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Emotions in the Museum of Medicine. An investigation of how museum educators employ emotions and what these emotions do

Cecilia Rodéhn 

Centre for Gender Research, Uppsala University, Sweden

ABSTRACT

The aim of this paper is to explore how museum educators employ emotions when they are doing guided tours and to investigate what these emotions do. The paper explores five guided tours in the Museum of Medicine (Uppsala, Sweden) located in the former Ulleråker psychiatric hospital and asylum. The guided tours take place in the exhibitions focusing on surgery, nursing and mental care, but this paper focuses on guided tour in the exhibition displaying mental care. The guided tours were filmed and documented using participant observation. The material is analysed with the help of Sara Ahmed's queer-feminist phenomenological approach to emotions. The paper shows that the museum educators used a multitude of emotions to orient the students' emotional experiences and their knowledge about mental care and mental illness. Emotional restraint, fear, antipathy and sympathy were expressed in relation to patients, and this contributed to an othering of patients. The depiction of patients was used to express empathy in relation to caretakers. The study reveals that the appropriation of emotions works along sanist norms that largely contribute to a further marginalisation of patients. The paper, therefore, calls for a further examination of sanist norms in cultural heritage productions.

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Introduction

The aim of this paper is to explore how museum educators employ emotions when they are doing guided tours and to investigate what these emotions do. Guided tours are in this text understood as a way of doing heritage (Smith 2015, 460), where heritage is not understood as a thing or a place but regarded as 'a cultural process in which social and cultural meaning is negotiated, made, re-made and/or rehearsed' (Smith and Campbell 2011, 86). Heritage is a discourse that 'frames a set of cultural practices that are concerned with utilizing the past for creating cultural meaning for the present' (Smith 2015, 459). It involves acts of performance of remembering and ways of embodying this remembering (Smith 2006, 47). I suggest, therefore, that guided tours are activities where heritage is performed and, drawing on Smith and Campbell (2016, 444), that emotions are 'constitutive elements' in this heritage making. Expressions of emotions in guided tours are important to study, as many museum and heritage practitioners are opposed to involving emotions (Smith and Campbell 2016, 448; Wetherell, Smith, and Campbell 2018) and try to distance themselves from emotions in an attempt to appear unbiased and scientific (Watson 2016, 77). Although trying to withhold emotions, museum and heritage practitioners,

CONTACT Cecilia Rodéhn  cecilia.rodahn@gender.uu.se  Centre for Gender Research, Att: Cecilia Rodéhn, Engelska parken, Humanistiskt centrum, Thunbergsvägen 3G, Box 527, Uppsala 751 20, Sweden

Academia: <https://uppsala.academia.edu/CeciliaRodéhn>

nevertheless, act out emotions in their work (Smith and Campbell 2016, 448; Watson 2016, 77). Since museum educators are often trying to appear 'objective' and withhold emotions, I find it important to study this kind of heritage practice. This paper, therefore, deals with guided tours that are intended to appear 'objective' and museum educators that appear to distance themselves from emotions.

The focus on museum educators, instead of visitors, is an intentional choice, as visitor studies have dominated museum studies (Macdonald, 2011, 2). In the 1980s and 1990s, for example, emotions were explored in terms of visitors' learning and their experiences (Andersson 1989; Treinen 1994). The visitor-centred research may be an effect of constructivist approaches to learning that shifted attention from teaching to visitors' experiences. Learning and visitors' meaning-making, consequently, became the center of attention as emotions were seen as a key dimension in audience activity (Falk 2009, 147). Smith (2015, 461–462) suggests that the idea of the museum as being about learning helps to ensure that 'museum professionals become central focus of analysis.' Although I do not fully agree with her, as I will show below, I concur with her critique of the 'learning paradigm' in museum studies as it 'obscure the emotional aspects of museum visits' (Smith 2015, 478).

In museum and heritage studies it has now been argued that it is impossible to understand why people visit museums and engage with heritage if emotions are not considered (Smith 2006; Gregory and Witcomb 2007; Watson 2015; Smith and Campbell 2016). Visitors were seen as active consumers and producers of emotions in museums, not vessels to be filled with information (Bangall 2003, 87). Emotions, thus, became understood as central in heritage-making in terms of how visitors were both engaging and disengaging with emotions (Gregory and Witcomb 2007; Smith 2006, 2010, 2015, 2016; Watson 2015, 2016; Smith and Campbell 2016; Dudley 2017). The sensory non-discursive level and how affect is provoked by the museum atmosphere was also understood as interwoven in the museum experience (Gregory and Witcomb 2007; Witcomb 2013; Schorch 2014; Tolia-Kelly, Waterton and Watson 2017; de Jong 2018). In many of these discussions emotions and feelings are regarded as something positive and something that should be promoted in museums, as it is argued to provide a deep and critical insight amongst visitors. Dudley (2017), for example, calls for museum practitioners and scholars alike to determine how to facilitate meaningful emotional engagement amongst visitors. It is also suggested that emotions can facilitate a new imagined future (Witcomb 2013). Trofanenko (2014) even argues that educators should work to harness the potential of emotions in the educational pursuit. Others suggest that emotions, such as empathy, should be fostered in museums (Gokcigdem 2016). However, I agree with Watson (2015, 296) when she writes that the question is less about how visitors react or engage with emotions but more about 'how we ensure that they are ethical experiences'. This, I suggest, can be achieved if we turn the focus not only to visitors but also to museum and heritage professionals.

Further studies on museum and heritage practitioners' work is important since the focus on visitors, following Macdonald (2011, 2), has become a dominant lens in museum and heritage studies. I agree with Tran and King (2007, 131) who suggest that there has been limited recognition and understanding of museum educators' work, and I follow Best (2012, 35), who holds that guided tours have been overlooked in research, leaving little insight into the practices of tour guides. This is not to say that museum educational practices are not explored. There are, on the contrary, studies discussing guided tours in relation to visitors' emotions (e.g. Gokcigdem 2016). What is suggested here is that museum educators' doing of guided tours is not explored from the perspective of museum educators' techniques and especially not in terms of how emotions are utilized. When museum educators' work is investigated, it is always, with a few exceptions, discussed in relation to visitors, their experience, and in terms of visitors' learning outcome (see Rodéhn 2017 for a discussion). There is a need to explore how practitioners do guided tours and how they employ emotions in their practice as this can shed light on the emotional work in museums. In investigating this I aim to answer Smith and Campbell's (2016,

455) call to further study the ways in which emotions are consciously managed and regulated, as well as Wetherell, Smith and Campbell's (2018) suggestion to further investigate what emotions do in museum contexts.

Theoretical and methodological approaches

In this paper I use Sara Ahmed's queer-feminist phenomenology as a theoretical and methodological approach in order to discuss emotions (Ahmed 2006, 2008, 2010, 2014). Ahmed stresses that emotions are cultural practices; they are relational and considered as produced in the interplay between spaces, objects and people. The body, gender and sexuality play vital roles in the performance of emotions, and Ahmed explains that it is in contact with others that emotions come into being (Ahmed 2010, 238, 2014, 13). Adopting this approach, also suggest that I remain hesitant to focusing my research on affective moments, on the precognitive and on atmosphere (e.g. Tolia-Kelly, Waterton and Watson 2017; de Jong 2018). On the contrary, I regard emotions as performative – they involve repetition, actions and the embodiment of cultural discourses and knowledge.

The performative approach to emotions also means that emotions can affect people – emotions *do* something (Ahmed 2010, 2014). Ahmed suggests that emotions involve discussions of motions, using phrasing such as being touched or moved by emotions as well as proximity and distance between people, using phrasing such as wanting to be close to objects that brings happiness or trying to create distance from people who evoke disgust (Ahmed 2014, 2010). Ahmed calls this the relationality of emotions, and it involves actions or relations where subjects are *oriented* toward or away from others (Ahmed 2014, 8). *Orientation* is Ahmed's (2006) way of theorizing how the bodily, the social, and the spatial are intertwined. She argues that emotions involve a sense of orientation, and the investment in emotions means that we are directed a certain way (Ahmed 2010, 54). For Ahmed orientations are not only about starting points, that which is already known (norms), but also about how bodies move and are moved in space (not only physically but also mentally). Being oriented means being asked to follow *directions*, which is her way of explaining how bodies are put in normative lines (Ahmed 2006). Ahmed (2006, 14) suggests that the body is oriented from *lines* – norms – that we are forced to, or freely, align with. Yet, lines are not prescribed but recreated by being followed; – they are performative. If, drawing on Ahmed (2010, 45, 54), emotions are an affective form of orientation, then emotions are crucial to guided tours because to educate is to orient, and education means being directed in normative lines.

In order to study the doing of emotions and what emotions do I initiated field research at the Museum of Medicine (Uppsala, Sweden) during the early spring of 2015. The Museum of Medicine is located in one of the former administrative buildings at the now (almost) closed Ulleråker psychiatric hospital and asylum. A small museum of psychiatric care was founded on the building's first floor in the 1980s and presented material culture and social memories collected by the 'Friends of Ulleråker' – an organization of families and relatives of the staff members working at the psychiatric hospital. Later, in 1995, a museum of medicine, exhibiting medical equipment, was installed on the first floor in the same house. The material was gathered and organized by Lars Thorén, a surgeon at Uppsala University Hospital, together with pediatrician Ingrid Richter Thorén and pharmacist Stig Ekström. The two museums merged in 2004 into the Museum of Medicine.

Every year, hundreds of university students studying medicine and nursing at the Uppsala University are given a guided tour of the museum as part of their education. The students are, during approximately an hour, taken around the museum by volunteers and curators who tell them about medical history (on the bottom floor) and about Ulleråker psychiatric hospital (on the first floor). The guided tours could be described, drawing on Whitcomb (2013, 259, 2014, 58–60), as a 'pedagogy of walking'. It is a guided tour that is based on information where visitors are instructed to look at objects and listen to the guide. Witcomb (2013, 259, 2014, 58–60) suggests

that this practice excludes a mediation of emotional and sensational knowledge production intended to transform the individual. However, I will show that the ‘pedagogy of walking’ involves a multitude of emotions that encourage visitors to feel.

Five guided tours were investigated using participant observation. During the field research I was assisted by Hedvig Mårdh and Patrik Klingborg. The guided tours were carried out by two curators and two volunteers in the museum. In this paper I have called them Curator 1, Curator 2, Volunteer 1, and Volunteer 2, and I refer to them collectively as the museum educators. The curators have higher degrees in the history of ideas, and the volunteers have a background as attending physicians. I refrain from describing them any further in order to protect their anonymity. The museum educators and the students that participated in the guided tours were informed about the study in advance and signed written consent. The students were informed that their participation would not be part of the study.

Participant observation is a method of open-ended enquiry, where the researcher seeks to explain cultural patterns by following and observing a performance of practice such as a guided tour (see Jorgensen 1989). The guided tours were also filmed using a mobile camera. The reason for filming the guided tours was that performances are fluid and complicated to study (Schechner 2002, 38–42). The video recording allowed me to better access what the museum educators were doing and saying during the guided tours. Coupling the film and the participant observation helped me to understand how emotions were tangled up in discourses.

Ahmed’s (2014, 45, 91) term *sticky signs* is used to discuss how discourses about patients are materialised in the guided tours and how this was connected to emotions. The performativity of emotions depends on the reiteration of discourses and how emotions ‘stick’ to subjects and objects in this process (Ahmed 2014, 91–93). Objects become sticky because they are repeated, and the constant repetition makes them appear to have an inherent truth. When objects become sticky they are saturated with affect, and they become sites of personal and social tension (Ahmed 2007, 126, 2014, 8–13, 91, 195). Objects, for Ahmed, are not only material culture but also concepts and signs; for instance, she discusses hate-speech as a *sticky sign* and as a way to show how language works as a form of power (Ahmed 2014, 91). Drawing on Ahmed (2014, 191–202) I suggest that the doing of emotions in guided tours is bound up with the repeated (sticky) use of signs. The way that people and practices are presented in the guided tours are a result of reiterated discourses to which emotions *stick*.

Sticky signs produce social differences and draws boundaries between the ‘self’ and the ‘other’ (Ahmed 2014, 10, 191–202). The differentiation is produced by adhering to norms, for instance, able-bodied norms, which are a systematic discrimination against, and oppression of, people with disabilities. The differentiation is commonly referred to ableism (McRuer 2006). In this paper I will, instead, use sanism as term to address differentiation between the self and the other. Sanism is similar to ableism and refers to normative ways of thinking that construct mental illness as a binary position, with its opposite as mental health. Sanism is based on stereotypes that construct people suffering from mental illness as the ‘other’, and it results in the marginalization of people with mental differences (Lewis 2013). Othering is the basis for abjection, which is a process involving a rejection to that which is considered to disturb the social order. In this process the abject has one quality: – being opposite to the self. However, there is nothing essential about abject, and abjection or ‘othering’ is structured by performativity (Kristeva 1982, 1–5, 25; McRuer 2006). I use Ahmed’s writing coupled with Lewis, McRuer and Kristeva’s texts to support a discussion of how museum educators employ emotions and what these emotions do.

Not expressing emotions

I start the discussion of the guided tours with an investigation of not expressing emotions. In doing so, I begin at the very end of the guided tour where the museum educators discussed treatment of patients. Treatments were described in seemingly non-emotional ways, focusing on

details such as the effects on the hormone and cell level. The museum educators first discussed lack of treatments in the past but soon moved over to discuss hydrotherapy, insulin therapy, electroconvulsive therapy, and lobotomy as well as malaria inoculation. They ended the evolutionary story with the introduction of Hibernal (chlorpromazine) that assisted in fundamentally changing mental care. The museum educators demonstrated instruments used when treating patients, and the story centered on technical advances. This is a kind of technicalization of the history of mental illness, and research shows that this is not uncommon in museums where illnesses are often equated with technologies (Andersson and O'Sullivan 2010, 146–147). The focus on medical discoveries and its effects resulted in that patients' experiences were marginalized. Patients became, during the guided tour, a 'site', not people, on which medicine was deliberated and where medical advances could be explained. Consequently, patients' bodies became, in the narrative, pieces of flesh that were worked upon, used, and on which 'objective' methods and discoveries, were described to the visitors. The museum educators remained unsentimental when describing the methods and discoveries, and their gestures also echoed this emotional state.

Patients' experiences were only briefly mentioned during the guided tours, and the museum educators described treatments as 'very painful' (Volunteer 2) and that 'people felt terrible' (Curator 2). Curator 1 expanded a bit on this subject:

And there have been practices that to our ears sound more like torture than medical treatments, but I think that it is more important to remember that the people working here were not some sort of sadists. They were doing the best they could with the means that they had. But it should not be forgotten that there are some people that have been very poorly treated by mental care.

While 'some' patients' feelings were acknowledged, they were presented as secondary to the experiences of the hospital workers. Further, I suggest that the comments on patients' feelings and on maltreatments were primarily not an act of caring for patients, but used to show how medicine had advanced over the years, how it had improved, and how attitudes had changed for the better. An example of this could be found in Volunteer 1's narrative. When arguing that Hibernal modernized psychiatry, the Volunteer said: '(...) Then in 1952 the big thing revolutionized psychiatry entirely (...)'. Curator 1 discussed treatment using similar language but admitted that medicine was not perfect: 'One can at least say that these modern medical treatments have resulted in that one could abandon some of the worst methods where force were used.' I noted that the museum educators expressed emotions of pride and joy when talking about advances in medicine but that they withheld emotions when talking about patients. When talking about patients they controlled their movements and limited them to minimal gestures; they controlled their speech and indicated importance by using different intonations and accentuating words differently. For instance, a much softer tone was used when stating that pain was inflicted upon patients. It appeared as if the museum educators were distancing themselves from what was being said.

Emotional restraint is not uncommon in this field and heritage practitioners are often opposed to dealing with emotions; they try to distance themselves from feelings in an effort to mediate an 'objective' truth (Smith and Campbell 2016, 448; Watson 2016, 77). Yet, not being emotional can be considered a performative and emotional state (Smith and Campbell 2016, 448), and I suggest that the non-expression of emotions, both in terms of narrative but also in gestures, play a role, as '[e]motions show us how histories stay alive' (Ahmed 2014, 202). Drawing on Ahmed, I suggest that the emotional restraint narrative and gestures in the guided tours were ways to keep histories, tradition and values within the medical practice alive. This can be further explained drawing on Eriksson's research on how attending physicians expressed gender relations. She shows that doctors publicly depict their profession as masculine and unemotional and that they greatly value emotional restraint (Eriksson 2003, 98).

Histories are bound up with emotions only insofar as what *sticks* (Ahmed 2014, 54, 202) and I suggest that withholding emotions was a *sticky sign* that *stuck* to the guided tours because objectivity, rationality and emotional restraint were considered good practices of emotion, performances that were elevated as a sign of cultivation (see Ahmed 2014, 3). Seeing emotional restraint as a refined sign is problematic, as not expressing emotions are commonly associated with able-bodied and sanist men, whereas women and people suffering from mental illness, on the other hand, are considered irrational, emotional, and not in control of their bodies and desires (see Ahmed 2014, 10; Obermark and Walters 2014, 66). Thus, withholding emotions must be understood not as an absence of emotions nor is it, as Smith (2010) and Dudley (2017) suggest, about disengaging with negative emotions but rather it is a different kind of emotional *orientation*. This *orientation* of emotions assists in identifying who it was possible to feel with (who was the legitimate object of emotions) and whom it was possible not to feel with. It functions much like Wetherell, Smith, and Campbell (2018) argue about the fostering of a political position. I will now turn to discuss what this does and what consequences this has for the doing of heritage.

The patients

During the guided tours it became evident that caretakers and other staff members were legitimized objects of emotions, whereas patients were not. This could be seen in how the patients were depicted: as wild, dangerous, and screaming out of anguish. For example, Curator 1 said that before the introduction of the medicine Hibernal (chlorpromazine) in the 1950s: '(...) there was never ever quiet out here: there were always people screaming somewhere.' Curator 2 said: '(...) it was quite loud and messy and people were feeling terrible (...)'. Volunteer 2 made no temporal reference and said that: '(...) I'm telling you that there were patients that stood in corners screaming in terror, followed by devils or something like that.' Patients were, in these statements, described as acting in non-normative ways. I suggest and I will continue to show below that these statements make patients occupy an abject mind – a mind that is considered not 'proper' or socialized, one that disturbs the social order (see Kristeva 1982, 4). The portrayal of patients as the 'other' reveals the norm that the patients were described to fail to uphold. McRuer (2006, 20–21) argues that for a disabled body/mind to uphold normative able-bodied and sanist values they must first be docile; in other words they must be corrected and, in this case, be made silent (not screaming out in anguish or, as I will show below, dangerous and wild runaways). McRuer suggests that a docile body/mind is a mind that is subjected, transformed and improved and such bodies/minds come into existence through disciplinary methods. This includes trying to control a, for example, a depressed mind with training, treatment and medicine (McRuer 2006, 20–21). When such treatments are not seen as able to produce docile bodies/minds it often results in abjection – the feeling of antipathy (see Kristeva 1982, 4). Abjections make it possible to reject or turn emotions away from mental illness and for museum educators to refrain from emotional expressions when talking about treating patients.

Abjection relies on past associations of patients and how associations *stick*. The 'exotic' and voyeuristic remembrances of psychiatric hospital connected to horror and chaotic hospital scenes are often that which *sticks* (Dudley 2017, 195; Rodéhn 2018, 44). This can be seen in popular culture's depiction of hospitals seen, for example, in *Don't Say A Word* (2001) or *Suicide Squad* (2016) portraying uncontrollable and violent patients acting out on doctors and caretakers. In museums there are also a long tradition of depicting people with mental illness as freaks, monsters or victims (Obermark and Walter 2014; Birdsall, Parry and Tkacyk 2015). Patients have been constructed culturally 'to function as delivery vehicles in the transfer of extreme sensation to audiences' (Snyder and Mitchell 2006, 162). Cross (2010, 131) suggest that these depictions enable the audience to recognize and identify that it is 'madness' that is being portrayed. Although the guided tours did not try to evoke horror and extreme affect, they drew on these cultural conventions and, in doing so, patients became a *sticky sign* saturated with feelings of unhappiness.

In these guided tours, unhappiness is associated with people that do not live according to the norm and unhappiness is expected to reside within the bodies of these people. Not living according to norms may result in that people associated with mental illness are marginalized (see also Ahmed 2010, 95–98).

The marginalization of patients could be seen in how the museum educators describe the patients as dangerous. Violent and dangerous patients were a trope that underpinned the guided tours, even when museum educators attempted to contest it, like in Curator 2's depiction the hospital:

There was both calm patients and there were semi-worried patients and worried, so they had that division of patients, right. And that determined also where people were placed when they were admitted to the hospital (...) yes, it was often so that many that were admitted were, yes, not violent. That was the criteria, so that they would not hurt themselves or others. If they didn't hurt someone then they had quite a lot of freedom to roam around within the [hospital] area and participate in different activities, farming, tending to the gardens and those kinds of things. But if it was a patient that was regarded as violent, yes, then it was not so good and there was the kind of infirmary called storm departments where patients were not able to move around freely.

The curator explained that although some patients were violent, many were not. The Volunteers approached the issue quite differently. Volunteer 2, for example, described patients as '(...) dangerous to themselves and others' and the volunteers drew heavily on their own experiences of working at psychiatric hospitals to exemplify exactly how violent patients were. They also used objects, made by patients, to materialize the narrative of dangerous and violent patients. Volunteer 1 said, when facing a vitrine displaying a club, that: 'If you wanted to hit the caretakers across the head you could always make a club (...) as a caretaker you always had to have eyes in the back of your neck (...)'. Volunteer 2 stated at the same vitrine that: '(...) and on the upper shelf you see some of them, the collection of tools we have that was assembled to kill the caretakers.' The idea of violent patients was used to explain the need to guard patients, and the volunteers told stories of how the caretakers guarded the inmates day and night. Although Curator 1 said that patients rarely ran away, the Volunteers, nevertheless, described violent attempts to break out of the hospital. Volunteer 2 stated when facing a vitrine displaying objects made in occupational therapy: '(...) So on the lower shelf you can see different attempts to make keys in order to try to open locked doors.' So not only were patients described as violent and dangerous; they were also described as trying to break out and potentially pose a threat to the rest of the community. Consequently, by focusing on violent and dangerous patients, the museum educators depicted the inmates as a category of people to be feared.

Fear is an important component when 'othering' people. Fear divides people and keeps them divided as people turn away from that which is feared (Ahmed 2014, 62ff). Turning away is, nevertheless, ambiguous because while people may express abjection to peoples' actions, such as planning to kill caretakers or screaming, they are not completely cut off from that which is felt as dangerous or that which fills them with fear. On the contrary, Kristeva (1982, 9) suggests, abjection acknowledges the presence of fear. Consequently, that which is feared also connects people with potential fear to be felt, and to feel fear one must also be near that which is being feared (Ahmed 2014, 3–4, 63). So for fear to be expressed, and for patients to be understood as feared or violent and dangerous, the museum educators had to constantly situate the patients in relation to the caretakers.

The expression of fear effectively worked to describe caretakers as men. This was done despite the fact that there were plenty of representations and pictures of female nurses and caretakers in the exhibitions. For example, Volunteer 1 said,

(...) caretakers who were men took care of regular business down here, but there were no women. Why not?

[A student replies]

Yes, you had to wrestle. It was, it was about violent patients and that was the real problem. To be able to keep violent patients down, and calm, and that is why there they had men that were educated for two years, it was hard currency out here.

The volunteer described that only men did the ‘regular business’ at the hospital because it required strength and the ability to be rational and in control. Presenting caretakers and doctors as men is not uncommon in museums of medicine, and research shows that men are often seen in their roles as controlling and constraining feminized patients (Obermark and Walter 2014, 67). These kinds of presentations are underpinned by a heteronormative gender logic, where women are seen as weak, not be able to fend for themselves, irrational and less able to do a man’s work and are considered physically subordinate to men. This logic explained why ‘only men worked at the hospital’. Women were, in this narrative, not only made invisible but their competences and contributions to the history of mental care were also diminished.

Emotions, in terms of the portrayal of patients, worked on multiple levels on the guided tours. Expressions of feelings of fear – fear of dangerous patients – put patients in the position of the ‘other’, as an unhappy subject residing outside sanist norms. This norm validated the description of force and control of patients, and, as mentioned above, it authorized the non-emotional and medicalized description of mental care. The depiction of patients as violent and dangerous also worked as an investment in men and in masculinity. (Sane) Male caretakers and male doctors were described as active agents in mental care and, consequently, in history, resulting in a marginalization of female histories. I suggest, therefore, that emotions cannot be considered as isolated from norms associated with gender and/or sanism. On the contrary, norms are organizing principles for how emotions are expressed in a museum. Further, the museum educators used these norms to evoke empathy in visitors, a discussion to which I now turn.

Work, work, work

The portrayals of patients, as discussed above, may result in visitors distancing themselves from patients’ experiences, which can shut down opportunities for visitors to empathize with patients (Birdsall, Parry and Tkaczyk 2015, 52). Shutting down empathic engagement is a key question in museum and heritage studies, and researchers discuss how visitors disengage with emotions when encountering marginalized groups and difficult pasts (Gregory and Witcomb 2007; Smith 2006, 2010, 2015, 2016; Smith and Campbell 2016; Dudley 2017). Whereas these studies focus on visitors’ feelings, I nevertheless suggest that it is important to recognize what Treninen states: that visitors’ emotions are often controlled and suppressed when in the company of museum practitioners (1994, 59). Therefore, I turn the focus to how museum educators *orient* visitors to engage with some but not other emotions. I will show how the museum educators *directed* visitors to empathise with caretakers. In order to understand the *orientation* of emotions it is necessary to be reminded that the visitors – medical and nursing studies students – were in some guided tours shown around by former attending physicians. This context may be an explanation for why focus was placed on caretakers. This emotional orientation, as seen above, is far from uncomplicated and was often made at the expense of patients.

A focus on the living conditions at the hospital was one way to make visitors empathise with caretakers. This can be seen in terms of what Volunteer 1 said when entering into one of the exhibition rooms:

(...) the staff lived here with the patients in rooms of this type, no toilet, no shower and nothing like that; it was very primitive, low salary, if any. They had somewhere to live, but there was nothing more than that. How the heck could anyone take such a job?

The museum educator depicted the harsh conditions in which caretakers had to live with (dangerous) patients while at the same time being poorly paid. This could be further seen in the depiction of caretakers as being equally (and unfairly) incarcerated, much like the patients.

Curator 2 said that: ‘Up until 1900, people really could not leave without permission from the attending physician, who locked the gates.’ What is depicted here is a work situation where the staff members had to live within the walls of the hospital area and also have written permission to leave. Volunteer 1 stated something similar saying: ‘One had to have permission to leave the area, one was socializing with idiots – it was considered back then – all the time (...).’ ‘Idiots’ was a reference to patients in an attempt to *direct* empathy to caretakers. The Volunteer clarified that s/he used the word to emphasise how patients were considered in the past.

Empathy is about taking another’s perspective (Trofanenko 2014, 27); it can be defined as when we feel *with* someone (Arnold-de Simine 2013, 111). In the tours, visitors are *directed* to feel along *lines* of emotional *orientation* and not along other *lines*. During the guided tours the museum educators *directed* the visitors to feel *with* the caretakers and encouraged visitors to take their perspective. Central in the doing of empathy was the question of why anyone would work during such circumstances. Volunteer 1 asked this question, as seen above, and he posed it in another guided tour, showing what caretakers had to face in their daily work: ‘It was dirty, and there was poo and pee and there was latrine. It was dirty and there was no spare time. How the heck would anyone take a job like that?’ Central in this question was the abjection of patients and living with (dangerous, violent, and dirty) patients, not being able to take a break during the job and having to handle faeces. Living and caring for patients was presented as something that brought suffering and patients became *sticky signs* saturated with feelings associated with an unhappy life.

Portraying the patients as the root for the caretakers’ suffering is a form of blaming the victims. Depicting patients in this way is a continuation of the othering of people with mental illness. This emotional orientation is not uncommon when considering the results in Smith (2010), Gregory and Witcomb (2007, 268), Arnold de-Simine (2013, 47) and Dudley’s (2017) research on visitors emotional response to war, colonialism and mental care in museums. It shows that visitors empathize with people of their own ethnicity, race or mental condition rather than with the ‘other’. This research can assist in the understanding of the guided tours, where the volunteers (former health care professionals) when guiding students (future health care professionals) *directed* empathy to what they considered people in a similar situation and away from patients. They asked the visitors to recognize the caretakers’ feelings on the basis that they had, or would come to, experience something similar when working in hospitals. Smith (2010) and Dudley (2017) suggest that this is to close down empathic emotions about the other. Nevertheless, I suggest that it is a question of a different emotional *orientation*. It is not so much a question of who they do not feel with but a question of who they feel with, how they come to feel with them, and how this emotional orientation is constructed on the abjection of others. This way of creating empathic emotions is highly problematic, and focusing on suffering should discourage violence against marginalized groups – not continue it (see Byrne 2009, 244; Watson 2015, 296). Investigating who the target of empathic emotions offers a way to focus on the centre, on the norm, and the organizing principles of emotions. I will now continue to explore how norms organize emotions.

Living at Ulleråker

Despite the negative associations connected to patients and to living and working at the hospital, Ulleråker was at the same time described as a place of happiness and as a place where patients and staff members lived and worked together. Happiness played a role in the guided tours to mitigate the feelings of unhappiness and present another perspective on life at the hospital. I want to explore, with the help of Ahmed’s writing, this doing of happiness to see what happiness does. Ahmed, in her critique of happiness, suggests that there is a ‘happiness script’ and within this *line of orientation* happiness is considered a social good. It participates in making things good, and it entails that we are *oriented* the right way. Happiness means being *in line*, being according to norms (Ahmed 2010, 2, 9, 13, 54).

Happiness was, during the guided tours, connected to leisure. Volunteer 1 says,

... patients and staff members socialized a lot. They had parties, they did theater performances, they had film screenings (...). They had a lot in common and probably quite a lot of fun...

Patients' happiness was expressed in terms of socializing. The museum educators described that caretakers 'socialized with the patients' and that they 'socialized a lot'. Socializing can be regarded as an expression of caretakers' kindness and as a way of making patients happy – relieved of mental illness. A happy life was also promised through theaters, films and other events and as such happiness was connected to material culture that mirrored these events, such as theatre costumes and a film projector on display in the exhibition. The film projector's ability to bring happiness to patients can be seen in Curator 1's statement:

In this house and in the big assembly hall there were sometimes activities for patients. Among other things, they showed films, actually once a week. A film projector was bought in 1917. Film screenings were festive occasions here...

In this statement the curator specifically indicated that the use of the film projector was a joyful occasion.

Objects, like a film projector and theater costumes, can evoke and anchor emotions (Turkle 1997). This suggests that happiness does not reside in objects, but happiness is promised through proximity to specific objects (Ahmed 2008, 11). The film projector, thus, is attributed as a condition for happiness because it is expected to bring enjoyment. This suggests, drawing on Ahmed (2010, 34), that being directed toward specific objects that are already attributed as enjoyable should bring happiness, as the affective values are already in place. Happiness is an expectation that follows from the proximity of these objects; if someone is close to an object associated with happiness, then that person is understood as happy (see Ahmed 2008, 11; 2010, 25). In other words, patients close to the film projector are articulated as happy, and the hospital is articulated as a happy place.

Objects, like the film projector and the theater costumes, come to represent good feelings. Good feelings get *stuck* to objects and in *sticking* to objects they promise a happy life (Ahmed 2010, 33). Therefore, when the museum educators turn to, for example, the film projector, the theatre costumes, and the assembly hall and use them, talk about them as useful in bringing happiness, they also *direct* the students to happiness. This *orientation*, on the one hand, provides a different understanding of the hospital than the one depicting it as a prisonlike environment with wild inmates. On the other hand, this presentation is also problematic, and I suggest, drawing on Ahmed (2010, 87), that the museum educators cover up the unhappiness of mental illness and the stigma connected with the psychiatric hospital in this presentation. Happiness, thus, become a strategy to bear the pain of the patients' suffering, or, rather, it becomes a strategy to conceal the pain. On this idea, Ahmed states that 'happiness involves a way of avoiding what one cannot bear' (Ahmed 2010, 64). The museum educators avoided the unbearable by turning to objects that promise happiness and, in doing so, the objects propel the history to a happy end, meaning that the psychiatric hospital was expressed as not such a bad place after all. Therefore, drawing on Ahmed (2010, 132, 2014, 227), I suggest that what happiness did to the guided tours was it provided a distraction; it assisted in camouflaging social hierarchies and pain inflicted upon patients. I hold that happiness was not so much a feeling but, drawing on Ahmed (2010, 10), an instrument in the guided tour. I suggest that it was a pedagogical strategy where the students were turned away from empathizing with patients and, instead, asked to empathize with caretakers.

Conclusion

The examination of the guided tours reveals that the museum educators employed normative discourses when portraying patients as dangerous, dirty and violent. These *sticky signs* were saturated with feelings of antipathy, fear and unhappiness. The *sticky signs* worked to sustain the expression of emotional restraint when describing mental care. By portraying the poor working conditions and the

hospital as a place of happiness, the museum educators, on the other hand, situated caretakers as people to empathize with. I suggest, therefore, that the doing of heritage can be understood as a performance where emotionally charged sanist depictions are made. Museum educational practices are understood as the being made in the making of these depictions. The doing of guided tours can, thus, be understood as inscribing emotions and ideas about sanism in the museum educational practice. Consequently, in this text I have showed how doings, norms and emotions are entangled and how they are enmeshed in the heritage of mental illness.

I have suggested that emotions become more than feelings; – they are tools and pedagogical strategies employed to *orient* students along *lines* of emotionally charged knowledge about mental care and mental illness. I suggest that these are sanist *lines of orientation* and that the heritage production is permeated by sanist norms. The investment in sanist norms casts people suffering from mental illness as the ‘other’ and attaches negative emotions to patients. Currently, most of the focus in this area of research is on how people with mental illness are presented, how the depiction is associated with negative emotion, and how this doing of heritage continues a subjugation of already marginalized groups in society. In addition, attention needs to be turned to how sanism as a norm permeates the entire heritage system. Investigations are needed in terms of how sanism organizes the way that we talk about heritage, how it influence heritage practices (museum education, exhibitions, collection keeping, etc.) and how sanist norms influence how museum practitioners use emotions. Moreover, inquiries need to be made into how the employment of sanist emotions *orient* visitors in museums – how visitors are *directed* to feel certain things about people with mental illness and the heritage thereof. It is important to further discuss how sanism, is connected to positive emotions and how this *orientation* is privileged within heritage practices. Focusing attention on the role of sanism and associated emotions makes it possible to start addressing ways of doing a more diverse heritage.

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Notes on contributor

Cecilia Rodéhn holds a PhD in Museum Studies from the University of KwaZulu-Natal (South Africa) and works as a researcher at the Centre for Gender Research, Uppsala University (Sweden) where she also teaches gender studies. Rodéhn is currently engaged in research focusing on the cultural heritage of former psychiatric hospitals and asylums. Previous research has focused on museum practices during the South African democratization process and various issues related to museum education.

ORCID

Cecilia Rodéhn  <http://orcid.org/0000-0001-8139-2701>

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