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Research Article

Autonomy of Individuals with Alcohol-Related Disorders: Informed Consent and Empowerment

João Paulo Barbosa Azevedo*

Mental health professional, PhD student in Bioethics, Matosinhos, Porto, Portugal

Abstract

Informed consent is a central concern in the care practice of individuals with alcohol- related disorders, with research and clinical practice indicating that they often refuse or abandon treatment early. In the relational care encounter it is important not only to recognize the patient as the subject of will and decision-making power, but also to pay attention to the experiences of vulnerability and the importance of promoting autonomy. These issues are particularly relevant when individuals with alcohol-use disorders come to treatment suffering from coercion or disturbed by anxiety and/or depression. A study on informed consent ethical practice was conducted on a sample of 85 professionals from the Addictive Behaviours and Dependencies network of the Regional Health Administration of the North, Portugal. A questionnaire was used to survey ethical attitudes. The results suggest the importance of reinforcing the practice of informed consent of individuals with alcohol-related disorders suffering from coercion, anxiety or depression as a place of a psychological empowerment process.

Keywords: Alcohol-related disorders; Bioethics; Informed consent; Professionals

Introduction

The clinical and social complications of harmful use of alcohol are well known and are a globally recognised public health problem [1]. The recent pandemic of COVID19 and measures to restrict individual autonomy to contain transmission of the virus have had a significant impact on alcohol drinking patterns and led to an increase in the prevalence of alcohol use disorders (alcohol abuse/dependence) and alcohol-related harms [2]. It has been a political and ethical concern of different countries to increase the involvement of people with alcohol-related disorders in treatment that can help them resolve their dependence and address the physical, mental and social consequences attributable to alcohol consumption [2].

In the context of specialised clinical care for alcohol-related disorders, treatment generally consists of pharmacological intervention in addition to psychotherapeutic support for recovery and quality of life and involves participation in a process of continuous care [3-5]. However, research and clinical evidence show that refusal of treatment and early withdrawal from treatment are not uncommon among individuals with alcohol-related disorders [6-8]. Individuals with alcohol-related disorders are heterogeneous in many ways and differences between patients may be as important as their characteristics when seeking to obtain and ensure participation in treatment [6,7,9-12]. A consistent line of research has emphasised the centrality of the experience of personal autonomy to consent to and engage in treatment [13-15], but does not focus on Informed Consent (IC) as an expression of personal autonomy that supports an individual's intention to adopt health interventions that encourage healthy choices.

IC, as a way to obtain and ensure participation in treatment, is an integral part of the therapeutic approach in alcohol-related disorders [16]. Except for severe psychiatric, neurological or cognitive conditions, individuals with alcohol abuse/dependence are considered competent in the decision making sphere [17], but it is recognised that there is a impaired autonomy related to deficits in self integration and in ability to implement the decision made [18,19]. The issues of autonomy and its immanence for the IC of individuals with alcohol- related disorders constitute an ethical challenge as to what it means to respect autonomy and the different ways to approach this autonomy in clinical practice. In mainstream bioethics, respecting autonomy by ensuring that the conditions for informed consent are met makes patients less vulnerable to the decisions of health care providers by suppressing undue paternalismo [20]. Still, even in competent patients, issues regarding vulnerability and power asymmetry in clinical relationship often arise [21,22] which appeal to the responsibility of professionals in the promotion of health and the qualification of the care provided. The ethical foundation of care considers the relationships established in the clinical context and the dynamics of the interaction between the patient and the health professional to be at the centre of ethical concern. The guiding principle of caring is that decisions are made within relationships [23-25], requiring relationship time and empathic dialogue, space for reflection and thoughtful discussion, involving all those who are involved in the patient's suffering [26]. From the perspective of ethics of care applied to the clinical context, the patient is a person, unique and the bearer of a life story, with needs, resources and expectations, and a participant in the treatment [27,28]. From this perspective, the respect for autonomy, expressly established in the IC, is related to an approach that, recognising the patient as a subject of will and decision-making power, also takes into account the experiences of vulnerability and the importance of promoting autonomy and the personal and contextual resources necessary for decision-making

***Corresponding author:** João Paulo Barbosa Azevedo, Mental health professional, PhD student in Bioethics, Rua Alfredo Cunha, 367, 4450-024, Matosinhos, Porto, Portugal, Tel: +351 933411087; E-mail: joao.p.azevedo@arsnorte.min-saude.pt

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[21,22,29,30]. This approach implies a psychological understanding that autonomy, as self-regulation and integration in exercise [31], is inscribed in the history of development and in current life, giving meaning to the experience of illness and suffering. The person needs to the able to understand himself and his decisions and to have the confidence to act according to one's analyses [32]. In this sense, person-centred care contributes to the empowerment of the patient by involving him/her in the decision-making process regarding treatment plans [33-36].

In the therapeutic approach a central issue is how to obtain and ensure treatment participation when individuals with alcohol-related disorders come to treatment suffering from coercion, anxiety or depression. Perceived coercion may be associated with increased self-stigma and decreased empowerment [37,38]. Suffering due to anxiety and depression deepen the deficit of personal autonomy and these psychopathological conditions are associated with communication difficulties within the clinical relationship [39,40]. The attitudes of professionals that enable a greater perception of the patient's autonomy may favour his involvement in the treatment [41-43], even when he presents psychiatric comorbidity [44]. On the other hand, coercive attitudes may generate resistance or resignation by the patient [45,46]. Based on the fact that suffering generated by restrictive external conditions and situations of excessive deference in the relationship with others or by psychopathological symptoms can increase pre-existing vulnerability and interfere with the IC, a study with professionals was conducted with the aim of contributing to the improvement of care through the creation of an informative leaflet on IC, guided by psychological empowerment.

Methods

Design

A cross-sectional, quantitative, descriptive and analytical study was conducted on a sample of 85 professionals from the Addictive Behaviours and Dependencies network of the Regional Health Administration of the North, Portugal. The study was approved by the Health Ethics Committee of the Regional Health Administration of the North.

Objectives

Main objectives:

- to describe the ethical attitudes of professionals in the IC of the person with alcohol-related disorders
- to analyse the relationship between the ethical attitudes of professionals in the IC of the individual with alcohol-related disorders who attends treatment suffering from coercion, anxiety and depression with the ethical attitudes towards the right to refuse treatment

Specific objectives:

- to describe the ethical attitudes of professionals in the IC of the person with alcohol-related disorders in the usual therapeutic approach
- to describe the ethical attitudes of professionals in the IC of the person with alcohol-related disorders towards refusal of treatment in the usual therapeutic approach
- to identify the ethical attitudes of professionals in the IC of the person with alcohol-related disorders who attends treatment suffering from coercion
- to identify the ethical attitudes of professionals in the IC of the person with alcohol-related disorders who attends treatment suffering from anxiety
- to identify the ethical attitudes in the IC of the person with alcohol-related disorders who attends treatment suffering from depression
- to analyse possible differences between the groups defined as "no agreement" or "agreement" with the use of a paternalistic attitude in the person with alcohol- related disorders who comes to treatment suffering from coercion, anxiety and depression regarding ethical attitudes towards refusal of treatment in the usual therapeutic approach

Study participants

The target population of the study were the professionals (physicians, psychologists, nurses, and social workers) who carried out treatment activities in the Units of the specialised health care network for Addictive Behaviour and Addictions. A convenience sample was used consisting of 85 professionals who voluntarily agreed to participate in the study. The inclusion criterion was established as professional experience with people with alcohol-related disorders assisted in outpatient care. The sample was composed of professionals of both genders. Most professionals were female (68.2%; n=58). The mean age of the sample was 47.6 (σ = 9.5 years), with a minimum age of 31 years and a maximum age of 72 years. The prevalent age groups include 35-44 years (32.9%; n = 28) and 45-54 years (32.9%; n = 28), soon followed by the age group ≥ 55 years with a percentage of 28.2% (n = 24). About 6.0% (n = 5) of the respondents have an age between 25 and 34 years. The prevalent professional group in the sample was psychology (35.3%; n = 30), followed by the medicine group with 28.2% (n = 24). The frequency of the nursing group was 22.4% (n = 19) and the social workers 14.1% (n = 12).

Instrument

The Questionnaire on Ethical Attitudes (QEA) was used to collect information. This is a self-answering instrument designed with the purpose of measuring the ethical attitudes of professionals in the IC of the individual with alcohol-related disorders. The theoretical assumption underlying the construction of the EQ was that the IC is the place for the expression of patient autonomy in clinical practice [20]. The first question of the QEA collects information about ethical attitudes in the IC in the usual therapeutic approach based on the observation of its components theorized in the literature [20,47] (Competence; Voluntariness; Information disclosed; Understanding; and Decision). Each of these components was operationalised through a question, with a total of five items. A sixth item was included on the observation of the expression of the patient's opinion regarding the treatment, in line with the contributions that emphasize the importance of the patient's free expression in the IC [48]. The second question aims to collect information on the ethical attitudes of professionals in the usual therapeutic approach towards the patient's right to refuse treatment, namely: a) attitude of non-interference; b) paternalistic attitude conceived as forcing the person to accept the treatment; c) attitude of motivational intervention. Another part of the QEA includes three questions which, respectively, collect information about the IC of

the person with alcohol-related disorders who attends treatment suffering from coercion (under legal and social pressures), anxiety and depression, with and without insight into the alcohol problem. For the first and second questions of the QEA the respondent answers using a Likert scale, where 1 corresponds to "almost never" and 5 corresponds to "almost always". For the other questions, the respondent answers using a Likert scale, where 1 corresponds to "Strongly disagree" and 5 corresponds to "Strongly agree". For the validation of the instrument, the internal consistency was analysed through Cronbach's alpha with the purpose of assessing whether the total number of items used in the operationalisation of the construct correlated. An α=0.887 was obtained, which corresponds to an appropriate reliability.

Procedures

Institutional authorizations were obtained to access the professionals' email addresses. The professionals were contacted through an email to inform them about the study, its objectives, as well as the ethical precautions to preserve anonymity, confidentiality, protection and security of the data to be collected and the voluntary participation. A second email was sent to all professionals with the link to access the QEA created in the Google Form platform@ which included the IC to participate in the study. The collected data were entered into a database, and the statistical study was performed using the computer program SPSS Statistics (IBM 2011. IBM SPSS Statistics for Windows, Version 23.0.). The variables were described by relative frequency as well by mean value and standard deviation. Student's t-test for independent samples was performed to analyse possible differences between the groups defined as "no agreement" and "agreement". The significance level of the statistical tests was 5%.

Results

Descriptive analysis of variables

The data obtained in questions 1 and 2 of the QEA are presented with reference to the relative frequencies of the sample according to the groups "almost always/very often" and "almost never/sometimes or rarely". The data obtained in the remaining questions are presented with reference to the relative frequencies of the sample according to the groups "strongly agree/strongly agree" and "strongly disagree/disagree/neither agree nor disagree".

Attitudes in the IC of the individual with alcohol-related disorders in the usual therapeutic approach

The prevalence of "almost always/very often" was found regarding the attitudes of ensuring voluntariness (97.6%; n=93), of deepening the insight into the alcohol problem (96.5%; n=82), of valuing the expression of the patient's opinion (96.5%; n=82), of making the disclosure (96.5%, n=82), of ensuring the understanding of the information provided (96.5%; n=82) as well as of ensuring freedom of choice (92.8%; n=79) (Table 1).

Attitudes towards refusal of treatment in the usual therapeutic approach

The prevalence of "Almost never/Sometimes or rarely" using the attitude of non- interference with refusal of treatment (54.1%; n=46) and the attitude of forcing the person to accept treatment (paternalistic drift) (90.4%; n=79) was observed. We also observed a prevalence of "almost always/very often" use of motivational intervention (96.4%) when dealing with treatment refusal (Table 2).

Attitudes	Almost always/Very often % (n)	Almost never/Sometimes or rarely % (n)
Deepen Insight/Alcohol problem	96,5 (n=82)	3.5 (n=3)
Spread the word	96,5 (n=82)	3,5 (n=3)
Ensure understanding	96,5 (n=82)	3,5 (n=3)
Ensure the voluntariness	97,6 (n=83)	2,4 (n=2)
Ensure freedom of choice	92,8 (n=79)	7,2 (n=6)
Take an interest in the expression of patient opinion	96,5 (n=82)	3,5 (n=3)

Table 1: Relative frequencies regarding attitudes in the IC in the usual therapeutic approach.

Attitudes	Almost always /Very often % (n)	Almost never/Sometimes or rarely % (n)
Non-interference	45,9 (n=39)	54,1 (n=46)
Paternalistic drift	9,6 (n=8)	90,4 (n=79)
Motivational intervention	96,4 (n=82)	3,6 (n=3)

Table 2: Relative frequencies regarding attitudes towards refusal of treatment in the usual therapeutic approach.

Attitudes in the IC of the individual with alcohol-related disorders who attends treatment under coercion

The prevalence of "strongly disagree/disagree/ neither agree nor disagree" was observed regarding the use of paternalistic drift, both in the person with insight (77.8%; n=66) and without alcohol problem insight (72.9%; n=62). We also found a prevalence of "strongly agree/ Agree" regarding non-interference with treatment refusal (75.3%; n=64) and the use of motivational intervention (95.2%; n=81) in the IC of the individual with alcohol- related disorders who attends treatment suffering from coercion (Table 3).

Attitudes	Strongly agree/ agree % (n)	Strongly disagree/Disagree/ Neither agree nor disagree % (n)
Paternalistic drift in person with insight/Alcohol problem	22,2 (n=19)	77,8 (n=66)
Paternalistic drift in the person without insight/Alcohol problem	27,1 (n=23)	72,9 (n=62)
Non-interference	75,3 (n=64)	24,7 (n=21)
Motivational intervention	95,2 (n=81)	4,8 (n=4)

Table 3: Relative frequencies regarding attitudes in the IC of the person with alcohol-related disorders who attends treatment suffering from coercion.

Attitudes in the IC of the person with alcohol-related disorders who attends treatment suffering from anxiety

The prevalence of the frequency "Strongly agree/Agree" was observed regarding the attitude of resorting to non-interference with refusal of treatment (76.5%; n=65) and of using motivational intervention (94.1%; n=80). The prevalence of the frequency "strongly

disagree/disagree/neither agree nor disagree" was observed regarding the attitude of forcing the person to accept treatment (paternalistic drift), both in the person with insight (78.8%; n=67) and without insight into alcohol problem (78.8%; n=67) (Table 4).

Attitudes	Strongly agree/ Agree % (n)	Strongly disagree/ Disagree/ Neither agree nor disagree % (n)
Paternalistic drift in the person with insight/PLA	21,2 (n=18)	78,8 (n=67)
Paternalistic drift in the person without insight/PLA	21,2 (n=18)	78,8 (n=67)
Non-interference	76,5 (n=65)	23,5 (n=20)
Motivational intervention	94,1 (n=80)	5,9 (n=5)

Table 4: Relative frequencies regarding ethical attitudes in the IC of the person with alcohol-related disorders who attends treatment suffering from anxiety.

Attitudes in the IC of the person with alcohol-related disorders who attends treatment suffering from depression We found the prevalence of the frequency "Strongly agree/Agree" regarding the attitude of not interfering with the refusal of treatment (75.8%; n=65) and the attitude of motivational intervention (96.5%; n=82). There was also a prevalence of "strongly disagree/disagree/neither agree nor disagree" regarding forcing the person to accept treatment, regardless of whether he/she recognizes alcohol problem or not (75.2%; n=74) (Table 5).

Attitudes	Strongly agree/ Agree % (n)	Strongly disagree/ Disagree/ Neither agree nor disagree % (n)
Paternalistic drift in the person with insight/Alcohol problem	24,8 (n=21)	75,2 (n=64)
Paternalistic drift in the person without insight/Alcohol problem	24,8 (n=21)	75,2 (n=64)
Non-interference	75,8 (n=65)	24,2 (n=20)
Motivational intervention	96,5 (n=82)	3,5 (n=3)

Table 5: Relative frequencies regarding ethical attitudes in the IC of the person with alcohol-related disorders who attends treatment suffering from depression.

Comparison between the groups defined as "no agreement" vs. "agreement" with the use of a paternalistic attitude in the person with alcohol-related disorders who comes to treatment suffering from coercion, anxiety and depression regarding ethical attitudes towards refusal of treatment in the usual therapeutic approach

The three questions on the IC of individuals with alcohol-related disorders who attends treatment suffering from coercion, anxiety and depression were related to the question on ethical attitudes towards refusal of treatment in the usual therapeutic approach. To analyse possible differences between groups, "strongly disagree", "disagree" and "neither agree nor disagree" responses were converted into the category "no agreement". The answers "Strongly agree" and "agree" were converted into the category "agreement".

In the person with alcohol-related disorders who attends treatment suffering from coercion

No statistically significant differences were observed between the group "agreement" vs. "no agreement" with the use of a paternalistic attitude in the person with alcohol-related disorders who comes to treatment suffering from coercion regarding ethical attitudes towards refusal in the usual therapeutic approach ($p > 0.05$).

In the person with alcohol-related disorders who attends treatment suffering from anxiety

Statistically significant differences were observed between the group "agreement" vs. "no agreement" with the use of a paternalistic attitude in the person with alcohol- related disorders who attends treatment suffering from anxiety regarding ethical attitudes towards refusal in the usual therapeutic approach. It was found that most professionals agree with forcing the person to accept treatment, either when the patient has presents insight into alcohol problem (M=2.7 vs. M =1.4; $p = 0.001$) (Table 6) or not (M=2.5 vs. M=1.3; $p = 0.013$) (Table 7). No statistically significant relationships were found with the other attitudes towards treatment refusal in the usual therapeutic approach.

In individuals with alcohol-related disorders who attends treatment suffering from anxiety it is appropriate to use coercion if they recognise their alcohol problem and need treatment			
	No agreement	**Agreement**	
	M (σ)	**M (σ)**	**p**
Non-interference	3,4 (1,3)	3,1 (1,6)	0,614
Paternalistic Drift	1,4 (0,9)	2,7 (1,4)	0,001
Motivational Intervention	4,8 (0,5)	5,0 (0,0)	0,217

Table 6: Comparison between the groups defined as "no agreement" vs. "agreement" with the use of a paternalistic attitude in the person suffering from anxiety with insight regarding ethical attitudes towards refusal of treatment in the usual therapeutic approach.

In individuals with alcohol-related disorders who attends treatment suffering from anxiety it is appropriate to use coercion if they do not recognise the problem and need treatment			
	No agreement	**Agreement**	
	M (σ)	**M (σ)**	**p**
Non-interference	3,4 (1,3)	2,9 (1,4)	0,235
Coercion	1,3 (0,5)	2,5 (1,5)	0,013
Specific Intervention	4,8 (0,5)	4,9 (0,4)	0,713

Table 7: Comparison between the groups defined as "no agreement" vs. "agreement" with the use of a paternalistic attitude in the person suffering from anxiety without insight regarding ethical attitudes towards refusal of treatment in the usual therapeutic approach.

In the person with alcohol-related disorders who attends treatment suffering from depression

Statistically significant differences were observed between the group "agreement" vs. "no agreement" with the use of paternalism in the person with alcohol-related disorders who attends treatment suffering from depression regarding ethical attitudes towards treatment refusal in the usual therapeutic approach. It was found that most professionals agree with forcing the person to accept treatment, either when the patient has presents insight into the alcohol problem (M=2.6

vs. M=1.4; p=0.001) (Table 8) or not (M=2.4 vs. M=1.4; p=0.005) (Table 9). No statistically significant relationships were observed with the other attitudes towards treatment refusal in the usual therapeutic approach.

In individuals with alcohol alcohol-related disorders who attends treatment suffering from depression it is appropriate to use coercion if they recognise the problem and need treatment			
	No agreement	Agreement	
	M (σ)	M (σ)	p
Non-interference	3,4 (1.3)	3,3 (1.3)	0,904
Coercion	1,4 (0.9)	2,6 (1.3)	0,001
Specific Intervention	4,8 (0.5)	4,9 (0.3)	0,610

Table 8: Comparison between the groups defined as "no agreement" vs. "agreement" with the use of a paternalistic attitude in the person suffering from depression with insight regarding ethical attitudes towards refusal of treatment in the usual therapeutic approach.

In individuals with alcohol-related disorders who attends treatment suffering from depression it is appropriate to use coercion if they do not recognise the problem and need treatment			
	No agreement	Agreement	
	M (σ)	M (σ)	p
Non-interference	3,5 (1,3)	2,7 (1,2)	0,076
Coercion	1,4 (0,9)	2,4 (1,4)	0,005
Specific Intervention	4,8 (0,5)	4,9 (0,3)	0,612

Table 9: Comparison between the groups defined as "no agreement" vs. "agreement" with the use of a paternalistic attitude in the person suffering from depression without insight regarding ethical attitudes towards refusal of treatment in the usual therapeutic approach.

Discussion

A study on the practice of IC of individuals with alcohol-related disorders was conducted based on the collection of information about the actions and opinions of professionals in the health care network regarding Addictive Behaviours and Dependencies. As it is recognised that no single measure or combination of measures can provide a complete assessment of the quality of the decision [49], we did not intend to verify whether the ethical objectives of informed consent, patient autonomy and decision- making are achieved. The main objective of this study was to identify the ethical attitudes of professionals in the implementation of IC of individuals with alcohol-related disorders, particularly when accessing treatment suffering from coercion, anxiety and depression.

The results indicate the prevalence of the development of ethical attitudes that embody respect for the principle of consent in the usual therapeutic approach, with most professionals observing "almost always/very often" the procedures that testify to respect for the patient's autonomy (with frequencies of attitudes varying between 92.8% and 97.6%). The data indicate that professionals tend to observe the free choice and voluntary decision of treatment, being interested in the expression of the person about the treatment, suggesting that they promote the establishment of a relationship based on the recognition of the patient's right to participate in decisions regarding his health. In agreement with this result, it was observed that most professionals "almost never/sometimes or rarely" develop a paternalistic attitude towards refusal of treatment in the usual therapeutic approach (90.4%), including when the person comes to treatment suffering from coercion, anxiety or depression, disagreeing with its use regardless of whether or not the person presents insight into the alcohol problem (with percentages ranging from 72.9% to 78.8%).

On the other hand, a set of results emerged that point to the development of paternalistic attitudes, which may not be unrelated to the average age of the sample (M=47.6; σ = 9.5 years), indicating the relative ageing of professionals and the likely use of a paternalistic model of care. It was found that between 21.2% and 27.1% of professionals "Strongly agree/Agree" with the use of a paternalistic attitude in the person who comes to treatment suffering from coercion, anxiety or depression, regardless of whether or not they present insight into the alcohol problem. These data may suggest that professionals assess situations in which the person with alcohol-related disorders presents comorbidities with severe neurological, psychopathological or cognitive pathology, in the face of which accepting refusal to treatment would be a disregard of the duty to act for his or her benefit. Even so, the possibility of using coercion deserves reflection, in the recognition that when freedom is hindered, whether by adverse circumstances or the actions of others, the person may experience a "wound" in their identity, in their value and dignity [30] with unforeseeable consequences for the therapeutic relationship and the treatment [50]. In the same sense, statistically significant differences were observed between the groups defined as "Agreement" vs. "No agreement" with the use of a paternalistic attitude in the person with alcohol-related disorders who accedes to treatment suffering from anxiety and depression regarding the refusal of treatment in the commonly used therapeutic approach. It was found that most professionals agree with forcing the person to accept treatment in both the person suffering from anxiety with insight (M=2.7 vs. M=1.4; p=0.001) and without insight into the alcohol problem (M=2.5 vs. M=1.3; p=0.013) and the person suffering from depression with insight into the alcohol problem (M=2.6 vs. M=1.4; p=0.001) and without alcohol problem insight (M=2.4 vs. M=1.4; p=0.005). These data may indicate that professionals consider anxiety disorder and depression as particular vulnerabilities that may interfere with the decision- making process regarding treatment, as accepting treatment refusal would constitute a disregard for the principle of beneficence. This interpretation may be based on clinical arguments indicating that anxiety may affect the ability to retain the information provided and that depression may limit the ability to appreciate the information disclosed and to express an authentic decision [39,40]. Even so, the use of a paternalistic attitude should stimulate ethical reflection given that:

- it may generate an increased fear of stopping consumption and of the change proposed by the treatment, increasing the difficulty of reflection about the information disclosed about the health condition and may enhance erratic responses regarding the treatment [51,52]
- it may result in the increase of pressures arising from unequal power in the clinical relationship [39] and generate an interaction marked by attitudes of passivity and resistance on the part of the patient and by counter-attitudes tending to be more imposing on the part of professionals
- the anxious and depressive symptoms induced by consumption tend to disappear about a month after continued abstinence [53]
- the circumstances of mental disorder do not necessarily imply an inability to give voluntary consent [40], with patients maintaining an area of the mind preserved from the interference of the disorder and showing the capacity to make their own decisions

The use of a paternalistic attitude in individuals with alcohol-related disorders who attends treatment suffering from anxiety or depression may indicate an ethical concern with obtaining consent as a means of avoiding formal coercion, but it does account for the difficulties in obtaining consent in patients who are particularly resistant to accepting the help made available.

The set of data exposed suggests the importance of balancing the duty to protect people with particular vulnerabilities, even when they have the capacity to consent, and the avoidance of paternalism, due to its unpredictable impact on the clinical relationship and the decision-making process [54]. In this sense, another line of interpretation of the results indicates the development of attitudes that place the person with alcohol-related disorders at the centre of care. Even though it was found that most professionals "almost never/sometimes or rarely" opt for non-interference with refusal of treatment in the usual therapeutic approach (54.1%), it was observed that almost all of them recognize the importance of retaining the person in consultation for motivational intervention (96.4%), regardless of whether he/she goes to treatment suffering from coercion (95.2%), anxiety (94.1%) or depression (96.5%). The ethical response to motivational intervention reflects a concern with the promotion of the autonomy of the person with alcohol-related disorders, including when they go to treatment under coercion, especially since they may refuse treatment as a response to the disorientation caused by the threat they feel [30]. Under an ethical model of care focused on the person with alcohol-related disorders, it is considered important to reinforce the understanding that:

- the person suffers from a disorder of self-regulation, inscribed in their developmental history and current life, characterised by the non-cohesion of the self and deficits in self-regulation of tension and self-esteem that are heightened in the face of any situation in which they should position themselves autonomously [55-57]
- the experience of personal autonomy gives meaning to the way many patients respond negatively [51,52] as a way to avoid painful feelings of incapacity, self-devaluation or guilt for real or imagined losses
- the sense of self-regulation and integration occurs through the human relationship guided by authenticity, unconditional positive regard and empathy [34,35]
- people have not only needs but also capabilities and resources that must be involved in the decision-making process regarding treatment [58]
- under the assumption that praxis and decision-making are lived and experienced through relationships [23-25], the IC is an opportunity for a dynamic care process aimed at the psychological empowerment of the patient [36,59,60], in the recognition that participation in the treatment is indispensable to its success

In conclusion, and taking as reference the components of psychological empowerment indicated by Cattaneo and Chapman [60] in view of the intrapsychic change and in the person's social influence, it is suggested:

- to help the person to identify recovery as well as the value of regulating feelings and maintaining coherence, self-esteem, mental wellbeing, comfortable and comforting relationships and self-care behaviour [56,57] as personally meaningful ends, based on autonomously motivated intentional behaviours [15]
- to help the person to establish goals oriented towards "being able to be" and "being able to do" based on increasing both self-regulation and self-determination of one's own life in relation to the surrounding environment in the light of the experience of personal autonomy, particularly under restrictive external circumstances and situations of excessive deference in relation to others or psychopathological conditions
- to provide a deeper understanding of the alcohol problem (the physical, mental and social consequences of consumption as well as the vicissitude of relapse) by giving it a new meaning in the light of the person's life history and current life, helping them to identify protection strategies and available resources (therapeutic and others) to achieve the objectives set
- to help the person to achieve self-confidence through the perception that they can reach the objectives identified (self-efficacy) through the recollection of life experiences without the influence of consumption, with evocation and appropriation of personal resources and positive experiences
- to help the person to recognize his/her real level of capacity to effect the desired changes (competence), namely starting from the critical analysis of the triggering and maintenance factors of the problem in order to favour learning from previous personal experiences
- to help the person to evaluate the impact of the changes made in the meantime, helping to identify and appropriate the benefits brought about by the changes achieved, based on the perception of personal control as well as of the influence on the response of the surrounding human and non-human environment

The issues of autonomy and its immanence for Informed Consent (IC) are particularly challenged in therapeutic approach for Alcohol-Related Disorders. Suffering generated by restrictive external conditions and situations of excessive deference in relationships with others or by psychopathological symptomatology deepen pre-existing vulnerability and interfere with the IC of the person with Alcohol-Related Disorders. Based on the objectives of care practice to minimize refusal and early abandonment of treatment and to favour retention, those conditions require particular attention from professionals to the relational encounter of care as a way to sustain and not hinder personal autonomy. Different models of ethical analysis as well as different interpretations and beliefs of the professionals underlying the model of relationship they develop in the care practice may contribute, in concrete clinical situations, to an approach based on paternalistic drifts. Within the scope of intervention in Addiction and Dependence, it is considered relevant to reinforce the stimulus to pursue the humanisation of care. The importance of paying particular attention to the implementation of IC within the framework of a person-centred care ethic is emphasised, recognising how autonomy and vulnerability are expressions of a unique identity seeking recognition and meaning in the therapeutic relationship. It is known that health services have an increased ethical responsibility to make the rules of people's rights of access to care public and accessible and to inform them of their rights, published or explained in an understandable way in guides, posters, etc. As a bioethical implication of the present study, an informative leaflet on IC was built produced with the aim of placing aiming to place the person as a partner in the relational encounter, reducing initial anxieties and valuing the ability to choose and act in accordance with the possible quality of life they wish to have, as well

as encouraging professionals for an IC practice based on listening and empathic dialogue, against the backdrop of the responsibility of care and the prohibitions of undue paternalism. This booklet leaflet can be made is available by contacting the author.

Limitations of the Study

We recognise the limitation of the study in the generalisation of the results to the national population of professionals in the network of health care provision regarding addictive behaviours and addictions. The sample size limited the comparison between among groups of professionals, making it impossible to compare the opinions and ethical attitudes developed in the IC practice between the medical group and the other professional groups that make up the Treatment Teams, in order to verify possible variations between among groups. It was also not possible to make the comparison between among groups according to the age and gender of the professionals, limiting the appreciation of the results. The importance of reducing the interpretative bias of some items of the questionnaire is recognised, as well as the limitation arising from the use of an instrument not fully validated for the Portuguese population.

Conflict of Interest

The author does not have conflicts of interest to declare.

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