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HISTORICAL RESEARCH ARTICLE

Nursing care in electroconvulsive therapy in a Brazilian institution before the Psychiatric Reform

Cuidados de enfermagem em terapia eletroconvulsiva no período pré-reforma psiquiátrica numa instituição brasileira

Cuidados de enfermería en la terapia electroconvulsiva en el período prerreforma psiquiátrica en una institución brasileña

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Abstract
Background: Electroconvulsive therapy (ECT) is a part of Brazilian Nursing History that needs to be known to understand the evolution of knowledge and practice following the Psychiatric Reform.
Objective: To identify nursing care for inpatients undergoing ECT at a Brazilian psychiatric institution between 1980 and 1990.
Methodology: Social-historical study based on written documents from a Brazilian psychiatric institution and oral statements from nursing professionals, analyzed according to Foucault's framework.
Results: Nursing care was defined based on everyday experiences and provided before, during, and after ECT. Nursing professionals had no professional training. They acted autonomously, administering ECT to calm agitated patients, or accompanied physicians' interventions, providing care to reduce the side effects of ECT.
Conclusion: Despite being part of the asylum-style care model, ECT included nursing care to avoid unwanted effects. Nursing professionals witnessed the decline of ECT in society. The present study describes aspects of ECT that are inconsistent with today's practice.

Keywords: psychiatric nursing; nursing care; electroconvulsive therapy

Resumo
Enquadramento: A terapia electroconvulsiva (TEC) é parte do passado da enfermagem que precisa de ser conhecido, a fim de dar sentido às transformações nos saberes e práticas após a Reforma Psiquiátrica.
Objetivo: Identificar os cuidados de enfermagem na aplicação da terapia electroconvulsiva em utentes internados num instituto psiquiátrico brasileiro entre 1980 e 1990.
Metodologia: Investigação histórico-social em documentos escritos da instituição cenário e orais produzidos com profissionais de enfermagem, interpretados à luz do referencial foucaultiano.
Resultados: Os cuidados de enfermagem foram definidos pela experiência quotidiana e realizados nos momentos pré, trans e pós a aplicação da terapia electroconvulsiva. A enfermagem não tinha formação profissional e agia por conta própria, aplicando a terapia para acalmar utentes agitados ou acompanhando a aplicação pelo médico, prestando cuidados para reduzir efeitos colaterais.
Conclusão: Apesar do modelo manicomial, a aplicação da terapia electroconvulsiva contava com cuidados de enfermagem aos utentes para evitar efeitos indesejados. A enfermagem acompanhou o declínio da TEC na sociedade. Este estudo evidenciou características da TEC que não se adequam à prática contemporânea.

Palavras-chaves: enfermagem psiquiátrica; cuidados de enfermagem; eletroconvulsoterapia

Resumen
Marco contextual: La terapia electroconvulsiva (TEC) forma parte del pasado de la enfermería que es necesario conocer para dar sentido a las transformaciones del conocimiento y la práctica tras la Reforma Psiquiátrica.
Objetivo: Identificar los cuidados de enfermería en la aplicación de la terapia electroconvulsiva en pacientes ingresados en un instituto psiquiátrico brasileño entre 1980 y 1990.
Metodología: Investigación histórico-social en documentos escritos de la institución y documentos orales producidos con profesionales de enfermería, interpretados según el referencial foucaultiano.
Resultados: Los cuidados de enfermería se definieron por la experiencia diaria y se llevaron a cabo antes, durante y después de la terapia electroconvulsiva. El personal de enfermería no tenía formación profesional y actuaba por su cuenta, aplicando la terapia para calmar a los pacientes agitados o acompañando la aplicación del médico, proporcionando cuidados para reducir los efectos secundarios.
Conclusión: A pesar del modelo de manicomio, la aplicación de la terapia electroconvulsiva contaba con cuidados de enfermería a los pacientes para evitar efectos no deseados. La enfermería ha seguido el declive de la TEC en la sociedad. Este estudio pone de manifiesto las características de la TEC que no se ajustan a la práctica contemporánea.

Palabras-clave: enfermería psiquiátrica; atención de enfermería; terapia electroconvulsiva

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Introduction

The lack of historical records on the transition process of nursing care in electroconvulsive therapy (ECT) lead to the selection of the research theme of this study. In the 1970s-1980s, psychiatric institutions in Rio de Janeiro still used prolonged inpatient hospitalizations with solitary confinements following the asylum-style or institutional-based mental health care model. ECT was widely used as a treatment in Brazil until it began to be disputed by the Brazilian *Movimento da Luta Antimanicomial* (anti-asylum movement), inspired by the Italian Mental Health Care Reform. The movement denounced the use of ECT without medical prescription or as a form of punishing patients in psychiatric crisis, particularly those suffering from agitation disorders (Guimarães et al., 2013; Passos, 2019).

Italian physicians first administered ECT in the 1930s. It remains a controversial treatment used throughout the history of psychiatric institutionalization against patients' will, in inappropriate settings, and without the necessary resources to attend to possible side effects. Thus, it is viewed as an inhumane treatment procedure characterized by violence and against patients' rights (Miranda et al., 2019).

The movement supporting the Brazilian Psychiatric Reform used movie scenes and news reports showing the use of ECT to illustrate their campaigns against patient institutionalization, leading Brazilian society to associate ECT with asylum-style care or inhumane treatments. The movement's actions contributed to reducing the use of ECT in institutions following reformist ideals, even before the Brazilian Psychiatric Reform law was passed. Considering the area of practice and list of competencies, Mental Health and Psychiatric Nursing includes the delivery of therapeutic care to individuals in the community or health care institutions. The literature mentions that nursing professionals were part of the health teams administering ECT-related care and also participated in changing how patients undergoing this procedure were treated (Tanaka et al., 2021). For years, the role of psychiatric nursing professionals focused on administering medication, feeding, hygiene, and controlling the institution's environment, following the biomedical approach to treating inpatients with mental illness (Souza & Afonso, 2015).

The association between mental health and psychiatric nursing and ECT administration is discussed until today, with its therapeutic applicability gaining relevance since the issues raised by the Brazilian Psychiatric Reform movement. The delivery of nursing care before, during, and after the administration of ECT was among these issues. In the 1980s, due to the dissemination of anti-asylum ideas, it became mandatory for nursing teams to include graduated nurses. Something that until then was not required. Considering that nursing teams must not distance themselves from the ethical responsibility of their professional practice, the aspects involving ECT administration in a given period and institution must be historically described to allow mapping the construction of psychiatric knowledge and practices. Thus, the research question emerged: how does the nursing care provided to patients undergoing ECT allows describing the historical period before the Brazilian Psychiatric Reform?

This study aims to identify the nursing care provided in the administration of ECT to patients admitted to a Brazilian psychiatric institution in the 1980s-1990s.

Methodology

This social-historical study using a qualitative approach originates from a master's thesis and is based on written and oral historical sources. The study was set at the *Instituto Municipal Nise da Silveira* (IMNS - *Nise da Silveira* Municipal Institute) in Rio de Janeiro. The IMNS is described as a place of development of psychiatric knowledge and practices in Brazil.

The first phase of data collection involved the research of documents belonging to the IMNS History and Memory Collection. The documents available for research included: nursing reports (7), occurrence logbooks (20), and evaluation forms (134). Only ECT-related information was extracted from the documents. The written sources consisted of brief notes, mostly indicating that patients had received ECT on a given day, as observed in 46 forms, and the acquisition or maintenance of ECT devices. Thus, the second data collection phase focused on oral historical sources, allowing the recording of human experiences (Freitas, 2006).

The inclusion criterion for selecting participants was to have worked in the IMNS adult wards in the 1980s-1990s, with experience caring for patients who received ECT. Despite having worked in the ward, professionals without a nursing degree during this study's timeframe were excluded. Thus, nine participants were included in this study's sample as oral historical sources. The sample consisted of four nurses (N), four nursing technicians (NTs), and one nursing assistant (NA) who worked for at least 10 years during the studied timeframe providing nursing care to patients receiving ECT at the IMNS. Data analysis followed the historical research method. It is based on gathering a *corpus* about a phenomenon, submitting it to critical evaluation for source validation, and analyzing the data obtained through triangulation and interpretation. Foucault's concepts of "Power" and "Discipline" were used as the theoretical framework (Foucault, 2014; Padilha & Borenstein, 2005).

The research was approved by the Research Ethics Committee and guided by Resolutions no. 466/2012 and no. 510/16 of the Brazilian National Health Council/ Ministry of Health of Brazil, governing research with human beings and requiring the protection of participants and respect for bioethics principles.

Results

Between the 1970s and 1990s, Brazilian psychiatric care was grounded in the asylum-style care model. The asy-

lums consisted of infrastructures meticulously organized regarding time and space and aimed at modifying the behavior of individuals with mental illness to adapt to the institutional organization (Costa & Lotta, 2021; Kirschbaum, 1997).

In the mid-1980s, the care paradigm shift resulting from the movement of Brazilian Psychiatric Reform took its first steps at the IMNS. The changes in care delivery were also influenced by the new nursing professional practice regulations that required the presence of graduated nurses supervising the nursing team (Law no. 7498, 1986), as observed in the statements of the nursing staff:

> The mental health campaign had started, more nurses were entering, more technicians, things were expanding . . . but the evolution took a while. Breaking down that wall took time; it was very difficult. Here, the older staff offered a lot of resistance. New people started arriving with new mindsets and more evolved ways of thinking, with other training. (NT1)

"Nurses became part of the mental health team when the movement of the psychiatric reform became stronger, and the teams were structured differently" (N2).

This study's participants confirm that during this period of transition and introduction of new ideas about psychiatric care, ECT remained a routine treatment in the institution:

"The doctor always administered ECT in the morning . . . she arrived early to do it" (NT4).

"The doctor gave the electroshock, and we prepared the patient . . . we got the patients up at 5:00 a.m. to perform their hygiene" (NA1).

"It was centered on the doctor, following the hegemonic model that always existed; they made the decisions. We just participated in what happened" (N2).

Participants also report the administration of ECT in patients with psychotic episodes with severe psychomotor agitation. The team used ECT as a tool in addition to mechanical restraint techniques, as the physicians were not always present in the ward to prescribe chemical restraint medication:

> The more aggressive ones were restrained all the time: 6h, 8h, 12h, as long as necessary. They were restrained all the time. They were only freed to be fed, and then they were [again] tied up. In reality, what I saw was violence, I thought it was violence against the human being . . . , there was a point where ECT was administrated here as punishment. (NT1)

"In practice, when the patient was very angry, hit everyone, fought, ECT was used as a punishment to calm him down" (NT2).

"[ECT] was frequently used as punishment to make the patients afraid of it. If they did not behave in a given way, if they did not remain calm in the ward, if they broke everything . . . They were taken to ECT" (NT3).

"I did not participate, but I saw ECT being administered as punishment and not as a treatment about four or five times" (N3).

Like all punishment, the threat is part of the disciplinary system present in closed institutions. Thus, different health professionals used ECT to threaten inpatients:

"Unfortunately, we used to hear: look, I'm going to talk to the doctor to shock you because you are very agitated" (N2).

"It was like this: you are not going to be quiet, are you? Then you are going to get shocked. We took the patient to the shock room and shocked the patient" (N3).

The statements show that when there was no supervising nurse in the institution, nursing assistants and technicians, as well as non-medical staff, also administered ECT:

> The shocks were not only administered by a doctor, security guards, porters, or people unqualified to give any assistance. The ECT black box was kept in the wards. . . anyone could come and give the electroshock. Some told the doctor when he arrived the next day, and others did not. (N4)

"All [ECT] administrations as punishment were done by nursing assistants, guards, and *Auxiliares Operacionais de Serviços Diversos* (AOSD - Operational Assistants of Other Services)" (N3).

Brazilian psychiatric institutions used to hire individuals without formal training to work in the nursing team. The lack of professionals interested in working in the area led to the lack of personnel. Thus, as time passed and the experience was acquired, unqualified staff members rose internally to other positions in the institution, including within the nursing team. This situation occurred at the IMNS:

> When I entered here, I started as an AOSD . . . I was what was called an assistant; at that time, I worked as a nursing assistant . . . the senior staff that was about to retire told us how to separate the *Haldol*, *Phenergan*, *Promethazine* [medications], you know? By color. (NT3)
>
> There were the so-called guards; they were the AOSDs . . . At that time, the guards were anyone who could at least write their name and knew the medications. With this, they administered [medication], and provided care as if they were nursing assistants or technicians. But they had no training (NT1)

"Several professionals worked in the nursing team, but without any technical training. They were security guards, clerks, porters; for you to have an idea, there were even prison guards" (N2).

> The nursing team was often not qualified. When I arrived here, there were very few nursing assistants, an average of 12, 20 at most. The rest were from other categories: porters, security guards, AOSDs, and people who did not study to be working (N4).

In administering ECT, physicians requested the nursing staff's assistance to restrain patients physically. Physicians assigned this role to the nursing staff. This study's participants point out that this professional group started developing their knowledge of the treatment:

"They [the doctors] asked us to tidy the room, prepare the little box [the ECT device] . . . we maintained the patients' fast until 8 a.m., which was when she [the doctor] started administering it" (NT3).

"[ECT-related] care was provided by us of the nursing team" (NT1).
As the team was short-staffed, the nursing professionals were dedicated to preparing and protecting the patients receiving ECT, distancing themselves from other staff who used ECT as punishment. The statements testify that nurses provided care before, during, and after ECT:
"The patient fasted, the medication was given 1 hour or 30 minutes before ECT, and the vital signs were checked" (NT1).
"We bathed the patient before ECT" (NT4).
"We made a roll with some fabric ... gauze, pillowcase ... and put it in the patient's mouth so that he would not bite his tongue. We also checked the vital signs before and after ECT" (NT2).
"We had to hold the patient down during the treatment, a restraint" (NT1).
"We tied the wrists and ankles with ropes. We saw a person being tied up, really tied up, you know? There were some ropes; a leather belt, but it was already worn out by the use" (N3).
The statements gathered by this study about the care provided after the administration of ECT reinforce that the nursing team checked patients' vital signs, took them to bed, and monitored patients:
"After the treatment was finished, we took the patient back to bed. We observed if the patient remained aggressive or if he calmed down. Usually, they calmed down" (NT4).
"After the tremors [of the tonic-clonic seizures] passed, the patient regained consciousness. We put the stretcher next to the patient's bed, put it on a high position, with the headboard high, and restrain the patient, so he would not fall" (NT2).
"Care was also provided after ECT, which was the 24-hour monitoring of that patient" (NT1).

Discussion

The oral statements provide evidence linking the different facets of ECT during the period under study.
A considerable debate has occurred since the beginning of the Brazilian Psychiatric Reform movement in the late 1970s, particularly among the scientific community. The debate has focused on shifting the care model, including the therapeutic practices used, among which ECT (Kelly & Kelly, 2013; Souza & Afonso, 2015).
In the studied setting, the data obtained shows that administering ECT followed a routine imposed mainly by the medical team and followed by the nursing team without question. However, essential aspects regarding the ECT administration were omitted and not recorded in detail in the institutional documents this study consulted. Nevertheless, the research reveals the reality of ECT at the IMNS during the transition period between care models, marked by the arrival of graduated nursing professionals. Previously, nursing professionals were almost non-existent in the wards. The nursing teams consisted of different types of professionals, and the staff with nursing graduation courses was minimal.
The physicians held the knowledge and power in this clinical setting, although they were not always available or present. When they were absent, the nursing professionals assumed the power to control patients and employ disciplinary techniques, which clarified the institution's disciplinary pyramid during the period under study. This relationship of powers and knowledge led to using ECT for therapeutic purposes prescribed by the psychiatrist for symptom relief or as a nursing disciplinary practice to maintain order. The participants point out that this conduct demonstrates the nursing teams' lack of autonomy and subordination to the physician, which is common in scenarios with no graduated nurses.
The physician prescribed ECT without explaining to the nursing team and the patient the real reasons for the indication in a clear abuse of power derived from professional knowledge that harmed care delivery. Nevertheless, the nursing team knew that preparing and monitoring patients receiving ECT was part of their responsibility, so they took steps to administer the treatment with the least risk of harm to the patient.
When patients did not comply with the ward's disciplinary rules for maintaining order, they were restrained and received ECT. These practices indicated asylum-style care routines, which in Brazil started to be replaced during this period. The asylum-style care routines did not follow the professional nursing code of ethics and were carried out without nurse supervisors.
The disciplinary system points out the existence of a regime of sanctions, punishments, and rewards that allowed controlling the patients within the clinical setting. ECT was used for this purpose, mainly to control the agitation of inpatients. This use reflected the professionals' lack of training, who feared the patients' agitation and aggressiveness. Although using repressive techniques on patients must not be accepted in any situation, it is worth noting that agitated patients without appropriate medication almost always direct their aggressiveness toward health professionals and health settings. Thus, the evolution of psychopharmacology was decisive in reducing these more extreme cases of aggressiveness and advancing the Psychiatric Reform.
ECT has remained controversial until today. Much opposition to it is based on its administration as a form of punishment validated by psychiatrists, which brought visibility to the stigmas regarding its therapeutic use (Perizzolo et al., 2003). Brazilian psychiatry and mental health care made significant technological and care advances, among which the passing of Law n. 10,216/2001, protecting the rights of people with mental illness, and the Federal Council of Medicine's definition of the ECT administration protocol. However, the Brazilian Psychiatric Reform movement still does not accept the treatment, which is mainly administered in private clinics.
While researching history to fill the gap in nursing care, the responsibility of institutional managers is apparent, as they are accountable for hiring unqualified staff to work in the nursing teams. Even after Law No. 7498/86, regulating Brazilian professional nursing practice, came into force in the country, institutional managers allocated

unqualified professionals to care for large numbers of patients, paying them low salaries (Kirschbaum, 1997; Silva et al., 2017).

Nursing History demonstrates that these professionals were less valued in clinical settings. Physicians held the knowledge, and other health professionals had to obey their commands. Nursing teams worked as executors of physicians' disciplinary power. Consequently, the need arose to reflect on the training of nursing professionals in psychiatry. In Brazil, nursing education in psychiatry began in the late nineteenth century with the creation of nursing schools controlled by physicians (Guimarães et al., 2018; Kirschbaum, 1997; Rodrigues et al., 2016; Silva et al., 2017).

Following the teaching model adopted at the first Brazilian nursing school, physicians ran nursing schools, teaching psychiatry-related subjects and techniques inside hospital institutions. Also, nursing schools based on Florence Nightingale's teaching model stopped teaching the discipline of Psychiatric Nursing. This fact may be due to the lack of qualified nurses at the time, and the intention of training professionals from this category that remained submissive to physicians' knowledge, therefore maintaining the power hierarchy within the institutions and serving as an example to inpatients with mental illness (Kirschbaum, 1997; Silva et al., 2017).

The IMNS nursing team was mainly composed of nursing assistants who joined the institution as porters, guards, and AOSDs. These staff members had no nursing technical-scientific knowledge. They received their training while already working from the other nursing team members. However, graduated nurses were partially or entirely absent from the nursing team.

It is worth noting that the nursing team, primarily responsible for maintaining order within health institutions, consisted of professionals who cared for inpatients 24 hours a day. Thus, the nursing team acted in all disciplinary contexts, constantly monitoring inpatient spaces.

The hierarchical organization of the IMNS nursing team was characterized by each professional's level of knowledge, which was essential for maintaining order within the ward. Thus, care delivery followed an asylum-style care logic, in which the main objective was maintaining discipline. This focus led to the restraint of patients with mental illness to contain their agitation and comply with the institutional rules.

This study observed the connivance of the health team regarding the administration of ECT by the nursing team. The nursing team reported or not the use of ECT to the physician. This study could not ascertain how the nursing team informed the physicians of the use of the procedure. When those in charge decided to use ECT and subsequently communicated it to the physician, they had the physician's approval.

Although the medical team was responsible for prescribing the administration of ECT, nurses had to provide the necessary support for the procedure to be performed. This study organizes psychiatric nursing care according to its delivery before, during, or after ECT. Each phase is distinguished by the type and timing of nursing care required to meet the needs of patients with mental illness undergoing ECT.

This study's participants mentioned that the nursing care delivered before ECT included fasting, hygiene, checking vital signs and medication, and placing a mouth guard. During the procedure, the nursing team was primarily responsible for restraining the patient's upper and lower limbs. The aim was to prevent injuries and falls during the tonic-clonic seizures triggered by the electric shock. After ECT was administered, nurses primarily monitored patients during the first 24 hours after the shock, checking their vital signs. This study also found that after receiving ECT, patients could be mechanically restrained to bed to avoid falling when getting up. Mechanical restraints were used due to patients' usual disorientation after receiving the treatment.

Developed in the 1930s, ECT is the only biological treatment used today as a medical intervention procedure. It improved considerably regarding how it was previously administered. Today, the procedure is administered using muscle relaxants, anesthesia, and a specific and adequately equipped room. Thus, according to current literature, ECT is a safe and therapeutically efficient procedure (Monser et al., 2005 Perizzolo et al., 2003; Kelly & Kelly, 2013).

Some authors state that ECT progressed toward the 21st century with a much lower frequency of use than expected, considering the positive outcomes it presents. These authors associate this lack of use with the stigma bore by ECT due to this procedure's history of abuse and misuse (Perizzolo et al., 2003; Kelly & Kelly, 2013).

This study confirms that Brazil's anti-asylum movement strengthened between the 1980s and 1990s. Also, the entry of graduated nurses at the IMNS led to questioning the institution's nursing staff and their decision-making about using ECT, initiating a transformation in this institutional setting.

Slowly, the prescription and administration of ECT became the medical team's responsibility, while the nursing team prepared and accompanied the patients to receive the treatment safely. Moreover, the IMNS medical team selected and prepared the patients with mental illness to undergo the treatment and established the administration time. The entire nursing team understood and followed the medical team's orders.

In the 1980s, some authors, regardless of whether they were evidence-based or not, stated that the indication was for patients undergoing ECT to receive quality medical and nursing care. At the IMNS, when the physician prescribed ECT, nursing professionals were responsible for preparing patients, the material, and the setting and providing assistance during and after treatment (Stefanelli & Arantes, 1983).

The nursing care provided aimed to prevent or reduce any harm to the patient undergoing ECT, an indicator of knowledge about the effects of the tonic-clonic seizures triggered by its use. Although, generally, ECT was administered without prior planning with the nursing team, it was observed that care was provided before the treatment. Patients undergoing ECT fasted as a preparatory measure

for ECT to reduce the probability of vomiting and reflux. Maintaining the patients' fast was the responsibility of the nursing team, as was bathing patients, which was recommended to decrease skin impedance, that is, the resistance to the electric current caused by the skin's oiliness (Stefanelli & Arantes, 1983).

The participants also mentioned using a mouth guard to protect the patient's mouth, improvised with a cloth or roll of gauze, to avoid dental, mouth, tongue, or cheek injuries. The care delivered during the administration of ECT sought to reduce the chances of trauma and fractures. Thus, the nursing care delivered during ECT administration included holding and placing the patient's head to one side and mechanically restraining the upper and lower limbs. Ropes or belts were used to mechanically restrain patients, which contributes to reflecting on how the procedure was administered in this period. Mechanical and physical restraint during ECT administration was an action that, although it was aimed at preventing harm to the patient, aggravated the disciplinary characteristics of the treatment.

The literature indicates that most of the main side effects caused by ECT were temporary and benign, such as memory disorders and mental confusion, sialorrhea, or bone or soft tissue lesions. Most mortality cases are estimated to be related to the cardiovascular system.

This study describes how the anti-asylum movement influenced the change of conduct in the studied setting from the 1980s. This change of conduct advanced due to the management of nursing care performed by nurses, who, together with a group of professionals involved with the Brazilian Psychiatric Reform movement, moved away from the use of ECT as a punishment mechanism and introduced into the IMNS a less repressive model of nursing care.

Conclusion

This social-historical study describes how the IMNS nursing team regarded and administered ECT in the 1980s and 1990s and the nursing care provided before, during, and after ECT. The nursing professionals described the nursing care provided as primarily practical and executed only through repetition, without scientific support or questioning by the team members, demonstrating the poor professional qualification of most IMNS nursing professionals.

The nursing team formed a surveillance network aligned with the medical team that was essential for maintaining order at the institution. Maintaining order included using ECT, which the nursing team could administer first and report to the medical team afterward. The normalized use of ECT at the IMNS was fundamental for nursing professionals to be respected by the inpatients. As demonstrated by studies in other Brazilian institutions, ECT was used to coerce patients either by threatening to administer it or by actually using the procedure as punishment.

This study observed that before ECT, nursing care consisted of preparing the clinical setting and the patient for the procedure. The nursing professionals individually monitored patients who were going to receive ECT, maintained patients' fast, attended to their hygiene, and checked their vital signs, among other preventive care. During the ECT administration, nursing care aimed to prevent any harm to the patient with mental illness from the tonic-clonic seizures caused by the electrical shocks. The nursing professionals protected patients' mouths and restrained their upper and lower limbs. The nursing care delivered in the phase after the ECT administration included returning to and positioning patients in their beds, monitoring patients' orientation, and feeding them. It is worth noting that it was possible to observe in this study's participants' statements that they undervalued the nursing care provided in the phase after ECT. This attitude again demonstrates the nursing team's lack of knowledge regarding care delivery to patients with mental illness receiving ECT.

This study's identification of the use of ECT as both a therapeutic procedure and an asylum-style care practice emerges as a relevant precedent for other studies on the theme. Also, the results point out that to promote a nursing practice based on evidence and professional knowledge, nursing professionals must prepare adequately to deliver care to people receiving ECT.

Finally, ECT was part of the trajectory of psychiatric nursing care and included in the provision of specific care to patients with mental illness submitted to it, being necessary to avoid unwanted effects. The nursing team was responsible for protecting patients from the effects of tonic-clonic seizures, disorientation, and altered vital signs. The construction of knowledge in psychiatric nursing accompanies its practices over time, so it is essential to know its past. Nursing has accompanied the decline of the use of ECT in practice, and this study demonstrates aspects of ECT that are not appropriate for today's practice.

This study proves the influence of Brazilian Psychiatric Reform in the studied setting. The IMNS gradually reduced the use of ECT from the 1990s until it stopped administering it. The same occurred with inpatient psychiatric hospitalizations.

Author's contribuition

Conceptualization: Guimarães, J. C.
Data processing: Guimarães, J. C.
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