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REFLECTION ARTICLE

Electroconvulsive therapy, ethical and legal implications and the systematization of nursing care

Terapia electroconvulsiva, implicaciones éticas y legales y la sistematización del cuidado de enfermería

Eletroconvulsoterapia, implicações éticas, legais e a sistematização da assistência de enfermagem

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Abstract

The aim was to discuss the ethical and legal implications of electroconvulsive therapy and the Nursing work involved. It is a theoretical reflection. The critical conceptualization was based on readings of Ministerial Ordinances, Technical Reports, Resolutions of the Federal Councils of Nursing and Medicine, scientific literature, those current and considered classic for the understanding and discussion of the proposed theme. Finally, the NANDA International nursing classification systems were used for the formulation of Diagnoses, Classification of Results and Interventions. The results and discussions were presented dialogically in three thematic units: ethical and legal implications of carrying out ECT; differences in conception between groups that support ECT and groups that condemn it and contributions to nursing practice. ECT is accepted as a form of treatment by world institutions, however, it is quite controversial and the work of nursing is little discussed but is still systematized and extremely important.

Descriptors: Electroconvulsive Therapy; ECT; Mental Health Assistance; Systematization of Nursing Care; Nursing Care.

Resumén

El objetivo fue discutir las implicaciones éticas y legales de la terapia electroconvulsiva y el trabajo de Enfermería involucrado. Es una reflexión teórica. La conceptualización crítica se basó en lecturas de Ordenanzas Ministeriales, Informes Técnicos, Resoluciones de los Consejos Federales de Enfermería y Medicina, literatura científica, aquellas vigentes y consideradas clásicas para la comprensión y discusión del tema propuesto. Finalmente, se utilizaron los sistemas de clasificación de enfermería de NANDA Internacional para la formulación de Diagnósticos, Clasificación de Resultados e Intervenciones. Los resultados y discusiones fueron presentados dialógicamente en tres unidades temáticas: implicaciones éticas y legales de la realización de TEC; diferencias de concepción entre grupos que apoyan la TEC y grupos que la condenan y contribuciones a la práctica de enfermería. La TEC es aceptada como una forma de tratamiento por las instituciones mundiales, sin embargo, es bastante controvertida y el trabajo de enfermería es poco discutido pero aún sistematizado y de suma importancia.

Descriptores: Terapia Electroconvulsiva; ECT; Atención a la Salud Mental, Systematization of Nursing Care Atención de Enfermería.

Resumo

Objetivou-se discutir sobre as implicações éticas e legais imbuídas na eletroconvulsoterapia e o trabalho da Enfermagem envolvido. Trata-se de uma reflexão teórica. A conceituação crítica se deu a partir de leituras de Portarias Ministeriais, Relatórios Técnicos, Resoluções dos Conselhos Federais de Enfermagem e Medicina, literatura científica, aquelas atuais e consideradas clássicas para a compreensão e discussão do tema proposto. Por fim, foram utilizados os sistemas de classificações de enfermagem NANDA Internacional para a formulação dos Diagnósticos, Classificação dos Resultados e das Intervenções. Os resultados e discussões foram apresentados de forma dialógica em três unidades temáticas: implicações éticas e legais da realização da ECT; divergências de concepção entre os grupos que apoiam a ECT e os grupos que a condenam e contribuições para a prática da enfermagem. A ECT é aceita como forma de tratamento pelas instituições mundiais, porém, bastante polêmica e o trabalho da enfermagem e pouco discutido mais não deixa de ser sistematizado e de extrema importância.

Descritores: Eletroconvulsoterapia; ECT; Assistência à Saúde Mental; Sistematização da Assistência de Enfermagem; Cuidados de Enfermagem.

Introduction

Despite advances in historical-conceptual terms and scientific evidence, talking about mental disorders is still very complex, although interesting and instigating, especially when referring to forms of treatment. Thus, over time, the mentally ill person has been seen as a person who does not correspond to the standards established by society, in which their way of acting, thinking and interpreting the world, is at odds with social norms and precepts, causing discrimination and fear to that surround you[1].

Since ancient Greece, madness has not always been considered a negative thing. Philosophers such as Plato and Socrates highlighted the existence of a form of madness considered divine, a kind of manifestation of the gods, in which madmen would have access to hidden truths through delusions. In Classical Antiquity, there was a rupture between the mystical and the rational, and madness was moving away from its role as the bearer of divine truth and heading in an opposite direction, occupying the place of symbolic representative of evil[2].

However, in the Middle Ages there were already mechanisms for excluding the mad and it was not yet in this period that madness began to be perceived as a phenomenon that requires specific knowledge. It was only in the 18th century that it began to be seen as a mental illness, emphasizing scientific thinking and medical knowledge, and hospitals began to emerge as therapeutic spaces, delegating the practice to a specialist and providing the possibility of care and treatment. From there, the institution of classical psychiatry began[2].

Some forms of treatment for mental disorders have emerged over time, however, it was only from 1952 onwards that psychotropic drugs began to be used as an adjunct therapy, associated with therapeutic treatments, operative groups, psychotherapy, which caused a decrease in in the manifestations of the most expressive and harmful symptoms[3-5].

Faced with disqualified and inhuman care, with the use of electroshock and physical restraint practices, for example, the Psychiatric Reform process began divided into two phases: the first, from 1978 to 1991, comprises a critique of the hospital-centered model, while the second, from 1992 to the present, stands out for the implementation of a network of extra-hospital services. Both supported the progressive replacement of the hospital-centered model by decentralized and diversified services in therapeutic practices, advocating a reduction in hospitalizations and social reintegration[2,6,7].

It is noteworthy that, in 1987, mental health professionals, family members and patients gathered to hold the First Mental Health Conference, fighting for a society without asylums. In 1989, a Bill (PL) was presented by Deputy Paulo Delgado proposing a broad and profound reform in Brazilian psychiatric care, as well as the progressive reduction of psychiatric beds[8].

After several years and significant changes to its original text, on April 6, 2001, Law No. progressive movement of asylums, replacing them with open institutions[9].

The new proposed models make up the Psychosocial Care Network (RAPS), which is an integrated, articulated and effective network at different points of care, to meet people with demands arising from mental disorders or from the consumption of alcohol and other drugs. This network is formed by the services of Primary Health Care, Specialized Psychosocial Care, Urgent and Emergency Care, Residential Care of a Transitory Character, Hospital Care, Deinstitutionalization Strategies and Psychosocial Rehabilitation Strategy[7,4].

Currently, the reformulation of care practices in psychiatry is a reality in several countries. Alternative and psychosocial practices are being incorporated in the search for the construction of more humane and resolute therapeutic approaches. Despite this, it is observed that old and controversial therapies are still widely used, such as electroconvulsive therapy (ECT)[1].

ECT, also known as electroshock, is a psychiatric treatment in which changes are caused in the electrical activity of the brain, induced by passing an electrical current under the effect of general anesthesia, with the aim of inducing a seizure that lasts around of 30 seconds. The treatment is done in sessions and the number of applications is defined by the psychiatrist[10].

It was first performed in April 1938, in Rome, by Italian psychiatrists Ugo Cerletti and Lucio Bini. Despite its controversial image, this treatment method is used today, in such a way that when well indicated, in psychopathologies and correctly administered, it has significant results[11].

It is noteworthy that ECT applications are usually performed in the morning, with the patient fasting for at least eight hours. The treatment application team consists of a psychiatrist, an anesthesiologist, a nurse and two (two) technicians or nursing assistants[11].

Still regarding the procedure, the patient is placed in a horizontal dorsal decubitus position; the anesthesiologist administers a short-acting anesthetic and a muscle relaxant intravenously to prevent strong muscle contractions during the seizure. An airway blocker or teether is placed in the patient's mouth and the patient is positioned to make it easier for the airway to remain patent. Electrodes are placed over the temples (bilaterally or unilaterally) to apply the electrical stimulus. After the procedure, many patients wake up within 10 or 15 minutes and are often confused[11].

Furthermore, the efficacy and safety of ECT in the treatment of psychiatric diseases are evident. The technique must be administered following valid information, with the consent of a family member responsible for the patient and in accordance with the procedures for its administration. It is generally regarded as a low-risk procedure, however, in some cases it is considered high-risk, depending on the patient's clinical conditions[11-13].

Cases that are considered high risk that require additional precautions are for patients with a brain tumor or infarction, a history of myocardial infarction or cardiac arrhythmias, cardiac pacemaker, aneurysm, retinal detachment, pheochromacytoma, and lung disease. The

most common side effects of ECT are memory disorders and mental confusion[10].

In this context, Resolution of the Federal Council of Medicine (CFM) No. 1,640/2002 and 2,057/2013 recognizes the importance of this therapeutic method and regulates its application and the care that must be used during treatment. According to the resolutions, the use of ECT is a private act of the physician and must be performed exclusively in a hospital environment, with the following structure: life support and adequate anesthetic and recovery procedures in accordance with the Inspection and Inspection Manual of Medicine in Brazil[14-16].

Furthermore, the use of ECT in children (under 16 years of age) should only be done under exceptional circumstances. Regarding the assessment of the general clinical status of the patient before ECT, it is mandatory. In particular, cardiovascular, respiratory and neurological conditions must be evaluated and it is also essential to ensure that ECT is operated using modern machinery, registered and certified by Anvisa[14,15].

Therefore, it is essential to emphasize that there is a contradiction regarding the indications of ECT in the face of the prerogatives of the Ministry of Health, since, on the one hand, the current mental health policy does not indicate ECT as a form of treatment, as there is no statistically proven information on its benefits and effectiveness in all cases[17].

And on the other hand, to the detriment of the national mental health policy, Technical Note No. 11/2019, which provides for: clarifications on changes in the Mental Health Policy and in the National Policy Guidelines on Drugs Mental Health values practices such as ECT, and the hospitalization of children in psychiatric hospitals, this is a point that violates Art. 4 of Law No. 10,216[16,17].

In view of this exposition, the following questions arose: What are the ethical and legal implications of using ECT? Why is the use of ECT vehemently defended by a group of professionals and equally condemned by another group in the same specialty? How has Nursing been behaving in relation to the procedure?

To answer these and other questions, the aim of this manuscript is to discuss the ethical and legal implications of electroconvulsive therapy and the Nursing work involved.

Methodology

It is a theoretical reflection. The construction of this material took place in August 2021, from the critical conceptualization and mainly from readings of Ministerial Ordinances, Technical Reports, Resolutions of the Federal Councils of Nursing and Medicine, scientific literature published in journals with international and national arbitration indexed in the bases: VHL Regional Portal, Scientific Electronic Library Online (SciELO) and Capes Periodicals Portal (CAPES), mediated by the Health Sciences Descriptors (DeCS): “Electroconvulsive therapy”; “ECT”; “Mental Health Care”; “Systematization of Nursing Care”; "Nursing Care”.

In this way, current and classic documents were considered for the understanding and discussion of the proposed theme. Finally, the NANDA International nursing classification systems were used for the formulation of Nursing Diagnoses, in addition to the Classification of Nursing Outcomes (NOC) and Classification of Nursing Interventions (NIC).

Results and Discussion

For better visualization and understanding, the results and discussions were presented dialogically in four thematic units: 1) ethical and legal implications of carrying out ECT; 2) differences of opinion between groups that support ECT and groups that condemn it; 3) Nursing participation in the use and application of ECT and 4) contributions to nursing practice.

Ethical and legal implications of performing ECT

The legal aspects of the use of ECT are addressed by few authors, who cite only the recognition of this treatment by the CFM and take into account the importance of this therapeutic method and the care that must be used during treatment[14].

Thus, the constitutionality of invasive treatments such as electroshock is not resolved only by resorting to scientific argument; inevitably, its use is also regulated by the will of those involved. The knowledge of both the family and the user who will undergo the treatment are indispensable conditions for the ethical and legal support of the procedure and for its effectiveness[18].

However, the Ministry of Health is concerned that ECT should not be used indiscriminately as a form of treatment, even though it is recognized as a therapeutic resource for the treatment of stress and depression in extreme cases. It is related to corporal punishment and disciplinary control. It is imperative to emphasize that ECT disappeared from Europe with the end of the Second World War, but was abolished from the public mental health network in Brazil until the 1980s[1].

Currently, psychiatric associations and societies from different countries have been in favor of ECT and use it as a treatment, such as Australia, Canada, New Zealand, the United Kingdom and the United States. The concern is its use without the safety of anesthesia[10].

Currently, psychiatric associations and societies from different countries have been in favor of ECT and use it as a treatment, such as Australia, Canada, New Zealand, the United Kingdom and the United States. The concern is its use without the safety of anesthesia[19,20].

Thus, ethical aspects are generally not clearly addressed in the scientific literature. The approaches focus on indications, use of more modern equipment, performance of the procedure following the criteria of sedation and others. However, official positions that warn about the limits and restrictions on the use of ECT are not mentioned, such as, for example, the criticisms and reflections so deeply addressed by the psychiatric reform[20].

Thus, the principles of psychiatric reform add to their ideas discussions around ethics and humanization in psychiatry. Treating the disease, always considered incurable, is not the focus, taking care of people, including them in society, treating concrete subjects, real people is the

objective. Furthermore, it is essential to remember that the person's consent is essential before submitting him to any type of intervention[20,21].

Contemporaneously, the psychiatric reform emerged in the sense of questioning the asylum institution and the fragmented medical practice and of humanizing care, making an emphasis on active rehabilitation and social inclusion, to the detriment of custody and segregation[21]. In this way, new mental health care services and more integrated and individualized ways of assisting were created, in compliance with ethical principles linked to participatory care[20,21].

The wide use of psychotropic drugs in clinical practice needs to be discussed, as well as the use of ECT and other procedures without proper observance of side effects. There is a strong tendency to medicate and an expectation to receive medication. It is currently in the unconscious of people that pain, anxiety, sadness and other dysfunctions need to be medicalized, given the need for a quick response to all ailments, making the methods or forms of application of available therapies not always questioned[22,23].

Conception differences between groups that support ECT and groups that condemn it

Talking about ECT is, without a doubt, getting involved in a very controversial discussion, at least divided into two sides: defenders and opponents of something that does not simply provoke disagreement, but that separates positions at a very significant distance, enough to cause some discomfort. .

As discussed, ECT has historically been used as a method of torture, punishment, infliction of suffering, pain and punishment. Furthermore, the application was performed without anesthetics and many times at the end of the session the patient had bruises, injuries and fractures. This fact has been remarkable from a historical point of view, which leads many opponents to argue about the need for its ban[24].

In the meantime, the sentence by psychiatrist Moacyr Rosa, a researcher at Duke University, located in Durham, in the state of North Carolina, in the United States of America, illustrates the controversy surrounding ECT, stating: “It is unfair. Cardiologists are heroes when they shock the chest, and we are executioners because we shock the brain.” This speech reveals the pressure felt by psychiatrists who defend ECT and who constantly face criticism within their category and other social segments[1].

Likewise, the great opponent of ECT was the Anti-Psychiatric Movement, a product of popular philosophical ideas that had a negative view of psychiatric diseases, saying that they were nothing more than inventions, and that the practice of ECT was merely a measure of brutal punishment[25].

In this sense, there were also significant manifestos against the application of ECT, such as the “National Manifesto for the Prohibition of Experiments with Electroshock” in 2004, in which the writer Austregésilo Carrano Bueno, representative of the Users of the National Council for Psychiatric Reform at the Ministry of Health do Brasil, condemns the release of funds and the participation of people with mental disorders in research using the technique, alleging that the therapy is a form of torture[18].

Moreover, after all the evolution experienced by the technique of ECT application, this bad view in relation to the treatment has been decreasing over time, however, there can be negative outcomes, even obeying all the recommendations and protocolized care. In addition, cognitive memory disorders are the most likely to occur and are one of the biggest causes why patients themselves reject treatment[26,27].

Therefore, electroshock therapy came to be denounced by human rights supporters. The Federal Council of Psychology, on the other hand, is one of the professional councils that formally supports a position against the use of ECT in defense of Human Rights, in support of the anti-asylum struggle, the manifestations of users of the mental health system, who fight for the right to refuse to the application of ECT[1].

Furthermore, a note from the Regional Nursing Council - São Paulo section (Coren-SP), on Technical Standard No. 11/2019 of the Ministry of Health ratifies that the practice of ECT should not be deliberately encouraged, given that that its use must occur in extremely particular situations, with the consent of the family and the individual who is in psychological distress, under satisfactory and controlled technical conditions[28].

In summary, ECT when properly prescribed promotes clear efficacy, promoting the reduction of symptoms in the short term, but in some cases, they reappear over time, which leads the patient to perform treatment maintenance sessions. Although the technique has been misused for many years, this has never made the benefits obtained with the application invalid[29].

According to the American Psychiatric Association, highlights the effectiveness of ECT in patients with severe depression, suicidal ideation, catatonia, puerperal psychosis, gestational depression, neuroepileptic malignant syndrome, schizophrenia, bipolar disorder and Parkinson's disease[11].

In theory, the evidence presented is based on the rapid improvement of symptoms and especially when they do not respond to psychotropic treatment. Considering that the clinical indication is also considered relevant, because while some patients have positive answers after its application, others do not, being questions that remain unanswered, as well as there is real evidence of memory impairment in patients who over the years years underwent the use of ECT[13].

Nursing participation in the use and application of ECT

The literature brings meager care performed by nurses, which leads to the conclusion that for this reason the role of nursing in the application of this treatment is rarely reported. In any case, from the moment the technique is indicated, the nurse must provide the patient and their families with all possible information regarding the treatment, in a clear and complete way, using language accessible to the knowledge of each one and clarifying any doubts that may arise[1].

The nurse has his/her functions and responsibilities in the application of the technique, from the preparation of the patient, the family, the materials and the therapeutic environment conducive to the performance, ensuring the recommended fasting for the patient, which must be of at least 8 hours. It is necessary to guide the patient to wear the appropriate clothing, provided by the hospital, take him to the room, perform the positioning of the electrodes and observe him during the crisis, protecting him if necessary, register in the medical record, fill in the procedure file and, finally, refer you to the post-anesthetic recovery room[26].

It is extremely important that the nurse establishes a therapeutic bond with the patient and the family, providing confidence, security, fear relief and transmitting tranquility, bringing their knowledge clearly to these individuals[30].

Authors[31] conceive that the Nursing team is constantly present in the monitoring of people undergoing ECT, performing care before, during and after the aforementioned practice. In this regard, the Code of Ethics for Nursing Professionals, in its Art. 24 and 42, expresses that Nursing in all areas of its activity must be exercised with commitment and responsibility, being essential to respect the right to exercise the autonomy of the person or their legal representative in decision-making, free and informed about their health, safety, treatment, comfort and well-being[32].

In addition, according to Cofen Resolution No. 599/2018, it is up to the Nurse to perform Nursing care of greater technical complexity and that require adequate scientific knowledge and the ability to make immediate decisions. Such care includes the realization of the Nursing process through the nursing consultation in mental health, the prescription of nursing care aimed at the health of the individual in mental suffering, the use of theoretical models to support and systematize nursing care actions in mental health, among others[33,34].

Therefore, the participation of Nursing in this type of treatment is related to the support and care before and after the development of the technique, dealing directly with the patient, the family and the entire team, being its duty to welcome, guide and monitor at all stages. . Care must be guided by humanization and acts of respect, ethics, affection and attention towards the person with mental disorder.

Contributions to nursing practice

In view of the above notes, it is understood that the ECT technique, although surrounded by positive and negative aspects, which causes defenders and opponents of the realization, has still been used in Brazil, in the world and presents some favorable results[10,35,36].

As shown, nurses make up the minimum team to perform the procedure, which is responsible for developing a coherent and humanized care and, more than merely checking the efficiency and effectiveness components of the procedure, paying attention to the ethical and legal aspects of the therapy and its consequences. assignments as health professionals.

On this, a table is presented using the NANDA International nursing classification systems[37] for the formulation of Nursing Diagnoses, in addition to the Classification of Nursing Outcomes (NOC)[38] and Classification of Nursing Interventions (NIC)[39], for a coherent Nursing performance based on technical and scientific principles, related to patients with mental disorders presenting signs and symptoms/nursing problems associated with the indication of ECT, such as: sleep and wakefulness alterations, anxiety and depression crises, chronic alterations of mood, catatonia and others.

Based on the type of study presented, it is important to highlight that the proposed reflection questions remain under the results of new evidence, seeking more specifics regarding the promotion of mental health and the applicability of treatments to people with mental disorders, not only involved in ECT but also in a safe, effective and resolute way.

Chart 1. Presentation of Nursing Diagnoses, Expected Results and Nursing Interventions in patients with mental disorders with an indication for performing the ECT procedure. Goiania, GO, Brazil, 2021

NURSING DIAGNOSIS	EXPECTED RESULTS	NURSING INTERVENTIONS
Risk-prone health behavior related to low self-efficacy and inadequate understanding, evidenced by failure to achieve an optimal sense of control	Knowledge: Health Behavior	- Review the health history and previous documents regarding evidence of previous medical and nursing diagnoses and treatments; - Review data derived from routine measures for risk assessment; - Identify available resources to help reduce risk factors; - Identify biological, behavioral and environmental risks and their interrelationships; - Identify typical strategies to deal with problems; - Determine previous and current operating level.
Ineffective health control related to difficulty moving through complex health care systems and perceived susceptibility, evidenced by failure to act to reduce risk factors	Health Promotion Behavior	- Explore the individual's perception of their ability to perform the desired behavior; - Identify the individual's perception of the risks involved in not performing the desired behavior; - Provide information about the desired behavior; - Assist the individual to commit to an action plan to change behavior; - Use role-playing technique to train behavior.
Sleep deprivation related to non-restorative sleep pattern, evidenced by decreased functional capacity, confusion, and irritability	Sleep improvement	- Make an approximation of the patient's sleep/wake cycle in care planning; - Determine the effects of the patient's medications on the sleep pattern; - Monitor participation in fatigue-generating activities during wakefulness, to prevent excessive tiredness; - Adjust the environment to promote sleep; - Assist in eliminating stressful situations before bedtime.

Wandering related to overly stimulating environment, evidenced by pacing and long periods of locomotion with no apparent destination	Agitation Level: stability	- Include family members in planning, performing and evaluating care, as desired; - Identify habitual patterns of wandering behavior; - Provide the patient with an alert necklace or bracelet; - Provide an environment with little stimulation; - Monitor interactions, side effects and therapeutic effects of drugs and procedures.
Stressor-related self-neglect, poor executive function, and inability to maintain control, evidenced by lack of adherence to health activity and insufficient personal hygiene	Cessation of Negligence	- Monitor the patient's capacity for independent self-care; - Monitor the patient's need for adapter devices for personal hygiene, dressing, grooming, intimate hygiene and eating; - Encourage the patient to perform normal activities of daily living according to their level of ability; - Teach parents/relatives to encourage independence, interfering only when the patient cannot; - Establish a routine of self-care activities.
Acute confusion related to altered sleep-wake cycle and sensory deprivation, as evidenced by agitation, altered cognitive, psychomotor, and consciousness functions, inability to initiate goal-directed behavior, and misperceptions	Cognitive Guidance	- Include family members in the planning, delivery and evaluation of care, as appropriate; - Check the patient's physical, social and psychological history, customary habits and routines; - Monitor cognitive functioning, using standardized assessment tools; - Determine behavioral expectations appropriate to the patient's cognitive state; - Identify and eliminate potential risks for the patient in the environment.
Ineffective impulse control related to mood disorder, evidenced violent behavior, temper outbursts, and irritability	Self-restraint from Impulsive Behavior	- Choose a problem-solving strategy appropriate for the patient's level of development and cognitive functioning; - Assist the patient to identify the problem or situation that requires thoughtful action; - Encourage the patient to reward himself for good results; - Provide models that demonstrate the steps of the problem-solving strategy in the context of situations that are meaningful to the patient; - Encourage the patient to practice problem solving in social and interpersonal situations outside the therapeutic environment, followed by outcome evaluation.
Labile emotional control related to insufficient knowledge about the control of symptoms, stressors, fatigue and emotional disorder, evidenced by uncontrollable crying, expressions of emotions incongruent with the triggering factor and uncontrollable laughter	Adaptation to Change	- Discuss the emotional experience(s) with the patient; - Help the patient to recognize their feelings, such as anxiety, anger or sadness; - Identify what role anger, frustration and fury play for the patient; - Encouraging the patient to talk or cry to lessen the emotional response; - Stay with the patient and provide assurance of safety and protection during periods of anxiety.
Impaired mood regulation related to anxiety and impaired social function, evidenced by impaired concentration, hopelessness, dysphoria, detachment, and irritability	Mood Balance	- Assess mood initially and on a basis regular as treatment progresses; - Determining whether the patient presents a safety risk to himself or to others; - Consider the hospitalization of the patient with a mood disorder that represents a safety risk; - Monitor the capacity for self-care; - Teach decision-making skills to the patient when needed.
Risk of violence directed towards others related to impulsivity, pattern of violent antisocial behavior and pattern of violence directed towards others	Self-restraint of Aggression	- Assign a single room to a patient with potential for violence towards others; - Removing other individuals from the proximity of a violent or potentially violent patient; - Place the patient in a room located next to the ward for constant surveillance; - Guide the family on the importance of constant surveillance; - Provide paper plates and plastic cutlery at meals.
Risk of self-directed violence related to conflict in interpersonal relationship(s), social isolation, and insufficient personal resources	Anger self-restraint	- Remove potential weapons from the environment and guide the family to do the same; - Monitor the safety of items brought by visitors to the environment; - Allocate the patient who has the potential for self-harm with a roommate, to decrease isolation and the opportunity to act on self-destructive thoughts, when appropriate; - Limit access to windows, unless they are locked and shatterproof, as appropriate; - Provide ongoing surveillance in all patient access areas to maintain patient safety and intervene therapeutically as needed.

Conclusion

The reflective one showed that ECT is accepted as a form of treatment by both the Federal Councils of Nursing and Medicine in Brazil and by the World Associations that concern mental health and psychiatry, however, it is quite controversial and today of restrictive use in psychiatric clinics. , not used in substitutive mental health services.

Above all, it is essential to emphasize that the technique is among the typical means of intervention of the Hospitalocentric Medicalizing Psychiatric Paradigm, not only because it is a restricted technique of psychiatry, but above all because it takes psychic suffering as a neurochemical dysfunction, therefore alien to its sociocultural determinations are subjective.

It is also because of the fact that it was used in the past as a form of punishment, so there is a stigma of its use that still predominates in society in general. Therefore,

unfavorable criticisms are constantly presented by the media, which reinforces the fear about its applicability.

With regard to Brazil, publications are still incipient and discussions are predominant regarding the indication of treatment, description of the procedure technique and the benefits resulting from the reduction of symptoms presented by mental disorders. Regarding to nursing, the literature brings meager care performed by nurses, which leads to the conclusion that for this reason the role of nursing in the application of this treatment is little reported, but the nursing work process brings us a systematization of care in a holistic and instrumented, providing quality patient care.

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