

Histories of occupational therapy in Latin America: the first decade of creation of the education programs

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Abstract: This article aims to analyze the historical processes that allowed and promoted the creation of occupational therapy in Latin America. For the identification of the collaborators, the countries that are members of the Latin American Confederation of Occupational Therapy (Clato) were listed, the representatives in that organization were contacted and invited to collaborate, in order to be possible an initial survey of documents and subjects involved with such processes in different countries. In relation to the collection and organization of data, was made a historical delimitation of the first ten years in which was identified the beginning of the first programs in occupational therapy in Latin America, namely between 1956 and 1966. The countries whose programs were created in those decades were: Brazil, Mexico, Argentina, Venezuela, Chile and Colombia. As part of the results, it was possible to identify that the histories of occupational therapy and the creation of programs in Latin America include, among other things, the antecedents related to poliomyelitis epidemics and to the history of psychiatric care, as well as the presence of international cooperation movements, the hierarchy of professional careers and the processes of subordination of the female gender, as regards the insertion of women in work activities.

Keywords: *Occupational Therapy; Occupational Therapy/History; Occupational Therapy/Latin America.*

Histórias da terapia ocupacional na América Latina: a primeira década de criação dos programas de formação profissional

Resumo: Este artigo tem o objetivo de analisar os processos históricos que permitiram e impulsionaram a criação da terapia ocupacional na América Latina. Para a identificação dos colaboradores, foram elencados os países que são membros da Confederação Latino-americana de Terapia Ocupacional (Clato), tendo sido contatados seus representantes nessa organização, os quais foram convidados à colaboração, de maneira a ser possível um levantamento inicial de documentos e sujeitos envolvidos com tais processos nos diferentes países. Em relação à reunião e organização de dados, foi realizado um recorte histórico dos primeiros dez anos desde que se identificou o início do primeiro programa de formação em terapia ocupacional na América Latina, a saber, entre os anos de 1956 a 1966. Os países cujos programas foram criados nessas décadas foram: Brasil, México, Argentina, Venezuela, Chile e Colômbia. Como parte dos resultados, foi possível identificar que as histórias da terapia ocupacional e a criação de programas de formação na América Latina passam, dentre outros fatores, pelos antecedentes relacionados às epidemias de poliomielite e à história do cuidado no âmbito do adoecimento psíquico, além da presença dos movimentos de cooperação internacional, da hierarquização das carreiras profissionais e dos processos de subordinação do gênero feminino, no que se refere à inserção das mulheres no mercado de trabalho.

Palavras-chave: *Terapia Ocupacional, Terapia Ocupacional/História, Terapia Ocupacional/América Latina.*

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1 Introduction

The objective of this study is to know that it is necessary to look for the different historical interconnections that led to the arrival of occupational therapy in Latin America, and the movements that provided the creation of the first professional training programs in Latin-Americans. This is a relevant task for the understanding of the configuration of the occupational therapy area among us, even there is still little collective dominance over the histories of occupational therapy in these countries.

The objective of this proposal is to understand the historical processes of creation of occupational therapy, specifically on professional training programs, in the different countries of Latin America. The focus is on the identification of the first professional training programs, in order to understand the socio-political context of the countries when these programs were created. In addition, it is necessary to discuss the processes of creating these first programs, the necessary articulations that have provided the beginning of professional training programs and the main justifications for the creation of these specific programs in Latin American countries.

It is important to understand that when we refer to the idea of occupational therapy, we have different spheres ranging from care practices to specific populations, through the technical, professional and academic training proposals of a specific area of knowledge, to the regulatory processes and institutionalization of the profession.

This work focuses on the dimension of professional training programs. What is important to discuss here is the analysis of the historical processes and justifications used for the creation of vocational training proposals offered by educational institutions or by assistance institutions in the countries of Latin America.

In this way, the “idea” of Latin America is briefly discussed, and a historical overview of the creation of the profession in the United States is presented to contextualize and analyze the data produced in this research.

1.1 Latin America

Besides being important, a definition of Latin America is quite complicated and, at times, paradoxical. It is important because there is the task of locating a region, several languages and many

different and diverse historically and geographically people. It is complicated, precisely because of this enormous diversity, not only of people and cultures but also of discourses about these diversities. It is paradoxical because to speak of this complexity, there are often invading and colonizing nations, creating an identity of “Latin America” in opposition and asymmetry to these nations.

The concept of Latin America is from French, from the expression “*Amérique latine*”, used by French intellectuals to designate imperialism in Mexico, under the domination of Napoleon III, in the 1860s (BETHELL, 2009). However, before that, according to Bethell (2009), there are three authors who used the term “Latin America” on different occasions for the first time in 1856: José María Torres Caicedo, Colombian journalist, poet and critic; Francisco Bilbao, a Chilean socialist intellectual, and Justo Arosemena, a Colombian-Panamanian jurist, politician, sociologist and diplomat.

Some authors, such as Furtado (2007), identify 20 countries in this region: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Uruguay, and Venezuela. Also, they classify these countries among the Andean, Atlantic, and Caribbean. Other authors, such as Araújo (2006) and Souza (2011), understand the Latin American region as all the countries below the Rio Bravo, between the United States and Mexico, that is, 32 countries that are not considered Anglo-Saxon countries with the 20 above mentioned and also Guyana, Suriname, Belize, Antigua and Barbuda, Aruba, Bahamas, Barbados, Dominica, Grenada, Jamaica, Saint Lucia and Trinidad and Tobago.

In this region, Spanish, Portuguese and French are predominantly spoken, as a result of the invasion and colonization, and hundreds of other indigenous languages already extinct or in extinction due to the continuous processes of violence faced by these people, such as Guarani, Tupi, Aymara, Quechua, Nahuatl, Mayan, and Mapuche, as well as many other languages of African origin, brought by the traffic of enslaved people.

As a region, Latin America is based on several approaches. There are approaches that will understand and conceptualize it as a “natural region”, that is,

[...] understood as a part of the Earth’s surface, dimensioned according to diversified territorial scales, and characterized by the uniformity from the combination or

integration in areas of the elements of nature (CORREA, 2003, p. 23).

Others will say that the region is determined by statistical and measurement techniques (DIAS, 2009), as defined by Correa (2003, p. 32),

[...] a set of places where the internal differences between these places are smaller than those between them and elements of another set of places [...] define the region becomes a problem of efficient and statistical application.

In the mid-twentieth century, some authors started to produce the concept of a region by reinforcing its existence under capitalism (DIAS, 2009). Correa (2003, p. 44) explains that

[...] in the capitalist mode of production, the process of regionalization is accentuated, marked by the simultaneity of the processes of differentiation and integration, verified within the progressive globalization of the economy from the fifteenth century.

In this interpretation of Latin America,

[...] by rescuing colonial history, the role of Latin American countries within the International Labor Division, and relating exploiters and exploited people, we are accentuating the ideological character of Latin America as a region (DIAS, 2009, p. 25).

Also, Gomes (1995) argues that the main characteristics are regional consciousness, sense of belonging and regional mentalities, as elements that revalue the regional dimension as a lived space.

Therefore, to speak of a Latin American region implies an understanding that this discourse is inserted in a complex web of meanings and perspectives, sometimes close and coherent, but, at other times, opposite and contradictory.

1.2 The emergence of occupational therapy in the United States of America

A common statement in the different narratives around the history of the emergence of occupational therapy in the United States of America is the interventions carried out by women with different professional backgrounds under the care of men who, in general, are the authors of these narratives.

Morrison (2016) proposes to seek "alternative" views of the "official" history of occupational

therapy, emphasizing the centrality of women to their development.

Reorganizing the history of the origins of occupational therapy could be a way of placing the emphasis on the role of women in this process, a role that would be subsumed by situations of subordination of the female gender in their various historical contexts.

It is important to understand how the origins of the profession are closely linked to the possibility of insertion by women (mainly whites and urban elites) into other spheres of the social life, not only those related to the domestic space, emphasizing participation in educational institutions (especially religious), in universities and also as part of the response to the demands of the labor market (LOPES, 1991; MORRISON, 2016), even if such insertions have never been equal to those of men in these same spaces.

Some of these changes were possible due to the American social context of the late nineteenth and early twentieth centuries, in a society marked by the process of transformation of monopoly capital (BRAVERMAN, 1987).

In this context of transformations, women rejected marriage and dedicated their lives to teaching, nursing or social work. Others, although married, belonged to legions and charitable groups and/or other types of social help. This expansion of circulation and insertion in different social spaces was able to create feminine references in other public spheres (MORRISON, 2016).

The creation of Hull House, in the context of the Chicago School of Civics and Philanthropy is part of this process, in which many young women were driven mainly by the feminist movements of the time (ADDAMS, 1912), who changed notions of help and (based on moral and religious perspectives) to value their work activities, reconfiguring the emerging and demanding labor market, providing their insertions in some formal jobs (MORRISON, 2016).

Hull House was an extremely important shelter for the women's movement in Chicago (QUIROGA, 1995), contributing to the political, professional and work training of many women, and offering support to many families, mainly immigrants (ADDAMS, 2002).

Since androcentrism, if the history of occupational therapy would begin with moral treatment¹, from a feminist perspective, it was the movement of these social shelters that allowed many women (white and

urban elites) to be inspired and begin to develop activities (MORRISON, 2014), since poor women, black women or both, poor immigrant women, have always worked, in one way or another, outside their domestic spaces. For Morrison (2014), for the first time, women began to observe alternative ways of social participation, choosing to be distanced from traditional forms such as marriage and family.

The founding women of Hull House sought to understand the conditions and circumstances in which other women and immigrant families lived, which was, on the one hand, immediate aid and, on the other hand, a theoretical elaboration on these themes, a shared task with the University of Chicago (QUIROGA, 2000; MIRANDA, 2007).

Jane Addams and Ellen Gates Starr, as the principal founders of Hull House in the late 1880s, Julia Lathrop, as one of the first to join the institution, and Eleanor Clarke Slagle were the first women responsible for Hull House's actions. In the context of social action, this work of dealing with the demands of the social question of capitalist society that rose under the American foundations, under a political approach, also begins, for part of these women, to offer parameters for actions that, later, they would compose proposals about occupational therapy (MORRISON, 2016).

Adolf Meyer joins these women and begins working on the reforms in the treatment of mentally ill people, one of their assumptions being that the deplorable living conditions of the poor and working people in the cities that have grown up could be part of the causes that favor or maintain disease situations. Also, they also attempted to respond to the criticism of the time about the absence of "science" in these "new methods" employed in psychiatry, publishing some articles originating from these practices (ADDAMS, 1935; POLLARD; SAKELLARIOU; KRONENBERG, 2009; MORRISON, 2016).

In 1910, Adolf Meyer asked Julia Lathrop to nominate a social worker who could join the Johns Hopkins Hospital (in Baltimore City) led by him, to work with mentally ill people. Lathrop suggests Slagle, who accepts the nomination. After two years of work, Meyer highlighted Slagle as the main reference for the occupational therapy service. At the end of this experience, Slagle returned to Chicago in 1913 to found the first school of occupational therapy (MORRISON, 2016).

According to Morrison (2016) supported by Quiroga (1995), the main difficulties in the development of

the profession for the first occupational therapists are focused on two main aspects: 1) Positioning within the medical area; 2) Occupational therapy considered as a women's profession.

Since the beginning, occupational therapy was considered a new profession for women (LOPES, 1991; QUIROGA, 2000; LOPES; HAHN, 2004), and to be legitimized as a professional discipline to be recognized, articulations were sought with medicine until then a masculine area and, as today, with a high recognition and social power. The role of men within the visible world of medicine and the role of women within the invisibility of charity networks (QUIROGA, 1995) and good girls and ladies (LOPES, 1991) are the mechanisms employed by the first generation of occupational therapists (LOPES, 1991; MORRISON, 2016).

Eleanor Clarke Slagle, a social worker who joined Hull House, Susan Cox Johnson, a nurse who wanted to prove that occupations could improve the physical and mental health of inpatients in hospital settings, and Susan Elizabeth Tracy, nurse, one of the pioneers in the use of occupations as a treatment and one of the first to systematize their reflections, were the first women considered occupational therapists (MORRISON, 2016; REIS, 2017).

World War I began in 1914, however, the United States only officially entered in 1917, so the profession recognized that year in that country does not come as an immediate result of the War, but in that context. This historical moment enabled a great development and expansion of the profession, since occupational therapy was configured as one of the professions that comprised the "reconstruction aids", dealing with injuries and deficiencies generated by the War, participating actively in the rehabilitation processes (SANZ VALER; RUBIO; PASTOR, 2013; MORRISON, 2016).

Occupational therapy expanded in the United States in the first decades of the twentieth century, experiencing a major resurgence of this expansion in the years of World War II and coming to Latin America as a professional training program, beginning in the 1950s, as part of that second wave of growth.

2 Method

The data presented here and discussed were obtained in two main moments: 1) Identification of the research collaborators; 2) Search for didactic

materials, historical records and scientific productions on the history of occupational therapy in each country of Latin America.

The countries that are members of the Latin American Confederation of Occupational Therapy (Clato) were listed to identify the collaborators. Their representatives were contacted in the organization and they were invited to collaborate, so an initial survey of documents and involved individuals in such processes in different countries.

Clato was founded in 1997 (GÓMEZ LILLO, 2012) and it currently has the following countries: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, El Salvador, Mexico, Panama, Paraguay, Peru, Puerto Rico (considered as United States territory and not an independent country), Uruguay and Venezuela.

All the delegates of Clato (management 2015-2017) were invited to participate in the research. The invitation was made by e-mail and the delegates who agreed to participate answered a questionnaire of personal and professional identity and requesting the suggestion of documents, texts, articles, educational materials about the history of occupational therapy in their country. The delegates that became collaborators of the research in that first moment were of the following countries: Argentina, Brazil, Chile, and Colombia.

As the number of answers was low, after recurrent attempts to obtain some return, the search for contacts suggested by people who are or were Brazilian representatives in Clato began: Ricardo Lopes (delegate in Clato, management 2013-2015), Rosibeth Palm (former delegate who participated in Clato's management from 2000 to 2011) and Luciana Wertheimer (Clato's president, management 2013-2015).

Thus, the representatives of Costa Rica, Mexico, Panama, Peru, Uruguay, and Venezuela were accessed.

It was also possible to reach the representatives of countries recently joined in Clato: Bolivia, El Salvador, and Paraguay contacted during the XII Clato Congress in October 2017 in Mexico.

The starting dates of the first training courses in occupational therapy were searched in these 14 countries, as well as the identification of the reasons for the creation and the national and international articulations carried out for the beginning of occupational therapy training in Latin America.

Books, articles, interviews, theses, and dissertations that directly or indirectly addressed the history of occupational therapy in each of the countries were recommended. Some countries such as Argentina, Brazil, and Colombia have specific research groups on the history of occupational therapy, facilitating the identification of the materials. Other countries like Chile, Mexico, and Venezuela have important productions such as books and dissertations, but not so often.

For the analysis and presentation of the data presented here, a historical cut of the first ten years was made since the first training program in occupational therapy in Latin America, that is, between 1956 and 1966. This choice is justified by the interest in identifying pioneer training programs created in the first decade of institutional development of occupational therapy in Latin American countries. The countries with courses in this period were: Brazil, Mexico, Argentina, Venezuela, Chile, and Colombia.

The texts collected and analyzed were Brunetto (1975), Magalhães (1989), Lopes (1991, 1997), Nascimento (1991), Soares (1991), Trujillo (2002), Lopes and Hahn (2004), Gómez Lillo (2012), Testa (2012), Escobar and Sepúlveda (2013), Nabergoi et al. (2013), Rivas et al. (2013), Melo (2015), Bottinelli et al. (2016), Duarte et al. (2016), Morrison et al. (2016), Rodríguez, Camargo and Escobar (2016), Cascajares and Ramírez (2017) and Reis (2017).

3 Results and discussion

It is not possible to show a single history of occupational therapy in Latin America. This would be a mistake, a priori, because when deciding to tell a story, even if it is clear the point of view or consideration of facts, other relevant points of view and facts are left in the memory of those who do not tell it or not called to tell it (GIGANTE, 2008).

History is always told from another historical moment and diverse points of view. Only by this observation, we can already understand that realities are different, different epochs and words and their meanings are not necessarily the same. Therefore, when we choose words to tell a story, we not only describe a given reality, but we create and recreate this reality.

For Certeau (1982), when searching for a historical sense of an event, methods, ideas or even ways of understanding it are found, that is, there is a confrontation between past and present,

between what organized a given reality and what today is allowed to think it. Along the same lines, Le Goff (2005, p. 41) points out that “[...] there is no finished historical reality, which gives itself to the historian”.

Thus, the data presented here are interpretations, re-readings, re-articulation, and recreations of certain histories that relate to the movements of the creation of the occupational therapy profession in different countries of Latin America.

3.1 Background and references for the implementation of occupational therapy in Latin America

Poliomyelitis epidemics and the history of insanity (mainly for ideas of moral treatment) are some of the important milestones for addressing the histories of occupational therapy in Latin American countries.

3.1.1 Poliomyelitis and rehabilitation centers

Poliomyelitis has been a major cause of child death and disability for centuries until the creation of the vaccine against the disease in the mid-1950s (TESTA, 2012).

In Latin America, the first cases of poliomyelitis were identified and recorded at the end of the 19th century in Mexico, in 1906 in Argentina, in 1909 in Chile, in 1911 in Brazil, in 1915 in Colombia, and in 1928 in Venezuela. However, its epidemic recognition in these countries was declared between 1930, 1940 and 1950 (ECHEZURÍA, 1974; MALAGÓN; ÁVILA, 1982; CAMPOS; NASCIMENTO; MARANHÃO, 2003; LAVAL, 2007; NASCIMENTO et al., 2010; TESTA, 2012; BOTTINELLI et al., 2016; CASCAJARES; RAMÍRES, 2017).

Epidemic poliomyelitis and its consequences were one of the main arguments for the creation and/or expansion of physical rehabilitation centers and children’s hospitals and other care institutions in the Latin American context. For example, the creation of the *Hospital Infantil* of Mexico in 1943 (CASCAJARES; RAMÍRES, 2017), the Child Rehabilitation Center in Chile (ESCOBAR; SEPÚLVEDA, 2013), the Brazilian Beneficent Rehabilitation Association in 1954 (REIS, 2017; REIS; LOPES, 2018), among other rehabilitation centers and associations that had a significant

growth resulting from national investments and international articulations, due to concerns about the movement of people and goods in the face of the epidemic (MENDES, 1996), besides being some of the main institutions that began the programs of training in occupational therapy in 1950.

Characterized by Latin American countries that are forced to deal with the causes of these poliomyelitis epidemics while producing infection prevention techniques and care technologies for people affected by this disease, this regional context has triggered the development of related disciplines and the importation of knowledge and practices from countries in the North, which, given the agro-exporting economic interest that created important ties between the countries of these regions, they had already undergone this process and had more information, mainly in the area of health, during the period after World War II (BOTTINELLI et al., 2016; SOARES, 1991; SBRILLER, 1997).

This process has triggered the creation and expansion of careers understood as medium technologies, including occupational therapy (SOARES, 1991; GÓMEZ LILLO, 2012; TESTA, 2012; RIVAS et al., 2013; CASCAJARES; RAMÍRES, 2017).

3.1.2 Occupations and work in the rehabilitation process

For the histories of occupational therapy in Latin American countries and as important as the physical rehabilitation centers created or driven by the interests of poliomyelitis epidemics, there were psychiatric hospitals and institutions that dealt with people perceived as insane or with social problems (LOPES, 2016) such as prisoners, miserable, street people or prostitutes.

In Brazil, at Dom Pedro II Hospital, founded in 1852 in Rio de Janeiro, occupations were the subject of tailoring, carpentry, shoemaking, flowers, and tow parting workshops, based on an important perspective of moral treatment (NASCIMENTO, 1991; SOARES, 1991). In São Paulo, in the Hospital of Juqueri, inaugurated in 1898, the main functions of the occupation were in praxitherapy, or treatment by work, also quite influenced by the ideals of moral treatment (NASCIMENTO, 1991; SOARES, 1991).

This brings to the scene the use of activities and/or occupation and/or work, regardless the definition of occupational therapy and before the

creation of their professional training courses, as a form of “care” and/or “treatment” for the institutionalized psychic suffering, while at the same time, the institution was interested, helping in the task of controlling bodies, maintaining order and in those basic tasks for the functioning of these institutions, as unpaid and often obligatory work (NASCIMENTO, 1991).

In 1946, Nise da Silveira founded the Occupational Therapy Service of the National Psychiatric Center, in Engenho de Dentro - Rio de Janeiro, highlighting the expressive potential of freely chosen activities in the process of understanding “madness” and assistance to the patients, without necessarily being useful to the hospital, although they could also be useful (BRUNETTO, 1975; NASCIMENTO, 1991; MAGALHÃES, 1989).

In Colombia, in the mid-nineteenth century, the occupation/work began to be used to prevent/leave “vagabondage” and ascend to Catholic morality; which it was also linked to an economic and “progress” perspective, necessary for the consolidation of the Colombian Republic (DUARTE et al., 2016). Alluding to work with the poor, prison inmates and prostitutes, it was part of this conception that it was possible to rehabilitate “social problems” through occupation and work (DUARTE et al., 2016). The teaching and practice of crafts continued to function as strategies to combat evil customs and poverty, under the precepts of Christian morality and mostly Catholic (DUARTE et al., 2016).

In Argentina, at the end of the nineteenth century, moral treatment was used in the *Hospicio de las Mercedes*, where different workshops were proposed depending on the physical and psychic possibilities of the inmates, the health, or absence of the disease, though in terms of productivity and therefore, social labor insertion was of paramount importance (GÓMEZ, 2007).

In Chile, by the 1930s, there were publications by psychiatrists who advocated moral treatment and the so-called “labor therapy” in which workshops and occupations were used to promote benefits as treatment and to generate greater independence for patients (GÓMEZ LILLO, 2012).

It is possible to perceive a historical articulation around the discourses before the origins of occupational therapy in the Latin American countries, passing between the creation of a technology of care for the purpose of physical rehabilitation, thought as a response to the epidemics in the region, and the technical and scientific justification of a work

that already happened in psychiatric hospitals to give professional form to techniques, articulating to a greater or lesser degree, assumptions of moral treatment.

3.2 International cooperation

Due to the history of the poliomyelitis epidemics, different international cooperation projects played an important role in the creation and development of some of the first professional training programs in occupational therapy in the Latin American context.

The Organization of the United Nations (UN), the International Labor Organization (ILO), the World Health Organization (WHO) and the Pan American Health Organization (PAHO) are among the agencies and international organizations cited as important for this creation.

With its origins in organisms created with the end of the First War and sharing the historical context of World War II, that created walls between the capitalist world and the socialist, entangled by the Cold War, these organizations turn to an International Cooperation for the development that begins to be institutionalized through the emergence of norms, discourses, practices, agendas and behaviors of actors defined in a more organized, regular and predictable way (MILANI, 2014).

The main emerged and spread International Cooperation projects in the 20th century have an important link with the end of World War I and the effervescence of the Socialist Revolution that originated in Russia. During this period, it was believed that democratically elected regimes would not make the decision to be pro-war rather than self-defense and that only democratically elected regimes would tend to generate warlike conflicts. Thus, one of the strategies designed to avoid new conflicts was to disseminate liberal democracies throughout the world (LLISTAR, 2009).

While some international agreements began to gain centrality in global discussions, and with the outbreak of World War II, this liberal perspective was questioned, since Nazi Germany and fascist Italy had been created by popularly elected leaders, that is, the idea that the spread of democracies would put an end to wars was soon rejected.

In the 1960s, in the context of the Cold War, with the Cuban Missile Crisis, the space race and the military interventions of the United States of America and the Union of Soviet Socialist

Republics, military and diplomatic importance began to be the emergence of other actors such as multinational corporations and international organizations such as the UN, and the European Community (LLISTAR, 2009).

The initial reasons for the institutionalization of cooperation and development strategies cannot be dissociated from the Cold War, since the East-West rivalries, beginning in 1945, were a determining factor in the decision-making in the western liberal area to promote cooperation among the nations of the “free world” (MILANI, 2014).

There is a perception that international relationships and cooperation (and regulation) are carried out by actors that are not restricted to the states nations, in a network of complex interdependence (KEOHANE; NYE, 1977).

Some authors, such as Llistar, analyzed this world system based on the fact that these international interferences begin to be semipermeable, that is, permeable to some phenomena such as the relation with capital, military offensives, etc., but at the same time impervious to other phenomena such as the movement of people from “poor” and peripheral countries to “rich” and central countries in the world economy.

The selective pores of state borders make us more interdependent, even though interdependence does not necessarily mean symmetry² (LLISTAR, 2009, p. 20).

Therefore, in the discussions about global centers and economic peripheries, it is important to understand that “underdevelopment” is the result of historical relationships, that is, no former African, Asian or Latin American colony can explain its present without reiterating that its history has been ravaged by long years of invasions, exterminations, spoils, trafficking in enslaved people, racism, etc., while industrialization and economic prosperity are not only due to the skills and circumstances of the “developed” countries but also to overexploitation human and physical development in Africa, Asia and Latin America (LLISTAR, 2009).

These “international relationships” can also be conceptualized as “[...] the transnational interference that occurs between local or transnational social groups that inhabit different countries or between their states”³ (LLISTAR, 2009, p. 28), where the term “relationships” does not match reality, since it does not show directionality, shown in a neutral way. On the other hand, “interference” as

a vector, is able to better reflect these international processes, indicating the asymmetries (LLISTAR, 2009). Such interference is not necessarily negative, for example, there are positive interferences such as low-cost technologies, drugs, telephone and internet systems, etc.

The concept of “development” begins to be used after World War II. The decolonization and independence of Third World countries (those that were not considered developed capitalist countries or socialist countries) led to a questioning of the origin of inequalities between countries, and the notion of development was equated with economic growth and it was given a double objective: to modernize and to gradually reproduce the model established by the First World. From this point of view, the problem of underdevelopment rested exclusively on the South, and on whose responsibility growth, modernization and industrialization depended. And the only thing the North could do was offer help. This help was conceived as intrinsically good, necessary and humanitarian (LLISTAR, 2009).

In practice, the “desire for development” has contributed to the international cooperation relationships between these countries, with technical contributions from experts and cooperation agencies from countries in the global South (LLISTAR, 2009). Thus, military pacts support for dictatorships and development programs were closely linked in Latin America (ESCOBAR, 1998).

With these international cooperation processes, Latin America begins to receive advice from UN consultants, through articulation with the ILO and WHO, to carry out training courses, helping in the process of implementing rehabilitation programs, whether due to work-related accidents or the issue of poliomyelitis, among other technical help.

In the late 1940s, the UN began to coordinate, plan and provide reinforcement in rehabilitation areas, starting with various organizations such as the WHO, responsible for the training of rehabilitation professionals such as physicians, nurses, occupational therapists, physiotherapists, among others. The ILO had responsibility for professional rehabilitation through social security, and UNESCO was focused on special education (SOARES, 1991).

In 1951, the UN began sending emissaries to Latin America to identify possible locations for a rehabilitation center. One of these chosen places was the *Hospital das Clínicas* of the Medical School of the University of São Paulo (HC-USP), which

already had international recognition (SOARES, 1991).

In Brazil, both the Brazilian Beneficent Rehabilitation Association and the HC-USP were advised by these international agencies to introduce specialized rehabilitation practices that were previously non-existent in Brazil (SOARES, 1991). Also, the creation of professional training programs was also one of its results, as in the case of occupational therapy in Brazil, among other professions that were created and/or promoted in this context.

Still, on vocational training, some technicians and professionals who worked in the area of rehabilitation in HC-USP were sent to the United States to specialize. Soares (1991) points out that this was the case of Neyde Tosetti Hauck, social worker, and nurse, who studied occupational therapy at New York University, with WHO funding, as well as occupational therapists, brought to Brazil to contribute to vocational training programs (SOARES, 1991).

In Argentina, the creation of the National School of Occupational Therapy (ENTO) in 1959 was part of an agreement between the Argentine and British governments, through a technical cooperation agreement with the WHO (NABERGOI et al., 2013).

Even before the creation of ENTO as in Brazil, Argentine students and professionals began to receive scholarships to carry out professional training in other countries, as well as funding for visits to specialized services, specialists from other countries by Argentine institutions (NABERGOI et al., 2013).

Such agreements between the governments of Argentina and England and the WHO guaranteed the costs of professional training for Argentine students and professionals at Dorset House, Oxford. In 1959, a teaching team from this institution traveled to Buenos Aires to organize and create the first training program for occupational therapists in Argentina (NABERGOI et al., 2013).

In Venezuela, this pioneering creation was at the Venezuelan Institute of Social Security, with important support from the UN and resulted from the articulation with three physiotherapists and an occupational therapist from Canada for the creation of the National School of Rehabilitation in 1959 (RIVAS et al., 2013).

The second training program in occupational therapy in Venezuela in 1967 was the result of the articulation between the Venezuelan government,

the National Rehabilitation Program, and the Pan American Health Organization and the WHO, taking Carmen Forn, Argentina, head of the Department of Occupational Therapy of the National Institute of Rehabilitation in Buenos Aires as the technical consultant (RIVAS et al., 2013).

In Chile, in 1962, occupational training programs for physical rehabilitation were intensified. In an articulation between the Pan American Health Organization (PAHO) and the National Health Service, important funds were allocated to equip rehabilitation services in Santiago and other cities of Chile, while receiving rehabilitation specialists to prepare the proposal to create a national rehabilitation center (GÓMEZ LILLO, 2012; ESCOBAR; SEPÚLVEDA, 2013).

Also in 1962, the University Psychiatric Clinic in Santiago received the visit of the American Occupational Therapist Beatrice Wade for three months through the Inter-American Cooperation Program. This occupational therapist organized some courses and also a department of occupational therapy in this clinic (GÓMEZ LILLO, 2012; ESCOBAR; SEPÚLVEDA, 2013).

Also in the beginning of the 1960s, in Chile, the "Chile 21" and "Chile 5,000" agreements were created in the Ministry of Health between PAHO and the Chilean government, which allowed the creation of centers of physical medicine and rehabilitation and the arrival of specialists to contribute with training programs for occupational therapists, among others (GÓMEZ LILLO, 2012).

One of the results of these international articulations was the possibility of creating the training program in occupational therapy at the University of Chile, at the same time as scholarships were offered to professionals and Chilean students to undertake the training in occupational therapy at the National School of Occupational Therapy at Argentina (GÓMEZ LILLO, 2012). Reis (2017) brought the story of a Brazilian woman who also received this scholarship for her training in Argentina.

In addition to the international articulations with the United States, Canada, England, and other European countries, the transit around training programs in the 1960s had some configuration among the Latin American countries. Other examples in this context are the students from Honduras and El Salvador going to the training program in Mexico in 1961, as well as a student from Peru and another from Uruguay in 1962

and in 1964 a student from Panama and another from Costa Rica (CASCAJARES; RAMÍRES, 2017). There was also a student from Panama conducting training in the Venezuelan program in 1964 (RIVAS et al., 2013).

3.3 The implementation of training programs

The 1950s highlighted the beginning of the creation of occupational training programs in occupational therapy in the countries of Latin America. The process of creating these programs was linked to internal and contextual factors of each country and also to international factors, as already mentioned.

In countries such as Argentina, Brazil, and Mexico, before training programs were created, there were sporadic technical training courses in different formats⁴. Therefore, the arrival of the profession in some countries precedes the creation of training programs, either by international agreements that have brought occupational therapists from other countries or financed the training of Latin American occupational therapists in the United States or European countries or, the technical training of workers already linked to hospitals or rehabilitation centers to work in specific areas.

According to the data obtained in the gathered documents, it was possible to identify the first training programs in occupational therapy performed in the Latin American countries, nine of them in the period under analysis, as shown in Table 1.

The first training program in occupational therapy in Latin America was created in 1956, in the city of Rio de Janeiro (Brazil), linked to the Brazilian Association of Rehabilitation Benefit (ABBR); offered a two-year technical level training, having trained seven women in the first group (REIS, 2017).

The second training program, created in 1957 in Mexico City (Mexico), was linked to the Children's Hospital of Mexico, and it also had a six-month technical level, enabling six nurses to work in occupational therapy in the same hospital. Also in 1957, there was a new offer of the course for one year, having formed other six occupational therapists (CASCAJARES; RAMÍRES, 2017).

The third program in Latin America, created in 1958 in São Paulo (Brazil), was linked to the Institute of Rehabilitation of the Hospital das Clínicas of the University of São Paulo. This course was the result of collaboration and articulation of several organizations, such as the UN, WHO, and ILO. It lasted for two years and the first group was formed in 1959, with four occupational therapists (MELO, 2015).

Buenos Aires (Argentina) received the fourth program created in 1959, in the National School of Occupational Therapy, at the National University of San Martin. This course lasted three years and it was created following the standards advocated by the World Federation of Occupational Therapists (WFOT)⁵ (BOTTINELLI et al., 2016).

In 1959, the fifth training program was created in Caracas (Venezuela), linked to the Venezuelan

Table 1. Year of the creation of professional training programs in occupational therapy, in each country, institution, and city, during the first ten years.

Country	Institution	City	Year of beginning
Brazil	School of Rehabilitation of Rio de Janeiro - Brazilian Association of Rehabilitation Benefit	Rio de Janeiro	1956
Mexico	Children's Hospital of Mexico	Mexico City	1957
Brazil	Institute of Rehabilitation of the Hospital das Clínicas of the University of São Paulo	São Paulo	1958
Argentina	National School of Occupational Therapy - National University of San Martin	Buenos Aires	1959
Venezuela	Venezuelan Institute of Social Security - National School of Rehabilitation	Caracas	1959
Brazil	University Institute of Rehabilitation of the Medicine School of Recife	Recife	1962
Brazil	School of Medical Sciences of Minas Gerais	Belo Horizonte	1962
Chile	School of Medicine - University of Chile	Santiago	1963
Colombia	School of Medicine - National University of Colombia	Bogota	1966

Source: Documents gathered by the research.

Institute of Social Security, at the National School of Rehabilitation. This first program was of technical level during three years and graduated eight occupational therapists (RIVAS et al., 2013).

The sixth Latin American program created in 1962 in Recife (Brazil) was linked to the University Institute of Rehabilitation of the School of Medicine of Recife. It was a technical training course in "Rehabilitation" lasted two years and students could opt for physiotherapy or occupational therapy during the course (REIS, 2017). In its first offer, 34 professionals were graduated, including physical therapists and occupational therapists.

Again in Brazil, the seventh training program created in 1962 in Belo Horizonte was linked to the School of Medical Sciences of Minas Gerais. Technical courses in rehabilitation for physiotherapy and occupational therapy (REIS, 2017) were created.

The training program created in 1963 in Santiago, Chile, linked to the School of Medical Technology, School of Medicine, University of Chile was the eighth in Latin America. The first offer lasted for three years and three students participated in the first class. As in Argentina, this offer already followed the guidelines of WFOT (GÓMEZ LILLO, 2012).

In 1966, the ninth training program was created in Latin America, in Bogotá (Colombia), linked to the School of Medicine of the National University of Colombia. It was categorized as a technical level and lasted three years, graduating nine occupational therapists (RODRÍGUEZ; CAMARGO; ESCOBAR, 2016).

3.4 Hierarchy of professional careers and gender subalternation

It is possible to identify how the history of the creation of occupational therapy, in general and especially in Latin America is related beyond to the political, economic and social contexts and processes of international cooperation to deal with epidemics, organization and creation of techniques and professions in the area of health rehabilitation, while at the same time dialoguing with the insertion of women in higher technical education and in the labor market.

In the history of higher education institutions, they were not a space for women until very recently⁶, constituting a privileged scope for reproducing gender inequalities and strengthening the sexual

division of labor. Men had social recognition for their successful integration into the public sphere, including higher education, and women were also not visible also educationally and delimited to the private sphere (PAPADÓPOLUS; RADAKOVICH, 2006).

Until 1950, with the exception of Costa Rica, Cuba, Panama, and Uruguay, the percentage of women enrolled in higher education institutions in most Latin American countries was clearly below the demographic ratio in the total population of each country (BONDER, 1994). Only in the late 1980s, in virtually all Latin American countries except Colombia and Guatemala, women were slightly more than 40% of the student population in universities (BRASLAVSKY, 1994).

In this process of increasing the insertion of women in higher education in Latin American countries, occupational therapy and other professions created and/or promoted since the 1950s, are of great importance, since they have helped to reconfigure the role of women in higher education, the world of work and, in general, in the social context.

As in the United States, for example, occupational therapy, in its beginning in Latin America, articulates two main characteristics: 1) to be a profession considered subordinate to medicine, in the general context in the health area and, more specifically, in rehabilitation; 2) to be considered a profession for women and, precisely because of this, of lesser value in the hierarchy of professions.

Testa and Spampinato (2010) point out that in the Argentine context, careers complementary to medicine are created as a way of contributing with answers to the social and health demands that the hegemonic knowledge and professions of the time did not return. Occupational therapy was part of a proposal of a diverse team of professionals and technicians coordinated by physicians (MACDONALD, 1959; GONZALEZ, 1959; TESTA; SPAMPINATO, 2010).

Still in this perspective, the creation of occupational therapy in Argentina, according to Testa and Spampinato (2010, p. 178):

[...] was crossed by a system of gender that established hierarchies, privileges and inequalities, delimiting a professional field linked to a model considered as naturally feminine, consisting of activities of daily living, crafts and manual activities, child care, and a love part and abnegation to carry out the challenge of rehabilitation⁷.

With the access of women to higher education, in a very common way and with rare exceptions, this insertion occurs as a reprint within the frame of the traditional social roles attributed to women, such as care in the rehabilitation processes in health and education especially with its subordination to the masculine figure of the physician⁸, and with works that approximate the values of volunteerism (LOPES; HAHN, 2004; NABERGOI et al., 2013; BOTTINELLI et al., 2016; MORRISON et al., 2016).

In the context of occupational therapy, at the same time that access to higher education and university provided the insertion and participation in the labor market and different social spaces of a part of women hitherto dismissed from this universe, this insertion was possible through access to careers with less academic prestige and, therefore, having their theoretical and practical perspectives, directly subordinated to the hegemonic male view of some professions.

If we understand the first training programs in each of the countries analyzed here, we will identify that most of them, Brazil, Mexico, Argentina, Venezuela, and Colombia, with the exception of Chile, had their first occupational therapy training programs evaluated as technical level. This means that, in these countries, occupational therapy begins its course through technical training programs (as opposed to university training), understood and linked to other medical technologies and for this reason, its practices should be justified base on the hegemonic medical discourse, being submitted to this knowledge.

This can also be observed in other ways, for example by identifying that the direction of the first training programs was under the responsibility of physicians and not of occupational therapists or other professionals.

In Brazil, in the first training program (in ABBR), the Technical Council (formed by doctors) was the one who directed the training (LEMOS, 1985; REIS, 2017).

In Mexico, the first training programs began in the child rehabilitation service under the responsibility of the physician Alfonso Thoen (CASCAJARES; RAMÍRES, 2017).

In Venezuela, the direction of the program was linked to the direction of the Rehabilitation Service, with Dr. Alejandro J. Rhode and the support of two occupational therapists of the World Federation

of Occupational Therapists, May Hamilton and Katherine de Brecht (RIVAS et al., 2013).

In Chile, the doctor Livio Paolinelli was in charge of the coordination of the first training program, while occupational therapists were under-coordinators; the first occupational therapist to occupy the coordination of the program was Margarita León de Pérez-Guerri in 1963 (GÓMEZ LILLO, 2012; MORRISON et al., 2016).

In Colombia, the director of the first program was held by the Department of Rehabilitation, Dr. Jorge Pardo Ruiz, along with occupational therapists Patricia Ann Lang de Pardo, an American graduate of Western Michigan University, and Alicia Trujillo Rojas, a Colombian New York University (TRUJILLO, 2002; RODRÍGUEZ; CAMARGO; ESCOBAR, 2016).

Thus, the historical process of creation of occupational therapy in Latin America has this fundamental articulation between the creation of a technical career auxiliary to medicine among other important factors and discourses, while allowing the insertion of women in higher education of a technical nature, that is, in a subordinate way.

4 Final Considerations

Working with history, or rather the different possibilities and perspectives of organizing and analyzing historical processes is challenging at the same time as it is extremely necessary. In an attempt to organize the discourses and practices of a particular historical moment, we can reflect on their meanings, their needs and also their possibilities.

With the information gathered so far and with the organizations produced, it was possible to identify that the histories of occupational therapy and the creation of professional training programs in Latin America have antecedents related to the process of expansion of professional rehabilitation teams due to the poliomyelitis epidemics and the history of “care” for madness.

Also, these training programs were driven by international cooperation movements, shaping the creation of less prestigious techniques and professions in the hierarchies of medical careers, paramedics as they were called, as well as articulating processes of subordination of the female gender, regarding the inclusion of women in university higher education and, for some of them, in the labor market.

The drawing here bringing together fragments of the histories of occupational therapy in Latin America has these important characteristics that locate it in time and in a context, but that allow questions and projections, especially, in what Latin American occupational therapists (and their trainers) want and can produce in their historical time.

References

- ADDAMS, J. *Twenty years at hull house with autobiographical notes*. New York: MacMillan, 1912.
- ADDAMS, J. *My friend Julia Lathrop*. New York: MacMillan, 1935.
- ADDAMS, J. *The long road of woman's memory*. Urbana: University of Illinois Press, 2002.
- ARAUJO, M. C. *Prospectos da democracia na América Latina em 2006*. Rio de Janeiro: CPDOC/FGV, 2006.
- BETHELL, L. O Brasil e a ideia de "América Latina" em perspectiva histórica. *Estudos Históricos*, Rio de Janeiro, v. 22, n. 44, p. 289-321, 2009.
- BONDER, G. Mujer y educación en América Latina: hacia la igualdad de oportunidades. *Revista Iberoamericana de Educación*, Madrid, v. 3, n. 6, p. 9-48, 1994.
- BOTTINELLI, M. et al. Reflexiones sobre los orígenes de la formación en terapia ocupacional en Argentina. *Revista Ocupación Humana*, Bogotá, v. 16, n. 2, p. 11-25, 2016.
- BRASLAVSKY, C. *Desigualdades educativas de jóvenes y mujeres en América Latina y el Caribe*. Santiago: UNESCO, 1994.
- BRAVERMAN, H. *Trabalho e capital monopolista: a degradação do trabalho no século XX*. Rio de Janeiro: Guanabara, 1987.
- BRUNETTO, L. Terapia ocupacional: correlação teórico-prática. *Revista da Associação Brasileira de Psiquiatria*, São Paulo, v. 5, n. 19, p. 213-226, 1975.
- CAMPOS, A. L. V.; NASCIMENTO, D. R.; MARANHÃO, E. A história da poliomielite no Brasil e seu controle por imunização. *História das Ciências da Saúde*, Manguinhos, v. 10, p. 573-600, 2003. Suplemento 2.
- CASCAJARES, H. C. D.; RAMÍRES, G. P. *Terapia ocupacional em México: 60 años transformando vidas*. Ciudad de México: Imagia, 2017.
- CERTEAU, M. *A escrita da história*. Rio de Janeiro: Forense Universitária, 1982.
- CORREA, R. L. *Região e organização espacial*. São Paulo: Ática, 2003.
- DIAS, W. S. *A ideia de América Latina nos livros didáticos de Geografia*. 2009. 129 f. Dissertação (Mestrado em Geografia) – Universidade de São Paulo, São Paulo, 2009.
- DUARTE, C. et al. Precursores de la terapia ocupacional en Colombia: sujetos, instituciones, oficios. *Revista Ocupación Humana*, Bogotá, v. 16, n. 2, p. 93-109, 2016.
- ECHEZURÍA, E. Estado de la poliomielitis en Venezuela. *Bulletin of the Pan American Health Organization*, Washington, v. 8, n. 1, p. 66-71, 1974.
- ESCOBAR, A. *La invención del Tercer Mundo: construcción y deconstrucción del Desarrollo*. Barcelona: Norma, 1998.
- ESCOBAR, P.; SEPÚLVEDA, R. *Escuela de Terapia Ocupacional Universidad de Chile: aportes para una historia posible*. Santiago: ETOUCH, 2013.
- FURTADO, C. *A economia latino-americana*. São Paulo: Companhia das Letras, 2007.
- GIGANTE, M. A. *História oral de idosos asilados em São Carlos – SP: velhice, asilo e memória da cidade (1950-2008)*. 2008. 225 f. Tese (Doutorado em História) – Universidade Estadual Paulista, Franca, 2008.
- GOMES, P. C. C. O conceito de região e sua discussão. In: CASTRO, I. E. (Org.). *Geografia: conceitos e temas*. Rio de Janeiro: Bertrand Brasil, 1995. p. 49-73.
- GOMEZ, E. M. Referentes históricos de la utilización de actividades en Sudamérica. In: PAGANIZZI, L. (Org.). *Terapia ocupacional psicossocial*. Buenos Aires: Polemos, 2007. p. 23-30.
- GÓMEZ LILLO, S. *Antecedentes, creación y desarrollo de la terapia ocupacional en Chile: 50 años de historia*. Santiago de Chile: Abarca Girard Ediciones, 2012.
- GONZALEZ, L. Reunión inaugural. In: CONGRESO ARGENTINO DE REHABILITACIÓN DEL LISIADO, 3., 1959, Mar del Plata. *Anales...* Buenos Aires: Archivo Tesone, 1959. p. 19-26.
- KEOHANE, R.; NYE, J. *Power and interdependence: world politics in transition*. Boston: Little, Brown and Company, 1977.
- LAVAL, E. R. Anotaciones para la historia de la poliomielitis en Chile. *Revista Chilena de Infectología*, Santiago, v. 24, n. 3, p. 247-250, 2007.
- LE GOFF, J. Uma ciência em marcha, uma ciência na infância. In: LE GOFF, J. *A história nova*. São Paulo: Martins Fontes, 2005. [s.p.].
- LEMOS, F. I. *Comunicação oral*. Rio de Janeiro: [s.n.], 1985.
- LLISTAR, D. B. *Anticooperación: interferencia norte-sur: los problemas del sur global no se resuelven con más ayuda internacional*. Barcelona: Icaria Antrazyt, 2009.

- LOPES, R. E. *A formação do terapeuta ocupacional: o currículo: histórico e propostas alternativas*. 1991. 215 f. Dissertação (Mestrado em Educação) – Universidade Federal de São Carlos, São Carlos, 1991.
- LOPES, R. E. A direção que construímos: algumas reflexões sobre a formação do terapeuta ocupacional. *Revista de Terapia Ocupacional da USP*, São Paulo, v. 4-7, p. 27-35, 1997.
- LOPES, R. E. Cidadania, direitos e terapia ocupacional social. In: LOPES, R. E.; MALFITANO, A. P. S. (Org.). *Terapia ocupacional social: desenhos teóricos e contornos práticos*. São Carlos: EdUFSCar, 2016. p. 29-48.
- LOPES, R. E.; HAHN, M. S. The education of occupational therapists in Brazil: history and perspectives. *WFOT Bulletin*, Hong Kong, v. 49, n. 1, p. 24-32, 2004.
- MACDONALD, M. Conferencia la terapia ocupacional en la rehabilitación del Lisiado. In: CONGRESO ARGENTINO DE REHABILITACIÓN DEL LISIADO, 3., 1959, Mar del Plata. *Anales...* Mar del Plata: Archivo Tesone, 1959.
- MACHADO, M. H.; OLIVEIRA, E. S.; MOYSES, N. M. N. Tendências do mercado de trabalho em saúde no Brasil. In: CONFERÊNCIA INTERNACIONAL SOBRE PESQUISAS EM RECURSOS HUMANOS EM SAÚDE, 2010, Rio de Janeiro. *Anais...* Rio de Janeiro: EAD/Ensp, 2010.
- MAGALHÃES, L. V. *Os terapeutas ocupacionais no Brasil: sob o signo da contradição*. 1989. 136 f. Dissertação (Mestrado em Educação) – Universidade de Campinas, Campinas, 1989.
- MALAGÓN, V.; ÁVILA, G. *Estado actual de la poliomiélitis en Colombia*. Bogotá: Academia Nacional de Medicina, 1982.
- MELO, D. O. C. V. *Em busca de um ethos: narrativas da fundação da terapia ocupacional na cidade de São Paulo (1956-1969)*. 2015. 133 f. Dissertação (Mestrado Profissional em Ensino em Ciências da Saúde) – Universidade Federal de São Paulo, Santos, 2015.
- MENDES, E. V. *Uma agenda para a saúde*. São Paulo: Hucitec, 1996.
- MILANI, C. R. S. Evolução histórica da cooperação norte-sul. In: SOUZA, A. M. (Org.). *Repensando a cooperação internacional para o desenvolvimento*. Brasília: Ipea, 2014. p. 33-56.
- MILLANI, H. F. B.; VALENTE, M. L. L. C. O caminho da loucura e a transformação da assistência aos portadores de sofrimento mental. *Revista Eletrônica Saúde Mental Álcool e Drogas*, Ribeirão Preto, v. 4, n. 2, p. 1-19, 2008.
- MIRANDA, M. El compromiso con la ciencia: conocimiento y técnica en el trabajo social. *Revista Internacional de Ciencias Sociales y Humanidades*, México, n. 2, p. 9-28, 2007.
- MORRISON, R. et al. Silvia Gómez Lillo y cincuenta años de terapia ocupacional en Chile: una biografía. *TOG (A Coruña)*, Galicia, v. 24, n. 13, p. 1-27, 2016.
- MORRISON, R. J. *La filosofía pragmatista en la terapia ocupacional de Eleanor Clarke Slagle: antecedentes epistemológicos e históricos desde los estudios feministas sobre la ciencia*. 2014. 378 f. Tesis (Doctorado en Lógica y Filosofía de la Ciencia) – Universidad de Salamanca, Salamanca, 2014.
- MORRISON, R. J. Los comienzos de la terapia ocupacional en Estados Unidos: una perspectiva feminista desde los estudios de Ciencia, Tecnología y Género (siglos XIX y XX). *Historia Crítica*, Chile, n. 62, p. 97-117, 2016.
- NABERGOI, M. et al. Cooperación técnica en rehabilitación: procesos iniciales de constitución de la formación académica y ejercicio profesional em Argentina. In: CONGRESO CHILENO, 8.; JORNADAS NACIONALES DE TERAPIA OCUPACIONAL, 2013, Viña del Mar. *Anales...* Chile: Universidad de Chile, 2013.
- NASCIMENTO, B. A. *Loucura, trabalho e ordem: o uso do trabalho e da ocupação em instituições psiquiátricas*. 1991. 150 f. Dissertação (Mestrado em Ciências Sociais) – Pontificia Universidade Católica, São Paulo, 1991.
- NASCIMENTO, D. R. et al. (Org.). *A história da poliomielite*. Rio de Janeiro: Garamond, 2010.
- PAPADÓPOLUS, J.; RADAKOVICH, R. Educación superior y género en América Latina y el Caribe. In: ORGANIZACIÓN DE LAS NACIONES UNIDAS PARA LA EDUCACIÓN, LA CIENCIA Y LA CULTURA – UNESCO. *Informe sobre la educación superior em América Latina y el Caribe, 2000-2005: la metamorfosis de la educación superior*. Caracas: IESALC-UNESCO, 2006. p. 117-128.
- POLLARD, N.; SAKELLARIOU, D.; KRONENBERG, F. *A political practice of occupational therapy*. Philadelphia: Elsevier, 2009.
- QUEIROZ, D. M. Mulheres no ensino superior no Brasil. In: REUNIÃO ANUAL DA ASSOCIAÇÃO NACIONAL DE PESQUISA E PÓS-GRADUAÇÃO EM EDUCAÇÃO, 23., 2000, Caxambu. *Anais...* Rio de Janeiro: ANPED, 2000.
- QUIROGA, V. A. M. Eleanor Clarke Slagle and Susan E. Tracy: personal and professional identity and development of occupational therapy in progressive era America. *Nursing History Review*, Philadelphia, n. 8, p. 39-70, 2000.
- QUIROGA, V. A. M. *Occupational therapy: the first thirty years, 1900-1930*. Bethesda: American Occupational Therapy Association, 1995.

- REIS, S. C. C. A. G. *Histórias e memórias da institucionalização acadêmica da terapia ocupacional no Brasil: de meados da década de 1950 a 1983*. 2017. 398 f. Dissertação (Mestrado em Terapia Ocupacional) – Universidade Federal de São Carlos, São Carlos, 2017.
- REIS, S. C. C. A. G.; LOPES, R. E. O início da trajetória de institucionalização acadêmica da terapia ocupacional no Brasil: o que contam os(as) docentes pioneiros(as) sobre a criação dos primeiros cursos. *Cadernos Brasileiros de Terapia Ocupacional*, São Carlos, v. 26, n. 2, p. 255-270, 2018.
- RIVAS, A. P. et al. Historia de la terapia ocupacional em Venezuela. In: CONGRESO DE LA CONFEDERACIÓN LATINOAMERICANA DE TERAPEUTAS OCUPACIONALES, 10., 2013, Caracas. *Anales...* Caracas: CLATO, 2013. p. 1-71.
- RODRÍGUEZ, L.; CAMARGO, N.; ESCOBAR, X. Terapia ocupacional: una perspectiva histórica desde la Universidad Nacional de Colombia. *Revista Ocupación Humana*, Bogotá, v. 2, n. 16, p. 26-45, 2016.
- SANZ VALER, P.; RUBIO, C.; PASTOR, M. A. La influencia de las ayudantes de reconstrucción en la historia de la terapia ocupacional. *Revista de Terapia Ocupacional*, Galicia, n. 18, p. 1-21, 2013.
- SBRILLER, L. *Introducción a terapia ocupacional: marcos conceptuales*. Buenos Aires: Catálogos, 1997.
- SOARES, L. B. T. *Terapia ocupacional: lógica do capital ou do trabalho? Retrospectiva histórica da profissão no Estado brasileiro de 1950 a 1980*. São Paulo: Huittec, 1991.
- SOUZA, A. América Latina, conceito e identidade: algumas reflexões da história. *Revista de Humanidades do Curso de Ciências Sociais da UNIFAP*, Macapá, v. 4, n. 4, p. 29-39, 2011.
- TESTA, D. Aportes para el debate sobre los inicios de la profesionalización de la terapia ocupacional em Argentina. *Revista Chilena de Terapia Ocupacional*, Santiago, v. 12, n. 1, p. 67-78, 2012.
- TESTA, D.; SPAMPINATO, S. Género, salud mental y terapia ocupacional: algunas reflexiones sobre la influencia de la historia de las mujeres y la perspectiva de género em nuestras prácticas. *Revista de Terapia Ocupacional da Universidade de São Paulo*, São Paulo, v. 2, n. 21, p. 174-181, 2010.
- TRUJILLO, A. *Terapia ocupacional: conocimiento y práctica en Colombia*. Bogotá: Universidad Nacional, 2002.

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Notes

¹ In the nineteenth century, Philippe Pinel in his work called “Medical-Philosophical Pact on Mental Alienation” understood that madness was an excess and deviation to be fixed by changing customs and motivating new habits and behaviors, proposing the bases for moral treatment. According to Millani and Valente (2008), moral treatment included the whole organization and production of the asylum routine, that is, the systematization of the use of time and space of inmates, subjecting the inmate, removing him from his world to fit it into a system of medical precepts and moral values. Also, Magalhães (1989, p. 55-56) emphasizes that “[...] articulating a therapeutic and police discourse, moral treatment establishes an ethic (or at least it rescues the medical domain) based, above all, in the value of the discipline and its main social product: the alienated work”.

² The selective pores of state borders make us more interdependent, although interdependence does not mean symmetry.

³ [...] the transnational interference between local or transnational social groups that inhabit different countries or between their states.

⁴ Here, the “training courses” are understood as the courses performed in Argentina before the creation of ENTO (BOTTINELLI et al., 2016), in Brazil, the occupational therapy courses for example, offered by Nise da Silveira (SOARES, 1991), and in Mexico, as training courses for nurses work in this area (CASCAJARES; RAMÍRES, 2017).

⁵ The first edition of the minimum training standards advocated by WFOT is from 1958.

⁶ In Brazil, for example, women’s access to higher education only at the end of the nineteenth century (QUEIROZ, 2000).

- ⁷ [...] it was organized by a gender system that established hierarchies, privileges and inequalities; delimiting a professional area linked to a world considered as naturally feminine constituted by the activities of daily life, handicrafts and manual activities, childcare and a share of love and selflessness to carry out the challenge of rehabilitation.
- ⁸ In the history of medicine, the profession was exercised mostly by men; in Brazil, in the 1970s, women were 11% of medical professionals (MACHADO; OLIVEIRA; MOYSES, 2010).