# MENTAL HEALTH TREATMENT ACCORDING TO THE ASYLUM MODEL (1960 TO 2000): NURSING PROFESSIONALS' STATEMENTS

*Andréa Noeremberg Guimarães[1], Letícia de Oliveira Borba[2], Liliana Muller Larocca[3], Mariluci Alves Maftum[4]*

[1] M.Sc. in Nursing. Assistant Professor, Nursing Department, Santa Catarina State University. Santa Catarina, Brazil. Email: deia_ng@yahoo.com.br
[2] Ph.D. in Nursing, Post-Graduate Nursing Program (PPGEnf), Federal University of Paraná (UFPR). Nurse at Clinics Hospital, UFPR. Paraná, Brazil. Email: leticia_ufpr@yahoo.com.br
[3] Ph.D. in Nursing. Honorary Professor, Nursing Department (DEnf) and PPGEnf/UFPR. Paraná, Brasil. Email: liliana@ufpr.br
[4] Ph.D. in Nursing. Assistant Professor, DEnf/UFPR. Paraná , Brazil. Email: maftum@ufpr.br

**ABSTRACT:** Thematic oral stories developed from 2010 to 2011. The purpose was to describe the nursing professionals' experience in the treatment of patients with mental disorders according to the asylum model (1960-2000). The data were collected through semi-structured interviews, carried out by two baccalaureate nurses and four nursing assistants in a psychiatric hospital in the state of Parana. Data were analyzed and presented in categories in accordance with the proposal of thematic analysis. The staff reported the following types of treatment delivered to patients with mental disorders: drug therapy, cardiazol shock, insulin therapy, electroconvulsive therapy – seen as an important resource to control agitation – use of cubicles and strong cells as common practices in psychiatric wards, and praxis physical therapy as occupation. They also made reference to bed sheet restraint, straightjackets and bed restraint using cotton bandages. Although many of these treatments are now discontinued and criticized, they were available and used during the studied period.

**DESCRIPTORS:** Nursing. Psychiatric nursing. Mental health. Treatment. Nursing history.

# TRATAMENTO EM SAÚDE MENTAL NO MODELO MANICOMIAL (1960 A 2000): HISTÓRIAS NARRADAS POR PROFISSIONAIS DE ENFERMAGEM

**RESUMO:** História oral temática, desenvolvida de 2010 a 2011. Objetivou descrever a vivência de profissionais de enfermagem no tratamento ao portador de transtorno mental no modelo manicomial (1960-2000). Os dados foram coletados mediante entrevista semiestruturada realizada com dois enfermeiros e quatro auxiliares de enfermagem, num hospital psiquiátrico do Paraná. Os dados foram analisados e apresentados em categorias de acordo com a proposta de análise temática. Os colaboradores relataram como tratamentos dispensados ao portador de transtorno mental, terapia medicamentosa, choque cardiazólico, insulinoterapia, eletroconvulsoterapia, entendida como importante recurso para controle da agitação, uso de cubículos e celas fortes como prática comum nos hospitais psiquiátricos, praxiterapia como ocupação. Discorreram ainda, sobre lençol de contenção, camisa de força, e contenção no leito por faixas de tecido de algodão. Embora muitos destes tratamentos estejam em desuso e sejam criticados, eram os disponíveis e utilizados no período estudado.

**DESCRITORES:** Enfermagem. Enfermagem psiquiátrica. Saúde mental. Tratamento. História da enfermagem.

# TRATAMIENTO EN SALUD MENTAL EN EL MODELO DE MANICOMIO (1960 A 2000): HISTÓRIAS NARRADAS POR PROFESIONALES DE ENFERMERÍA

**RESUMEN**: Historia oral temática desarrollada de 2010 a 2011. El objetivo fue describir la vivencia de profesionales de enfermería en el tratamiento al portador de trastorno mental en el modelo de manicomio (1960-2000). Los datos fueron colectados mediante entrevista semi estructurada realizada con dos enfermeros y cuatro auxiliares de enfermería, en un hospital psiquiátrico del Paraná. Los datos fueron analizados y presentados en categorías de acuerdo con la propuesta de análisis temática. Los colaboradores relataron como tratamientos dados al portador de transtorno mental, terapia medicamentosa, choque cardiozólico, insulinoterapia, electroconvulsoterapia, entendida como un recurso importante para el control de la agitación, uso de cubículos y celas fuertes como práctica común en los hospitales psiquiátricos, praxiterapia como ocupación. También discutieron sobre sábana de contención, camisa de fuerza, y contención en el lecho con fajas de algodón. Aunque muchos de estos tratamientos estén fuera de uso y sean criticados, eran los que estaban disponibles y eran utilizados en el periodo estudiado.

**DESCRIPTORES**: Enfermería. Enfermería psiquiátrica. Salud mental. Tratamiento. Historia de la enfermería.

## INTRODUCTION

Through Decree number 82/1841, the Mental Hospital *Dom Pedro II* was founded and opened in Rio de Janeiro in 1852, and later renamed National Mental Hospital for Mentally Disturbed People. Brazil was then the first country in Latin America to open a large mental hospital based on the French alienism, which maintained the asylum tradition to treat people with all types of mental problems, who were managed under all sorts of interventions and arbitrary actions.[1-3]

After that event, many asylums and psychiatric hospitals were built in the country. Therefore, psychiatric care has been linked to restricted treatment inside large psychiatric hospitals over the years, with long hospitalizations and maintenance of the separation of patients with mental disorders from the family and social contexts. The focus of care was not the patient, but the disease. People with mental disorders were marginalized, their autonomy was taken away, and they were not seen as active individuals in their treatment.[4]

Psychiatric hospitals had the responsibility to eliminate the symptoms of the mental disorder. For the treatment, resources were used and ranged from hospitalization to hydrotherapy treatment and excessive administration of medication, even including the application of electric stimulus or the use of surgical procedures. The objective of these psychiatric institutions was to use resources to correct what was seen as "abnormality". [5]

It was inside a psychiatric hospital that the Brazilian professional nursing activity emerged. Its origin was not aimed at improving care to patients, but to watch, control and punish them for their actions. There were no social exchanges between staff and patients, such as communication, affection and support,[6] the patients with mental disorders did not use to receive fair treatment, were often violently treated and, due to not being stimulated, their potentialities were reduced until they became unable to return to social life.[4]

It should be considered that, approximately since 1978, the model of mental healthcare in Brazil has been undergoing a redirection based on the Psychiatric Reform, which recommends the creation of new community treatment resources, such as Psychosocial Care Centers and changes in treatment and in the manner of understanding and dealing with people with mental disorder. To avoid repeating the practices adopted in the past due to lack of knowledge in times of care restructuring in this field, however, it is necessary to keep records of such practices through memories.

The timeframe of 1960-2000 used for this research is justified by the possibility of finding nursing professionals who had experienced their professional practice prior to 2001, when a legal framework for the restructuring of psychiatric care in the country was effectively established. Thus, this research was aimed at: describing the nursing professionals' experience in the treatment of patients with mental disorders according to the asylum model (1960-2000).

## METHOD

This is a qualitative research with a thematic oral story approach, developed from February 2010 to March 2011 in a psychiatric hospital in the state of Paraná with the participation of six staff members (two baccalaureate nurses and four nursing assistants).

Concerning the number of staff interviewed, the oral stories were usually explored in a reduced sense, due to the difficulties to work with large amounts of material.[7] Therefore, due to the quantity of material resulting from the statements, the option to interview six staff members was chosen.

The inclusion criteria were: to be over eighteen years of age and to have developed their professional practice in psychiatric institution during the period from 1960 to 2000.

Data were collected through semi-structured interviews, which were recorded and transcribed, based on the following question: please report the treatment methods applied to patients with mental disorders that you have experienced in nursing practice prior to the changes resulting from the psychiatric reform.

The research received approval from the Research Ethics Committee of the Department of Health Sciences at Federal University of Paraná (CAAE 4187.0.000.091-09), in compliance with National Health Council Resolution number 196/96.[8]

The statements were analyzed and presented in categories, in accordance with the thematic analysis proposal,[9] which includes the organization, classification and final analysis of data stages.

The data organization stage included the transcription of audiotapes, rereading of material, organization of statements and observation data. Thus, the transposition from oral to written statements was carried out in this stage and involved

three stages: transcription, textualization and transcreation.[7]

In the classification stage, exhaustive reading of the original texts was undertaken, resulting from the transcreation of interviews, which permitted retaining the relevance of the statements and the core ideas and organizing them into thematic categories.

In the final analysis stage, the data were organized into eight thematic categories according to the experience with the treatment methods reported by the staff: drug therapy, cardiazol shock, insulin therapy (insulin shock), electroconvulsive therapy, use of cubicles or strong cells, praxis physical therapy, bed sheet restraint, straightjackets and bed restraint using cotton bandages.

## RESULTS AND DISCUSSION

The staff reported having experienced several treatment methods applied to patients with mental disorders, and parts of their statements, in conjunction with relevant literature, are described below.

### Drug therapy

The statements showed that, until 1960, there were few drugs for psychiatric treatment and those available had insufficient action power to minimize the symptoms caused by the mental disorder. In order to reduce patients' agitation, excessive drugs were used, often associated to other types of treatment.

*There was little medication, almost none, and the existing ones were weak. We used Haldol 1mg and Amplictil 25mg; the newest drugs came later, such as Neozine and Amplictil 100mg. For cases when patients were too agitated, we also used Sonifen. We injected 1ml in the vein and, five minutes later, the person was sleeping. Then, Amplictil in conjunction with Phenergan started being used. The dosage of each medication was prescribed according to patients' agitation; when patients were too agitated and aggressive, three Amplictil and one Phenergan were prescribed* (C6).

Psychopharmacology started in 1952, when French researchers Jean Delay and Pierre G. Deniker successfully treated people with mental disorders using a new substance, chlorpromazine. They found that it reduced psychomotor agitation, hallucinations and delusions. This action was called neurolepsy and the new drugs with this use were called neuroleptics.[10]

Therefore, as from 1952, psychopharmacologic substances such as chlorpromazine (Amplictil®), levomepromazine (Neozine®) e haloperidol (Haldol®) started being widely used in the treatment of patients with mental disorders as a supporting therapy.[11] With the appearance and later increase in the quantity and quality of psychopharmacologic substances, there was a reduction in the onset of mental disorder symptoms.

The importance of drug therapy use in the treatment of mental disorder patients has been recognized; however, with the current psychosocial model, unlike the asylum model, emphasis is put on rational drug use in conjunction with other therapeutic approaches, such as consultations, therapeutic workshops, socio-therapy activities, operative groups, psychotherapy and other community activities, aimed at the social reintegration of patients with mental disorders.[12-13]

### Cardiazol shock

The staff member C6 reported to have experienced the use of cardiazol medication in the treatment of patients with mental disorders until the late 1960s; he reported how nursing professionals acted in this treatment method and expressed his position in relation to positive results of this practice in the reduction of agitation in some patients, as opposed to the oral drugs available at the time.

*We used it in very chronic patients, the effect was almost the same as the electroshock. Cardiazol was a drug that came in a 1ml ampoule. The doctors gave the prescription, we performed the preparation procedures before administration to patients, like with electroshock. Cardiazol was intravenously administered quickly and patients then had convulsions. This therapy had good results. It was very good in case of very agitated patients, because the oral medication did not have any effects* (C6).

Convulsive therapies to treat people with severe mental disorders date back to the sixteenth century, when the Swiss physician Paracelsus reported orally administering camphor to induce convulsions and treat madness. This information was largely forgotten until 1934, when the Hungarian neuro-psychiatrist Ladislas von Meduna started his work with convulsive therapy,[14] initially developing convulsive treatment induced with intramuscular camphor and later with intravenous cardiazol.[15]

The convulsions caused by cardiazol occurred quickly and violently and were hard to control. At times, they were so severe that they caused

spinal fracture in patients. With the discovery of other methods to treat people with mental disorders, such as neuroleptics and electroconvulsive therapy, cardiazol was gradually discontinued in the late 1940s and no longer used. Today, its importance is only historical.[15]

## Insulin therapy (Insulin shock)

Two staff members reported on the use of insulin therapy. However, only staff member C6 experienced it and thoroughly explained the nursing activity concerning the use of this technique which, according to his statement, was used until the early 1970s.

*We administered 10 units of subcutaneous insulin at five o´clock in the morning and added 10 units every day until patients went into a pre-coma. On the day following the pre-coma, we added 10 more units of insulin and patients went into a coma. Thereafter, the dosage was always the same, if patients went into a coma, for example, with 100 units of insulin, then they would always take this dosage until the end of the treatment. If the doctor had prescribed 30 comas, we noted the day they made their first coma, counted 30 comas and ended the treatment. It was common for doctors to prescribe 30 insulin comas and the electroshock in coma. As soon as patients went into a coma, we injected 20ml of intravenous glucose, and they started waking up. Then, we got them up and told them to drink a solution of water and sugar, which already was prepared. Patients were generally sweating. They were directed to shower, washed themselves, changed their clothes, had a very sweet coffee, ate two to three bread rolls. After that, they sat in the courtyard and walked a little* (C6).

The insulin shock therapy was discovered by the Polish neuro-psychiatrist Manfred Sakel and officially reported in 1933. The introduction to insulin therapy in psychiatry occurred when Sakel caused convulsions with an overdose of insulin and accidentally discovered that this treatment was effective for patients with psychoses, such as schizophrenia.[15]

It consisted in the use of increasingly higher dosages of intramuscular insulin until patients went into coma. At first, this condition was reverted with glucose after 15 minutes, but attempts were made to increase subsequent comas to up to one hour. At times, there was the need for more than 60 applications in order to see the results.[14]

In accordance with Sakel findings, more than 70% of his patients improved after undergoing insulin shock therapy. The disuse of this treatment increased when emerging researches showed that the real cure was not achieved and that the improvement was, most of the times, temporary.[15]

## Electroconvulsive therapy (ECT)

The staff members' reports showed that ECT was widely used in psychiatric hospitals until the mid-1970s. This treatment was seen as an important procedure at the time, because it was one of the few resources that contributed to reduce agitation and psychotic symptoms. ECT, however, caused fear and a traumatizing experience for patients, and even for those who applied it. In addition, some nursing workers used it as a punitive and coercive instrument.

*It was a device in which we put a heavy electrical load and wetted two little dolls with water and salt so that they acted as transmitters of electricity. We tied patients to a bed, we put a rubber inside their mouth to prevent them from biting their tongues, we gathered two or three people to stop patients moving and hurting themselves. The two dolls were placed to touch patients' foreheads at the same time, one on each side, we pushed a button and patients started immediately convulsing. The people who usually participated in the application of electroshock were the doctor and the nursing team. It was a bad experience for patients, it was not comfortable. So much that, in the second or third application, we had to grab patients and force the administration. There were times when the staff used that as punishment, if patients were disruptive they were given a shock. Electroshock was not only a treatment, it was a punishment as well. In some cases, electroshock helped a little, stopped patients' delirium, reduced agitation, some people improved with it. But for others, this treatment did not work. I believe that this made patients chronic, causing other implications, took away their ability to react. Eight years ago, there was a doctor who was transferred here, he tried to bring back electroshock treatment but this was not accepted by the team* (C1).

ECT, initially called Electroshock Therapy, was first used in Rome in 1938 by Ugo Cerletti and Lucio Bini.[14] Despite this method having been widely used since its appearance, its popularity declined in the 60s and 70s. This may be associated with the appearance of more effective psychotropic drugs and the increasing movement against this procedure caused by its wrong use to punish, control or threaten patients.[5]

Despite the decline in the use of ECT during the last fifteen years, this practice has regained the

spotlight.[5] This treatment is considered effective for some people suffering from severe mental disorders, such as major depressive disorders, catatonia, mania and some cases of schizophrenia. Currently, some psychiatric associations have positioned themselves in favor of ECT, and several countries have included it as an elective treatment for mental disorders. In Brazil, the Federal Medicine Council (CFM) regulated this method through Resolution number 1640/2002.[17]

When performed, ECT should occur in a hospital, under anesthesia, after assessing of the patient's medical condition. Before performing the procedure, the agreement of patients or people responsible, when they do not have mental conditions and/or minimum age for this, must be obtained. But when it is not possible to obtain such document, doctors can apply the treatment, provided that they take responsibility for the action.[17] It is important to note, however, that there is not a standard procedure concerning the number of ECT applications. Thus, the maintenance of this therapy depends on patients' assessment after each session.[18]

In a study undertaken at the Institute of Psychiatry of Federal University of Rio de Janeiro, the data of 69 medical records about the use of ECT from 2005 to 2007 were compared with previously developed research and investigations concerning this topic in other countries. The results showed that all applications performed in the institution were in accordance with valid criteria and that, although the use of ECT is controversial, it is a good method for the reduction of severe symptoms. In this study, the authors also stressed the importance of studies focused on determining the standard number of applications necessary for a good response of patients undergoing this treatment.[18]

## Cubicle or strong cell

Staff reported the existence of strong cells, which consisted of small individual rooms, closed with doors of reinforced material, containing one or two openings at the top in order for the professionals to see the patients inside the cubicle and at the bottom to hand over the meals. In all of these restricted spaces, there was a place for people to make their physiological needs and lie down.

People were taken to the cubicles when they were too agitated or aggressive. However, these spaces were also used by some of the staff as punishment for patients. There was no time limit established for the reclusion, it could be from 2 to 3 hours, or even several days. Based on the statement of staff member C3, these cubicles were shut down in the hospital where this study took place at the end of the 1980s.

*There were the cubicles where patients were thrown in. It was a cell. When patients got agitated, they were put in this place, they went to cubicles for every little thing. There was only one patent and a grass mat on the floor in there, if anything. It was dark, there was a little window on top. Food was thrown in through a small door* (C3).

*The cubicles were closed rooms, of about 3 square meters, with an opening at the bottom of the door to be given food and one on top to allow us to see the patients, they had a toilette of those on the floor and a mattress. In order to inject the medication, there was the need for more than one nursing assistant to go in and hold the patients. For the shower, patients were taken out of there and then the nurses would put them back in there. The doors were very strong so they could not break them. It seemed like a solitary. Very agitated patients who abused other patients or staff members were put in there. It was not punishment, it was isolation because they could not be left in the unit. They generally did not want to go there, they were scared, nobody wants to be enclosed, they were forced. There, they were isolated for seven days, sometimes longer. The intention was that they thought about it, that they calmed down* (C4).

In a research undertaken in Paraná, involving families experiencing the treatment of people with mental disorders, a person expressed the experience of being isolated in a cubicle after disagreement with another patient. He mentioned that, during the reclusion period, it was not possible to eat or ingest liquids. People lost track of space and time and, when removed from that place, they were confused and disorientated.[19]

MS Decree number 224/1992, with a view to ensuring care humanization and preservation of the citizenship of people with mental disorders in psychiatric hospitals, banned the use of strong cells, among other determinations.[12-13] GM Decree number 251/2002 maintains the ban of these restrictive spaces,[12] a practice which causes exclusion and suffering to hospitalized patients.

## Praxis physical therapy

Another treatment modality reported by the staff was praxis physical therapy, in which patients performed work tasks, such as gardening and the

creation of chicken and pork, under the guidance of the staff. This practice allowed patients to have an occupation, with therapeutic action. However, this was widely used as a form of labor exploitation until the 1980s.

*The vegetable garden was concluded around the year 2000, but at that time it was reduced and its operation was different. When it was really active in the 1980s, it was huge. Patients were taken to the vegetable garden and there they moaned the lawn, planted, watered, harvested. I thought that was good because it was a way for them to get occupied but, on the other hand, I think that it was too much effort for them, because people who ran those activities often took advantage of them.* [Name of staff member] *who has already retired, physically abused patients, whipped them. He really made patients work* (C4).

Praxis physical therapy consisted of the therapeutic use of labor. In Brazil, it was regulated in 1890 through Decree number 206-A, which approved the instructions for medical legal care to mentally disturbed people. It can be noted that this resource was aimed at the "mentally disturbed indigent", who were able to work in agriculture and industries in the colonies. These places were created primarily to solve the overcrowding problems of poor and homeless people at the National Mental Hospital for Mentally Disturbed People. However, there was also interest in providing therapeutic treatment based on work, mainly in activities like agriculture, livestock and handicraft.[2]

Also, inside asylum institutions, there were a number of people with conditions to perform activities who did not have any occupation. Therefore, in 1903, Hermann Simon used patients' workforce to build a hospital and recorded the improvement this activity caused on the patients, thus introducing occupational therapy.[20]

The use of labor activities as a form of therapy was one of the most important applications of moral treatment. A large number of psychiatric institutions of the colony type for mentally disturbed people originated everywhere in Brazil. The idea was that people with mental disorders could work in these places, mainly in farming, as work would make them recover.[21]

In a study about the therapies used in a psychiatric hospital in Santa Catarina between 1941 and 1961, praxis physical therapy was also mentioned. It was a resource aimed at filling the entire time of patients with mental disorders. Work was viewed as away to internalize the attention to people, the coordination of their actions, the submission, among other qualities. Patients performed activities that were allowed, considering both their hazard level and individual abilities in relation to various areas of the institution, such as sawmill, pottery, carpentry, swine, farming, weeding, laundry, sewing, cooking and cleaning.[22]

Despite the positive aspects of praxis physical therapy, the statement of staff member C4 showed the poor use of this technique until 1980s. This was a condition imposed on patients, aimed at productivity. People even got whipped like slaves. If, on the one hand, this practice appeared to have therapeutic action based on occupation and contact with nature, like other therapies mentioned herein or in other researches, it brought more iatrogenic results than cure and rehabilitation, due to its misuse by nursing professionals, doctors and hospital owners.

## Bed sheet restraint and straightjackets

Staff reported the use of bed sheet restraint, also known as alligator, until 1990. When explaining about this technique, they simultaneously gave information about straightjackets. For them, the positive aspect about the bed sheet restraint was that it was quickly placed; however, it used to hurt patients. The straightjacket or vest caused great risk of patients' falling down. These techniques were adopted or had their use intensified after the banning of cubicles.

*The vest was placed on patients who hurt themselves, they only had their arms tied up, they could walk, but there was the danger of falling down, nurses needed to pay attention to this. Now, the bed sheet restraint tied the people to beds. Patients were placed lying down, we put on them a canvas with leather sleeves and buckle straps that tied up their legs and arms to the bed. We used to put there a protection not to crush the limbs. People could not be restricted like this for too long so that it did not hurt them and, as soon as the doctor sedated them, the bed sheet restraint was removed. When patients could not sleep, even after taking medication, we talked to them, if they were calm we took the restraint off. But I remember there were several occasions when we unrestrained people and immediately had to restrain them again. As soon as we unrestrained them, they abused us* (C6).

The straightjacket or vest was introduced by Pinel in the nineteenth century, and it replaced the chains, handcuffs and strong cells used in asylums. This resource was considered a less painful form of physical restraint, more temporary and less

restraining than other resources used at the time.[23]

For over 50 years, the straightjacket was used in psychiatric treatment. It was widely used in Brazil. It was made of resistant canvas fabric, had very long and closed sleeves to be tied up at the back. Patients were kept tied up, restrained and harmless.[10] Due to restraining only the upper limbs, the straightjacket allowed people not to be restrained to the bed, but it increased the risk of falls and injuries, especially on the face, since it affected balance and reduced the chances of patients using their arms for protection when falling down.[24-25]

These notes are consistent with the staff members' statements and can also be seen in the results of a research involving nursing professionals in a psychiatric hospital, which focused on physical restraint. The participants mentioned that, when the straightjacket was used, patients usually fell over and hurt themselves, and sometimes it was necessary to have stitches. They emphasized that this type of restraint did not completely avoid people from abusing others, since they could use their lower limbs, which were not restrained.[24-25]

The bed sheet restraint was made of a thick canvas and leather straps; therefore, it provided unpleasant contact to the people restrained and sent a message of fear and aggression, revealed by the nick name "harness" given by patients. In the research mentioned above, the participants made comments that are consistent with what was expressed by the participants in the present study. They stated that the bed sheet restraint had a very rudimentary physical structure, was very heavy for patients, was uncomfortable and often caused them injuries. Despite the above, this type of restraint was an easy and good technique because, according to the participants, it was quickly placed on patients.[24-25]

## Bed restraint using cotton bandages

Physical restraint to bed using cotton bandages was another technique mentioned by the staff, which is still used nowadays. However, due to the changes caused by the psychiatric reforms, they explained that this is not used as a first choice. It is applied to protect patients, other people and for the restrained patients to have time to think about their actions. This procedure is used under medical instruction. Some care actions performed during physical restraint were reported by the staff, such as the correct performance of the technique, the constant monitoring of the person being restrained, the verification of vital signs and circulatory conditions and the assessment of nursing supervision.

*Currently, physical restraint is performed with the use of bandages to preserve physical integrity of patients, for protection of other people and also in cases when patients are too anxious, cannot stop and have time for themselves. All restraints are performed under medical prescription. In situations of aggression, when patients are agitated, hitting, breaking, nurses perform the technique, but the doctor is immediately informed to give the prescription. Then, nursing supervisors go there, check all care provided, how patients' circulation is, their general conditions. The restraint time is of three hours at most. But there are patients who are sometimes very agitated and this period may be extended with constant monitoring and follow-ups* (C2).

*The restraint has to be therapeutic. Some of the care is important, as restraining patients as close as possible to the nursing station, not leaving them alone, constantly watch them, verifying their vital signs, checking if they are well, if it is working and if they continue to be too agitated, calling a doctor to check if there is the need for medications; not giving them liquids or food and stopping other patients from doing so* (C1).

As a therapeutic measure, physical restraint to bed using cotton bandages should only be performed as a last resource, after all other attempts to calm patients down using verbal approaches have been exhausted.[26] This practice involves the use of mechanical or manual resources to limit patients' movements, in order to protect them against themselves or other people.[14]

Such situation requires discussion and regulation of this issue by the professional category, besides being therapeutically performed and not negligently or as a form of punishment for people going through a moment of pain, therefore weakened by their conditions.

A study[25] aimed at investigating the ways in which physical restraint occurs has revealed that the participants mentioned the use of this resource as a therapeutic measure, which should be used in cases of psychomotor agitation, aggression and when there is the need to establish limits. In their view, the use of physical restraint to bed using cotton bandages has, most of the times, positive results, such as reduced anxiety and release of anger. Furthermore, there were reports showing that, in some situations, this technique leads to exemption from medication use and allows time for the people restrained to rethink their actions,

their lives and even express feelings that had not been previously mentioned.

Another concerning situation is the use of appropriate bandages for restraint and the nursing care provided, such as the continuous monitoring of the restrained people, their comfort, protection, assessment of medical and obstetric comorbidities, control of vital signs, blood perfusion and nursing evaluation.[25]

## CONCLUSIONS

The staff members' statements served to retrieve information about the care provided to people with mental disorders in psychiatric hospitals during the studied time period (1960 to 2000). This history helps to understand the present, arouses the discussion about mental health, its participants and scenario, the influencing factors over time and their impact and implications to society.

The reports expressed in this study showed that the treatments used in institutions where the staff worked are consistent with those used in psychiatric hospitals of major Brazilian centers. The biological therapies mentioned were: psychopharmacological therapy, cardiazol shock, insulin therapy and electroconvulsive therapy. Of these, the cardiazol shock and the insulin therapy are no longer used, and the electroconvulsive therapy is used in some research and treatment centers for mental disorders. The therapies based on the moral ideology, such as labor activities, and physical restraint therapies such as strong cells, bed sheet restraint, straightjackets and bed restraint using cotton bandages were mentioned by the staff, being that the use of strong cells is forbidden under federal laws.

It is important to emphasize that some types of treatments, which are now considered incipient and in disuse, were the ones available during the studied time period, from 1960 to 2000; however, despite having been created for therapeutic purposes, they were, at times, used in a ruthless and coercive way.

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Correspondence: Mariluci Alves Maftum
Avenida Pref. Lothario Meissner, 632, 3º andar
80210-170 − Jardim Botânico, Curitiba, PR, Brasil.
Email: maftum@ufpr.br

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