ik denk dat dat ook wel goed kan zijn.	You only have to tell what you think of something, or which impressions you get. So, that could have an effect in itself I believe, so doing an activity in a group, directing it not too intensely towards exposing yourself, but towards talking with each other about something you saw and experienced. I think that could be quite good.
Want depressie dat is ook een eh, relatieprobleem eigenlijk. […] He dus als het lukt om met behulp van kunst in gesprek met anderen te komen, en iets misschien over jezelf te vertellen, over wat je erbij voelt en bijvoorbeeld iets uit kunnen leggen op een wat meer indirecte manier, want soms is het wel heel lastig om dingen uit te leggen. Dan zou dat wel heel werk, eh helpen, ja.	Actually, depression is also a relational problem. […] So, if it works out to engage in a conversation with others by means of art and perhaps tell something about yourself, about what you feel and for instance be able to explain something in a more indirect way… […] That would work, yes.
alle zintuiglijke waarnemingen zijn per definitie in het hier en nu. En door je aandacht daarop te richten laat je ook bijna per definitie de soort van gedachtestromen, negatieve gedachtestromen in je hoofd los.	All sensory observations are by definition in the here and now. And by directing your attention towards that, you almost by definition let go of the streams of thought, negative streams of thought in your head.
je bewust worden van dat de waarneming iets anders is dan de interpretatie van die	becoming conscious that the perception is something different than the interpretation of

waarneming	that perception.
kunst is natuurlijk en dat heeft natuurlijk voor dat het ook waarschijnlijk wel makkelijk die aandacht gevangen kan houden, he, *ja*, dat je je dan een beetje afvraagt van wat zie ik eigenlijk, wat is het nou, en.. dus in die zin, denk gewoon dat dat wel kan werken, dat zeker, […] focussen, en echt op iets dat buiten en niet naar binnen	Art can probably more easily capture that attention, so that you wonder, what do I see, what is it… so in that sense, I think that could work, […] focusing, and then really on something external instead of internal.
dat het misschien ook een idee is als zij wat dingen zouden kunnen voelen. *Ja, ja.* Dus letterlijk voelen. Want dan hoef je er even niet over na te denken.	perhaps it is an idea that they could feel something. So, literally touch. Because then you do not have to think about it for awhile.
het gaat dus heel erg om in het moment te beleven van die kunst en daar kun je dus door zo'n multi-zintuiglijk aspect in te bouwen kan dat nog meer getriggerd worden. […] he, om verder uit het hoofd maar in het moment ja te beleven op eh heel veel verschillende manieren *ja* en dan het zintuiglijke aspect is eh denk ik heel positief.	It really is about experiencing the art in the moment, and by integrating such a multisensory aspect this can be triggered even more. […] To get out of your head, but experience it in the moment in multiple ways, and the sensory aspect is, I think, really positive.
Marja is daar echt een beetje mee aan het experimenteren van wanneer werkt het wel en wanneer ga je die lijn over van ja waarom zou ik nou, ik ben hier parfum aan het ruiken en moet ik nou denken dat die mevrouw die parfum opheeft, nou.. **ja precies**.. er moet een soort logisch.. het moet logisch zijn. *Ja, klopt.* En mensen zijn daar wel weer heel gevoelig voor	when you cross the line towards, well, why would I, I am smelling perfume and should I think that woman is wearing that perfume now? It should make sense, and people are very sensitive about that.
Anders dan het positieve gevoel, de inspiratie, een nieuw inzicht krijgen, maar of dat werkelijk voor iemand met depressie een therapeutische werking heeft…	more positive feeling, inspiration, [or] a new insight.
alle psychologische interventies, maakt niet uit welke, die moeten, dat is allemaal inherent, gaat het allemaal om een emotioneel correctieve ervaring.	every psychological intervention […] is inherently about an emotionally corrective experience
door middel van kunst he de meer te kunnen zoeken naar wat positieve ervaringen of eh gevoelens associaties te kunnen triggeren en die expliciet te ervaren.	by means of art investigating which positive experiences or feelings can trigger associations, and to explicitly experience these
want het zou zo zonde zijn als het alleen gekoppeld is aan ehh de depressie.	It would be a shame if it is just related to the depression.
het leren kijken, zodat je ook zonder rondleiding gewoon kunst kunt beschouwen	practicing how to look, in order to be able to engage with art without a tour as well.

zo heel veel dingen zijn er niet te doen om terugval te voorkomen, *nee*, en ik weet niet of je terugval heel hard mee gaat voorkomen, maar het kan wel misschien een handvat zijn, of iets wat voor sommige mensen prettig kan zijn	There are not many things to do to prevent a relapse, and I do not know if you will really prevent relapses with this, but it might serve as something to hold on to, or as something that could be pleasant for some people.
kunst is in die zin veel meer dan dan een een middel om even uit je huis iets te doen en weer terug in die depressie	In that sense is art much more than just a means to get out of your house and then get back into that depression.
Ja je activeert het brein natuurlijk eh wat globaler, *ja*, in plaats van alleen maar visueel, dus ik denk zeker dat dat ook meer op kan roepen inderdaad, geheugen op basis van eh het olfactorische systeem, geur, is heel sterk,	You activate the brain more globally instead of merely visually, so I definitely think this can invoke more. Memory based on the olfactory system, smell, is really strong
Nou wat bij mensen met een depressie gebeurt is dat die veel te eh veel te actief default mode netwerk hebben, dus die blijven veel meer in zichzelf gekeerd, bezig met die zelfreflectieve processen, en het lukt ze niet goed om uit, daar uit te komen, en dus contact met de buitenwereld te maken. *Nee.* Dus dat is echt aangetoond in onderzoek, dat dat default mode netwerk veel te, veel te actief is en niet goed inhiberen. Nou, maar bij mensen met een depressie komt daar nog bij dat dat default mode netwerk niet zomaar neutraal aan het reflecteren is, maar dat het ook heel negatief is, he dat zijn zelf de negatieve gedachten over zichzelf. Nou hoe je daar uit kan komen is gewoon door jou te, je te stimuleren, door iets anders te gaan doen en dus maar gewoon iets aan te bieden. Dus in die zin, neurologisch, als je eh bepaalde prikkels aanbiedt die juist eh zorgen dat het default mode netwerk even wat naar de achtergrond gaat, dat is zeker goed, ja.	What happens with people with a depression is that they have a way too active default mode network, which means they remain to themselves, working on those self-reflective processes, and they do not manage to get out of that and make contact with the outside world. […] Furthermore, this default mode network is not just reflecting neutrally, but negatively […]. A way to get out of that is just to stimulate you, by doing something else and just offering *something*. In that sense, neurologically, if you offer certain stimuli that cause the default mode network to retreat into the background for a while, that would definitely be good.
het feit dat je dat pad in de hersenen aanlegt	you carve out that [new] path in the brain.
ik zou zeggen dat het doel van een rondleiding is dat mensen ehm geraakt voelen en dat ze een verbinding voelen met Van Gogh of zijn kunstwerken	feel touched and to feel a connection with Van Gogh or his artworks.
als je kunst kijkt dat is een iets wat tussen jou en het object is.	When you are looking at art, that is something between you and the object
dan leer je je definiëren en dan leer je ook je eigen mening te ontwikkelen en eh ik denk dat daar uiteindelijk ook kunst voor bedoeld is, niet als zelfstandige unit, maar juist als ehh	you learn to define yourself and you learn to develop your own opinion, and I think in the end art is meant for that. Not as independent unit, but as carrier of emotions.

drager van emoties,	
He dat is dus je maakt van allerlei dingen mee, en wat wat geef je daar voor betekenis.. wat heb je daar voor gedachten over, want heb je daar voor denkpatronen over	You experience all sorts of stuff, but which meaning do you give to that, what are your thoughts about that, what are your thinking patterns about that.
Omdat we merken dat je een voertuig nodig hebt om mensen te helpen om het je persoonlijk te laten raken.	We notice you need a vehicle in order to help people with letting [art] personally touch you.
iemand moet toch op een bepaalde manier een plaats geven aan wat het wat het betekent om depressief te zijn, en uitdrukking daar in vinden, metaforen zoeken, nou dat is denk ik ook wel wat kunst ook eh kan doen.	someone has to internalise in a way what it means to be depressive, and find expression therein, search for metaphors. Well, I think that is what art can do.
we zijn eigenlijk juist eigenlijk uit op eh het loslaten van betekenis, haha, zou ik zo willen zeggen, *ja, ja,* omdat veel van die betekenissen die, zeker mensen met depressie, geneigd zijn te hechten aan zichzelf en anderen ook vaak negatieve betekenissen zijn, *ja,* en dan tekortschieten of ehm eh negatieve herinneringen of eh vergelijkingen met anderen of met situaties. Ja dus dus binnen zeg maar het mindfulness gedachtegoed worden mensen vooral aangemoedigd om dat op te merken, ook als een herinnering of als een associatie, of als een onderdeel of als een en ehm en ook dat gewoon weer loslaten en terug te keren naar tot tot wat je ziet en wat je voelt.	people with depression tend to attach negative meaning to themselves and others. […] People are particularly encouraged to notice that, also as a memory or association, […] and then to let go and return to what you see and feel.
omdat ik ervan overtuigd ben dat kunst eh voor iedereen is. *Ja.* En iedereen die kijkt op een bepaalde manier, maar uiteindelijk gaat het erom dat je met je hart naar kunst kijkt. En niet met de kennis die je in je hoofd hebt.	I am convinced that art is for everyone. And everyone looks in a certain way, but in the end it is about perceiving art with your heart. And not with the knowledge in your head
wat anders dan een traditionele rondleiding is is dat het veel meer interactief is, dus dat er echt vragen worden gesteld, waarop ze dan zelf, ja hun mening mogen geven. Dus we vertellen wel deels ook het kunsthistorische verhaal, maar daar ligt niet de nadruk op. Die ligt vooral ook op wat zie je, wat valt je op, wat voor gevoel krijg je bij dit schilderij, hoe wat is dit voor persoon, wat voor karakter zou die hebben denk je, en dat eh dat werkt wel heel goed.	Questions are asked, to which [the participants] can give their opinion. So, we partly tell the art-historical story too, but that is not the focal point. That is particularly on what do you see, what do you notice, which feeling do you get with this painting, what kind of person is this, what sort of character would it have… and that works really well.
ik denk dat juist soms informatie net dat haakje haakje […] kan geven voor iemand om	I think sometimes information can give just the right hook […] for someone in order to see

die verbinding met dat werk te zien.	the connection with that work.
Alles is een stimulus als je ze op de een of andere manier uit hun kokertje haalt. Wat ze er mee doen en of ze er iets mee kunnen dat is echt absoluut de vraag, maar alles kan toevoegen en wat het leuke is van kunst, een beetje partijdig, is dat het anders is. *Ja, ja.* Dus dus dat zet je bijna een beetje op het verkeerde been, dus je moet er wel wat mee, je kan er.. het is moeilijk om er meteen een standaard verhaal over te hebben.	Everything is a stimulus if you get them out of their cocoon. What they do with it and if they can do something with it that is absolutely the question, but anything can add. And the good thing about art is […] that it is different. […] It is difficult to immediately have a standardised story about it.
En eh het en het feit al dat ze de deur uitgaan. *Ja.* Een stap moeten maken, en hier naartoe, hier dan moeten zijn, *ja,* daar heb je alles al mee gewonnen.	And just the fact that they get out, have to make a step, get here, be here… with that you have already won everything.
het zou heel fijn zijn dat je voelt van ja nee, ik heb die energie wel, he, ik kan dat wel, ik kan er wel uit, ik kan dat bij mezelf komen en ik kan die beslissing nemen. *Ja.* En dat kun jij hier ook heel goed hier bereiken.	It would be so good if you feel like, yes, I *do* have that energy, I *can* do that, I can get out, I can get a hold of myself and I can make that decision. And you can achieve that here very well.
wat voor naamvorm doe je dan, hoe voorkom je dat mensen zich soort van, alsof er een vlaggetje op bij is van kijk deze mensen zijn depressief,	what kind of name would you use, […] as if there is a flag waving with look these people have depression.
heeft die er behoefte aan om in het museum gedefinieerd te worden als iemand met een depressie.	Would they have the need to be defined in the museum as someone with a depression.
gewóón gewoon	ordinarily ordinary
dus dat ook eh ja het een project is wat heel erg, ja, positief kennis heeft uitgedragen over mensen met dementie *ja* en hun eh.. *ja* niet hun beperkingen maar echt hun capaciteiten heeft laten zien en hoe mooi zo'n rondleiding kan zijn *ja* dus dat zijn ook wel in die zin ja in het algemeen heel ja anti-stigmatiserend werkt he. *Ja, ja.* Niet eh niet het plantje in het verzorgingstehuis *nee precies* maar iemand die actief met dierbaren in het museum ja in het moment kan leven.	spreads knowledge in a positive way about people with dementia, and doesn't show their disabilities but capacities. […] So, not the wallflower in the nursing home, but someone who can live in an active way with loved ones in the museum in the moment.
als mensen zich te veel identificeren met wat ze zien, of met het gevoel wat daardoor wordt opgeroepen of de gedachte, dat het ook nog een eh depressie kan versterken he, *ja*, dus dat het ehm, kijk ja, als mensen niet met een beetje afstand ernaar kunnen kijken en zich er in verliezen of zich ermee identificeren, dan	If people identify too much with what they see, or with the feeling it evokes, […] if people cannot look at it with some distance and lose themselves in it or identify themselves with it, then the depression perhaps only increases.

wordt de depressie daardoor misschien alleen nog maar erger.	
hangt natuurlijk een beetje af van wat voor kunst je laat zien, of je moderne kunst of je kunt natuurlijk ook zeggen van we gaan hiermee naar de klassieken toe, *ja*, he want ik denk dat dat wel eh iets is waar je een beetje rekening mee moet houden, dat ehm als je daar geen ervaring mee hebt, dat het met name moderne kunst kan natuurlijk bij mensen bijvoorbeeld zal oproepen van nou, dit is zo'n onzin, *ja, ja*, daar ga ik niet eens over nadenken.	Of course it depends on which art you show. […] Because I think, if you do not have experience with it, that particularly modern art can evoke something like, this is such nonsense, I'm not even considering it.
baat het niet dan schaadt het wel	It *does* hurt to try.
ik ben hier ook met een zanger geweest die manisch depressief is, en die wilde per se een Van Gogh kijken en daarna liep hij zo terug naar de uitgang, *ohja*, omdat hij gewoon veel te veel prikkels eh *ja, ja,* kreeg. […] Hij wilde gewoon niets anders meer op zijn netvlies hebben, behalve het werk wat hij gezien had. Ja.	He wanted to see a Van Gogh by all means, and walked to the exit like this [with his hands before his eyes], because he just received too many stimuli. […] He wanted nothing else on his mind, except the work that he saw.
En dat geldt voor dove bezoekers net zo goed als voor horende bezoekers.	which goes for deaf visitors as well as hearing visitors.
het lijkt net alsof ze onder een zwarte deken zitten, dus dat haalt ook heel veel nuance weg.	it seems they are always under a black blanket, which removes much nuance.
uit de biologie kan je ook bepaalde patronen halen waarbij instinctief eigenlijk al heel snel op reageren,	From biology there are certain patterns that are instinctively reacted to really quickly.
je kan een bos bloemen hebben en dan kan een jongetje van vier denken aan de begrafenis van z'n oma	You can have a bouquet of flowers and a four-year-old boy can be reminded of his grandmother's funeral.
mensen ervaren ook traditioneel een drempel om iets te vinden van kunst, want ja dat de gedachte leeft toch heel sterk dat er altijd iemand is die er meer verstand van heeft, en dat je hele domme dingen kunt zeggen	traditionally people experience a barrier to think something of art, because the dominant thought still is that there is always someone who knows more about it and that you can say really stupid things about it.
Dus je plaagt ze enorm door te zeggen wat voel je nou? *Ja.* Dus dus daar wil ik echt wel een land voor breken dat dat bijna niet het thema moet zijn, *nee*, maar dat je ehm eh ze confronteert met dingen dat ze nog wel dingen kunnen benoemen, dus nog kunnen ervaren, en *ja* en het woordje voelen… wees daar voorzichtig mee. […] Nee, want ze voelen niks… nee.	You tease them immensely when you ask what they feel. […] The word 'feeling'… be careful with it. […] Because they do not feel anything.

ja en ik vraag me af of je het kan voorkomen, dat een kunstwerk iets negatiefs triggert.	if you can prevent an artwork to trigger something negative.
maar tegenwoordig zijn we ook wel erg op gericht dat we bijna wat preventief of bij mensen met een lichte depressies noemen we dat ook een beetje de eerste staps interventies. *Oh ja.* En dat betekent dat dat zijn dingen als dat je op het internet gaat kijken of er een cursus is over depressie, of dat je een boekje leest over depressie, daar zou dit goed in kunnen passen.	Nowadays we really focus on prevention, almost. Or, for people with a light depression what we call first-step-interventions. This means there are things such as looking on the Internet if there is a course on depression, or reading a book on depression, and this [program] would fit there.
En de andere kant, ik zou ook beetje aan, er zijn natuurlijk ook mensen die aan lange depressief, depr, depressief zijn, en de behandeling een beetje afgesloten hebben en wel verbeterd maar niet hersteld zijn. […] die zijn meer, meer op zoek naar hoe ga ik mijn leven weer wat vorm geven. Daar zou dit ook kunnen passen	There are of course people who have been depressive for a long time, who concluded the treatment and have improved but are not fully recovered. […] They are searching for how am I going to shape my life again. And here too this [program] would fit.
Want, je kunt in dingen gaan wroeten waar nou waar je toch echt bekwaam in moet zijn om mensen daar weer uit te kunnen halen, dus zie je, daar zit.. het is heel leuk om een programma, het museum zou best een programma willen maken, maar dan moet er bijna zeker van zijn dat er een psycholoog meekomt, om stel dat iemand doorschiet, eh in welke vorm dan ook, daar op een goeie manier begeleiding in kan geven.	Because, you can bring up stuff that you need to be able to adequately react to in order to pull people out of that. […] Imagine someone going overboard, then [a psychologist] could provide support in an appropriate way
Maar en dan iemand met ervaringsdeskundigheid, en dan heb je ook meteen eh mensen die de toon kunnen pakken van hoe je mensen met een depressie het best kan benaderen en meeste kan uitnodigen.	who can hit the right tones in how you approach and invite people with a depression in the best way.
En niet de voorzichtige o help, nee, maar gewoon met elkaar [in gesprek gaan]	not with a fragile 'o help' attitude, but just [having a conversation] together.