The Influence of the Arts-and-Crafts Movement on the Professional Status of Occupational Therapy

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This paper explores why occupational therapists use arts and crafts as therapeutic modalities. Beginning with the turn-of-the-century origins of occupational therapy, the paper traces the similarities and differences in the ideas and beliefs of the founders of occupational therapy and the proponents of the arts-and-crafts movement.

The arts-and-crafts movement ultimately came to be regarded as an oddity; yet in its beginnings, it was widespread and deeply influential. Its origins can be traced to the work of John Ruskin, a mid-nineteenth-century British university professor. Ruskin (1884b) maintained that machines and factory work limited human happiness. He urged a return to simpler ways of life where experience was “more authentic” because less complicated by modern bureaucratic and industrial structures. Ruskin was a romantic, looking back to similar ages when human-kind purportedly was healthier because more connected with its environment, its work, and its religious values.

He found the Middle Ages especially attractive and lectured on facets of medieval life. Architecture especially interested him, and he pointed to the construction of Gothic churches as an example of how values were incorporated into people’s lives. Workmen completed uplifting projects which gave a central meaning to their lives (Ruskin, 1884a). He also maintained that humans, not machines, completed objects; therefore, work was not abstracted from life but had a place at its very core. The manufactured goods of his own time he found to be both aesthetically and morally unsatisfying because the worker was treated like an extension of the machine, completing only a part of the finished product.

Ruskin’s ideas were further refined by William Morris who criticized machine “gimcrackery” as threatening the foundation of civilized life (Rodgers, 1974, p. 77). These ideas struck a responsive chord in the United States as well as in Britain. They were most warmly received by the socially advantaged—not because of any widespread disaffection with the capitalist economic system, but because of a discomfort in some circles with excessive materialism and the shoddiness of mass production.

By the turn of the 20th century, the arts-and-crafts movement’s advocates formed a network which reached across America. Proponents were eager reformers celebrating nature, authentic experience, and honest design. Like their British contemporaries, they displayed a patrician contempt for the system of mass production, which was keyed to lower class tastes. They advocated the use of natural materials and processes and the purchase and use of hand-made items that were straightforward and simple in design. Indeed, for some advocates, the arts-and-crafts movement meant quality of design as much as quality of life.

In the United States, 25 arts-and-crafts societies appeared from 1895 to 1907 (Rodgers, 1974, p. 78). These handcraft clubs were filled with middle- and upper-middle-class Americans striving for self-improvement as well as social stability (Lears, 1981).
Reverence for authentic objects and simple but substantial designs for homes and furnishings testified to the good taste of arts-and-crafts proponents while at the same time conveying a comforting and traditional set of moral values (Wright, 1980). This was helpful in a world where strong ambitions threatened permanence and rapid social change heightened the need for stability.

Wiebe (1967) described late nineteenth century America as a "society without a core" (p. 12). Rapid social, economic, technological, civic, and cultural changes had created a "distended" society; yet people were still trying to understand the expanding American society in terms of their familiar, small-town environment. This simplistic orientation created even more problems since a larger vision of the future was required to deal with destabilizing forces such as westward expansion; millions of Eastern European immigrants; rising impersonal, industrialized work; technological advances that linked the country together; declining birth and death rates; changing roles of women; and economic instability.

The smug security of small-town America was ending and local community members felt as if they were losing control over their lives although the "enemy" was not always clear. People yearned for a slower paced life, governed by the old and authentic values. Thus, the arts-and-crafts movement rose in popularity, offering the promise of a more meaningful life style.

The Transformation of Medicine

Medicine was in part responsible for the initial direction taken by occupational therapy. By the turn of the twentieth century, American physicians were shifting to a scientific foundation. Disease was understood in terms of physiological processes rather than in terms of suffering or personal disorientation; specialists concerned themselves with organs and tissues rather than the whole patient; hospitals removed the sick from their environments and treated them as abstractions; and vital signs collected through such new instruments as the X-ray machine and interpreted by the laboratory obviated the need for the physician to listen to patients' complaints or win the patient's active partnership in treatment planning.

Yet some physicians, often those connected with the most prestigious institutions, believed that science, by itself, did not offer a complete answer to illness. They argued that earlier notions of mind-body unity were being overlooked in the new high-technology medicine.

Dr. Herbert J. Hall was one such dissenter. He was interested in neurasthenia, a medical problem that did not reduce itself easily to the limitations of new medicine. This disease was not obviously physiological, its symptoms were diverse and could be linked to the strain of American life. The malady was identified in middle- and upper-class persons who complained of "morbid anxiety, unaccountable fatigue, irrational fears, and compulsive or inadequate sexual behavior" (Beard, 1881, pp. 7–8; also Sears, 1981, p. 50).

Hall (1910) developed a work cure to take the place of the commonly prescribed bed rest. He based his therapeutics squarely on the philosophy espoused by the arts-and-crafts enthusiasts. After securing financial backing from the prestigious Proctor Fund, he developed a sanatorium in Marblehead, Massachusetts, and began to validate the success of his work cure. Hall joined a network of like-minded physicians.

Two other physician dissidents who also became interested in curative occupations were Adolf Meyer and William Rush Dunton. Both searched for ways to humanize the care of chronically ill patients. Meyer was impressed with the results he saw at Worcester Massachusetts State Hospital where his wife, Mary Potter Brooks Meyer, a social worker, developed an occupations program for ward patients. Adolf Meyer, as a researcher, was usually removed from direct patient care. Mrs. Meyer, therefore, operationalized his ideas on adaptation and the therapeutic prescription of activities (Hopkins, 1979).

In Chicago, the collaboration between Meyer, a medical leader, and Julia Lathrop, a social worker and civic activist, resulted in the application of arts-and-crafts ideology to chronically ill mental patients. Lathrop studied bookbinding at Kelmscott Press under Morris. She wanted to improve the lives of the less fortunate by applying the principles of the arts-and-crafts movement to patient programs. She fulfilled this goal by using her influence as a member of the Illinois State Board of Charities and Correction. She and another Board member, Rabbi Emil Hirsch, in 1906 organized one of the earliest occupations training courses (Addams, 1935).

Dunton, who also came to believe in the curative effect of goal-directed activity, applied the occupations cure to his patients at the Sheppard and Enoch Pratt Asylum in Towson, Maryland, as early as 1895. By 1908, his observations of patients' undirected efforts led him to search for an arts-and-crafts teacher. Using Studies in Invalid Occupations: A Manual for Nurses and Attendants by Susan E. Tracy (1912), a nurse, Dunton established his own training program.

In her book, Tracy described an occupations training course she designed in 1906 for nurses working at Adams Nervine Hospital in Boston. The text, which is basically a craft book, offered teaching strategies, supply lists, and treatment rationales for a variety of settings, including the homes of advantaged and disadvantaged patients. These progressive physi-
cians, Meyer, Hall, and Dunton, worked with social caretakers Lathrop and Tracy to link the holistic treatment of the past with modern, scientific approaches (Burnham, 1972). Combining ideas that were once important in medical practice with ideas from the arts-and-crafts movement, these individuals founded a new profession, which was later named occupational therapy.

The Arts-and-Crafts Origins in Occupational Therapy

Early occupational therapy practice combined the therapeutic and medical with the diversional and recreational use of activities. One of the earliest sources of overlap between these applications was the sheltered workshop. Hall and other physicians championed the development of sheltered workshops where patients produced carefully designed, well-made objects such as hand towels, ceramic vases, and cement pots. The craft objects were sold in shops that had three purposes—to employ talented people who could earn a living by making authentic objects, to give spiritual support to craftspeople who pursued crafts as an avocation, and to help employ the mentally and physically handicapped (“Craftsmanship,” 1906; Evans, 1974; Roorbach, 1913; Simikhovitch, 1906). These purposes frequently overlapped, and it soon became difficult to separate rehabilitation goals from the aesthetic ideology of the arts-and-crafts movement.

Following Hall’s lead, George Barton, an architect familiar with Morris, joined the Boston Society of Arts and Crafts in 1901. Barton was not a healthy man, and after a long struggle with tuberculosis he decided to move to Denver where he lost his left foot to frostbite in 1912. Depressed and ill, he returned to the East and sought the advice and counsel of both a physician and a minister who urged him to direct his energies toward a productive mission. Barton decided to help others instead of focusing on his own health and produced goods and squeezing profits (Boris, 1984). To survive, workshops shifted their focus from therapeutic arts and crafts to cost-conscious ventures that would reap profits. The individualistic thrust of early occupational therapy was lost in this shift to economic considerations.

Solvent workshop endeavors were rare even if workers were nondisabled, skilled, and efficient. Machine-made goods proved to be stiff competition in the marketplace, lowering prices on workshop-produced goods (Boris, 1984). To survive, workshops shifted their focus from therapeutic arts and crafts to cost-conscious ventures that would reap profits. The individualistic thrust of early occupational therapy was lost in this shift to economic considerations.

The early occupational therapy link to the arts-and-crafts movement did not end with the demise of the therapeutic workshop. This influence was still evident in the 1930s and 1940s, long after the ideas and beliefs of the proponents of the arts-and-crafts movement disappeared from the American culture. Evidence is plentiful: Black (1935) discussed the employment of sheep herders in the Arts and Crafts League of New Hampshire, Ash (1940) presented the use of handicrafts with blind and retarded patients, the 1932 Annual Institute of Chief Occupational Therapists devoted 25% of its conference to a folk dance, a lecture, and a demonstration (Annual Institute for Chief OT’s, 1932).

Glaser (1930) noted that the eye, hand, mind, and creative imagination are stimulated by arts and crafts. In line with this thinking, occupational therapy schools offered courses in needlework, weaving, metalwork, bookbinding, and leatherwork. The missions and philosophies of occupational therapy and the arts-and-crafts movement were so intertwined that few therapists would have disagreed with Will Levington Comfort when he remarked that “there is something holy in the crafts and the arts” (as cited by Glaser, 1930, p. 131).

Healthy individuals were drawn to the arts-and-crafts movement because involvement with arts and crafts promised to settle nervous lives. The occupational therapy founders creatively applied these ideas to a neglected group of chronically disabled patients. These applications were varied and creative and included the management of pain during recuperation, the redirection of the wandering minds of elders, and the diversion of self-indulgent thoughts of depressives. Therapists were slow to depart from the prescriptions of the founders who had argued that the “scientific” prescription of arts and crafts could cure a variety of chronic problems generally considered outside of the domain of medicine (Tracy, 1912; Hall & Buck, 1916; Dunton, 1918).

Changes in Social Values Create Conflicting Philosophies

Only a thin line divided the arts-and-crafts philosophy from occupational therapy. Arts-and-crafts persons were diversionists using an activity to achieve a cure;
yet to them the craft product was as valued as the process. Therapists differed slightly, they focused more on the concept of function and were less concerned with the product, but they still used crafts.

Trained in specific modalities, many diversionists neglected the patient’s interest in the activity at hand. Consistent with their crafts training, they searched for information about specific crafts rather than exploring why the occupation cure succeeded. Diversionists fervently believed that craftwork alone was curative. This belief was based on the work ethic. The differences between therapists and diversionists grew more and more obvious in the 1930s and 1940s.

The overlap between personal interests and professional roles and responsibilities was also confusing. Even Dunton demonstrated a mixture of personal and professional interests, displaying his quilt collection at an occupational therapy meeting held at the Baltimore Handicraft Club (“OT Notes,” 1930). This mixture of values proved difficult for early therapists who were trained in fine arts and specific crafts. To abandon their commitment to craftsmanship, to embrace the process over the end product was a violation of their cherished belief in the arts-and-crafts movement. Diversionists were so tied to the arts-and-crafts ideology that they overlooked the process by which the therapist elicits the patient’s goals, values, and interest in the activity process (Dunton, 1928).

Furthermore, the professional occupational therapist was under severe strains. Health care’s focus on the individual further eroded as the status of physicians rose and medicine was transformed into a specialty practice based on scientific principles. In this milieu, the holistic philosophy of early occupational therapy practice was increasingly compromised as diversionists continued to focus on specific craft concerns (Hall, 1922).

The Depression contributed to the changes in health care delivery. In some states, over 40% of the population subsisted on relief. The national income plummeted to less than half of what it had been in 1929 (Stevens, 1971). The bleak industrial situation created shortages in health services and providers. Physicians’ incomes fell, nurses were unemployed, and hospitals developed insurance to guarantee payment. For many Americans, medical care became a luxury (Starr, 1982).

Occupational therapy survived using strategies such as “classes” to provide treatment to large numbers of patients. At the same time, leaders pushed therapists away from the values of the arts-and-crafts mission and toward the medical model (Mock, 1930; Munger, 1935). Occupational therapy leaders embraced functional concerns; arts-and-crafts values were subordinated to the functional orientation. Occupational therapy, like medicine, assumed responsibility for making decisions for the patient’s welfare. Unlike the developing science of medicine, however, therapists had no technology to measure the accuracy of their prescriptions.

Occupational therapy was caught in a web of conflicting ideas. The scientific goals of medicine pulled against the holistic goals of the arts-and-crafts movement. Change did not come smoothly. In 1930, Eleanor Clarke Slagle, a prominent occupational therapy leader, felt obligated to warn new graduates of Sheppard and Enoch Pratt Hospital that “handiwork alone was insufficient” (p. 271).

Joseph Doane (1931), a physician and president of the American Occupational Therapy Association, was equally emphatic when he differentiated between two groups of occupational therapists: “There are those who believe that the occupationalist who diverts and amuses and who as a by-product perhaps spiritually improves the sick, contributes the greatest good to the community” (p. 365). Doane maintained that the “occupationalist” is likely to possess less vision and training than the therapist who uses skills as a means to the performance end. Doane rejected the arts-and-crafts movement and promoted the science of occupational therapy. He noted that “Occupational therapy is not a fad which like many others seizes the imagination of a community or country and then suddenly relinquishes its hold” (p. 364).

Dr. Horatio M. Pollock (1934) traced occupational therapy back to Galen in the second century but noted that occupational therapy “has not yet won a place in the consciousness of a large part of the medical profession” (p. 362). In the same vein, Oscar M. Sullivan (1935), also a physician, predicted the future thrust of occupational therapy when he explained that although “craftwork constitutes the bulk of what is known as occupational therapy,” there was no reason that “another kind of practical work should not develop quite as much” (p. 107). It was merely a matter of opportunity and facilities.

Thus, the profession struggled during the 1930s and 1940s and ultimately lost the momentum enjoyed during the initial years of organizing. Pulled by internal tensions regarding the focus of the occupation process, therapists were also influenced by shrinking health resources, the rising status of physicians, the limited roles of professional women, and most distressing, the doubts raised by patients who questioned the merit of craft therapy. In short, few therapists, physicians, or patients remembered the lofty mission of the forgotten arts-and-crafts movement.

Dr. Harry Steckel (1934) noted “it is quite possible that patients do not fully realize or recognize the true value of occupational therapy, even if they are not particularly interested in the project worked on by them” (p. 494). Steckel believed that occupa-
nitional therapy could be improved by using a variety of projects with “more opportunity for personal choice, with a closer check upon the reaction of the patient to the type of work offered” (p. 498).

Thus occupational therapy survived the 1930s but was moored to the values of a forgotten social movement. Meanwhile, the medical profession had shifted from a holistic to a reductionist focus. During World War II, the occupational therapy profession struggled with the same unresolved tension between craft proponents and therapists, but the context had changed. Younger physicians no longer understood or valued the arts-and-crafts philosophy. Since occupational therapy practice did not seem scientific or theory based, they tended not to take it seriously. The example of a specific hospital offered below demonstrates that therapists changed little in their philosophy, theory, and therapeutic modalities during the first 35 years of practice. Few acknowledged that the context for health services had changed.

The Example of Norristown State Hospital

In 1884, Norristown State Hospital used occupations to control patients or as a “conspicuous feature of the management” (“Official Report,” 1884, p. 35). A physician reported that it was not necessary to restrain patients because “employment and varied diversions of the mind” (p. 60) were prescribed. Overcrowding compromised this idealistic beginning. Only such production-oriented activities as farming; sewing dresses, shirts, and sheets; and housekeeping chores survived. Overcrowding continued, and only a few patients were given occupations (“Sixth Annual Report,” 1885).

In response to the arts-and-crafts influence, a crafts person, Nancy Cresson, was hired in 1904 to teach Indian basket making. The focus on occupations was minimal until 1920 when the department for men’s occupational therapy was used as a supplement to medical treatment, a means to get the mentally afflicted back into the work force (“41st Annual Report,” 1920). That year, 52 men were so engaged. Yet at the same time, a nursing staff shortage caused the closing of the women’s arts-and-crafts workroom. Crowding continued, and only a few patients were given occupations (“Sixth Annual Report,” 1885).

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The male occupational therapy department was formally organized in 1924. Four therapists were assigned to over 4,000 patients. The department’s year end report contained the following facts for 1925: Activities included basketry, art, weaving, and sewing. The patients completed 245 rugs, 257 reed baskets, 324 raffia baskets, 27 leather items, 74 wood items, 92 embroidered objects, 97 lace objects, and 20 fiber mats (Norristown State Hospital, 1925). The arts and crafts focus is clear.

The hospital plant was in disrepair by 1930, and a drought also affected the farm. Yet occupational therapy thrived with four therapists and a supply and material budget. Physician turnover was problematic, but occupational therapy was even mentioned in the hospital mission although the main emphasis was on returning patients to the community. This was a time of opportunity when occupational therapists could have chosen to increase their influence because of the shortage of physicians and the limited status of other professionals. Therapists, nevertheless, were not prepared to take advantage of this opportunity.

Instead, the occupational therapists treated 600 patients during the year, producing 1,662 arts-and-crafts products. The occupational therapy department was described thus:

Among the diversional methods of treating the mentally sick and hastening recovery is Occupational Therapy—the scheme of scientifically arranged activities which tend to improve the mental and physical health of patients. (“Fifty-Second Annual Report,” 1931, p. 27)
The Unresolved Conflict of Values

As the profession matured, confusion regarding our therapeutic mission, goals, and treatment techniques still remained. The use of arts and crafts boosted professional visibility during the early years of development, but the profession paid a price for capitalizing on a therapeutic form that was part of a lay health movement. In fact, occupational therapy became locked into treatment modalities that reflected the social values of a forgotten era. Arts-and-crafts proponents and therapists did not always have similar goals. Surprising evidence of these differences can be found in a telling exchange that took place in 1935.

In a letter to William Rush Dunton, the editor of Occupational Therapy and Rehabilitation, Susan Colson Wilson suggested that occupational therapists needed a patron saint. She selected St. Birgetta for the role of patroness. This seemed to upset Dunton, an occupational therapy founder and leader. In a 1935 editorial, Dunton responded sarcastically that St. Birgetta might be an admirable patron for the Needlework Guild of America, but her selection as a patron of occupational therapy seems to unduly emphasize a particular craft rather than the special object to be gained by use of any occupation. (p. 223)

Wilson, the chief occupational therapist at Brook­lyn State Hospital, was an experienced therapist and an active member of the association. Her suggestion and Dunton’s subsequent reply symbolize the conflicting philosophies that continued to surface between the arts-and-crafts proponents and the medically oriented therapists.

Summary

This paper traced the effects of changing health care demands on occupational therapy founders and arts-and-crafts proponents. The Founders were responding to the emerging needs of patients whereas the proponents of the arts-and-crafts movement continued to focus on their original ideals. A study of past events underscores the overwhelming influence of the environment on professional practice. This influence must be recognized so that newly emerging public needs can be addressed.

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