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# Autonomy of individuals with alcohol-related disorders: informed consent

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## Abstract

Informed consent, as a way to ensure involvement and treatment adherence, is part of the therapeutic approach to individuals with alcohol-related disorders. Autonomy, as a core ethical value, and its immanence for informed consent presents ethical-clinical challenges in the case of individuals seeking treatment due to coercion, anxiety, or depression. Between April 2018 and June 2019, a prospective longitudinal observational study was conducted with 150 people with alcohol-related disorders attending a specialized treatment facility. The goal was to verify whether consent obtained under coercion, or influenced by anxiety disorder or depression determines therapeutic participation. Absence of judicial coercion and anxious symptomatology and the greater value placed on perceived autonomy in informed consent were related to participation. The study proposes contributions to strengthen the practice of obtaining informed consent based on the recognition and promotion of autonomy.

**Keywords:** Informed consent. Bioethics. Alcohol-related disorder. Patient participation. Coercion. Anxiety disorder. Depression.

## Resumo

**Autonomia da pessoa com problema de álcool: consentimento informado**

O consentimento livre e esclarecido, como forma de garantir envolvimento e participação em tratamento, é parte da abordagem terapêutica à pessoa com problemas relacionados ao uso de álcool. O valor ético central da autonomia e sua imanência para o consentimento informado apresenta desafios ético-clínicos no caso de pessoa que busca tratamento em situação de coerção, ansiedade ou depressão. Entre abril de 2018 e junho de 2019, conduziu-se estudo observacional longitudinal prospetivo que incluiu 150 pessoas com problemas relacionados ao uso de álcool assistidas em unidade especializada de tratamento. O objetivo foi verificar se o consentimento com interferência de coerção, perturbação de ansiedade ou depressão determina a participação terapêutica. A ausência de coerção judicial e sintomatologia ansiosa e a maior valorização da perceção de autonomia no consentimento informado relacionaram-se com a participação. Propõem-se contributos para reforçar a prática do consentimento informado assente no reconhecimento e promoção da autonomia.

**Palavras-chave:** Consentimento livre e esclarecido. Bioética. Transtornos relacionados ao uso de álcool. Participação do paciente. Coerção. Transtornos de ansiedade. Depressão.

## Resumen

**Autonomía de la persona con problema relacionado al alcohol: consentimiento informado**

El consentimiento informado, que garantiza comprometimiento y participación en el tratamiento, forma parte del enfoque terapéutico del manejo de la persona con problemas relacionados al consumo de alcohol. El valor ético de la autonomía y su inmanencia para el consentimiento informado tiene desafíos ético-clínicos en el caso de personas que buscan tratamiento en situación de coerción, ansiedad o depresión. Entre abril de 2018 y junio de 2019 se realizó un estudio observacional longitudinal prospectivo con 150 personas con problemas relacionados al consumo de alcohol, asistidas por un centro de tratamiento especializado. Este estudio pretendió confirmar si el consentimiento por coerción, trastorno de ansiedad o depresión influye en la participación terapéutica. La ausencia de coerción judicial y de síntomas ansiosos, así como la mayor autonomía en el consentimiento se relacionaron con la participación. Se proponen aportes para reforzar la práctica del consentimiento informado desde el reconocimiento y promoción de la autonomía.

**Palabras clave:** Consentimiento informado. Bioética. Transtorno relacionado con alcohol. Participación del paciente. Coerción. Transtornos de Ansiedad. Depresión.

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Research

Alcohol-related disorders can lead to a set of physical, mental, and social consequences that affect not only the individual, but also their family, society [1] and all those who, directly or indirectly, are implicated in the suffering of those who face this problem. The repercussions of this disorder weigh significantly how a person undergoes treatment and participates in the therapeutic process.

Individually, alcohol affects all organ systems. Anxiety disorders and depression induced by alcohol or that precede its consumption are also common [2,3]. In the social and family dimensions, significant occurrences are the disruption of personal relationships, crime and road accidents and absenteeism from work [4].

The treatment of people with alcohol problems generally requires the participation in a therapeutic process of long-term autonomous self-care, recovery, and quality of life [5,6]. Patient involvement is an important factor for the success of treatment [5] and a central aspect of the therapeutic approach, being source of concern among professionals given clinical and scientific evidence that people suffering from alcoholism usually refuse or abandon treatment early [7-9].

Informed consent (IC) guarantees involvement and participation in treatment procedures and is part of the therapy of people with alcohol-related disorders [10,11]. IC aims to ensure the respect for human dignity and affirm autonomy as the fundamental ethical value of the relationship between professional and patient. Being "self-regulation and integration in exercise" [12], autonomy is the mark of the "true self" [13], which requires experience—and, necessarily, experience in human relationships—as a possibility of existence.

Autonomy is fundamental for healthy psychological development and functioning. Restrictions on its free exercise experienced in past and current relationships (as occurred in the recent pandemic period, for example), may influence the emergence or decompensation of addictive behavior, understood as an attempt to alleviate the suffering of identity loss [14].

When it comes to consenting to a care procedure [15], the perception of personal autonomy is a basic assumption. Through it, the external or internal influences that impact the conditions essential to decision-making can be dealt with: willingness and the ability to reflect, based on the information received, on the risks and benefits of possible therapeutic modalities, as well as on the possible consequences of not receiving treatment.

In the treatment of people suffering from disorders related to alcohol use, the subjective experience of external pressures must be considered when leading them to start or remain in treatment, as well as anxiety disorder or depression. These factors may interfere with the perception of autonomy and even with the task of obtaining consent to treatment.

People often seek treatment under numerous social control strategies—legal, formal, or informal [16]—which may contain coercive elements. This can be defined as external pressure that expresses a threat, putting a person in a worse situation if they refuse treatment [17-19]. Coercion may result in the perception of an imposition [18,20], accompanied by the intensification of emotional reactions, which may interfere with the sense of personal autonomy and hinder decisions to accept help or trust others [21].

Interferences with the expression of autonomy can also increase when a person seeks treatment when feeling disturbed by anxiety or affected by depressive symptoms. People addicted to alcohol who suffer from anxiety may experience, as an increased danger, the risk of uncertainty associated with the choice of therapeutic modality and the decision to seek treatment, showing impulsiveness and hasty decisions in a relational encounter. Depressive distress, on the other hand, can boost feelings of insufficiency and hopelessness, mobilizing responses of disinterest in personal and relational values and treatment.

Communication difficulties related to anxiety—which may affect the retention of information—or to depression can arise, which tends to hamper intellectual processes, even if there is no clinical or research evidence showing that this population should be considered incompetent to provide consent to treatment [11,22].

The patient's right to autonomy is ethically expressed by the right to refuse treatment. The ethical challenge for professionals, therefore, is to respect their autonomy in seeking consent, recognizing that the participation of the person in the therapeutic process is indispensable [5,6].

In the context of caring for others, respect for autonomy implies its promotion and the promotion of personal and contextual resources for decision-making as a condition to ensure its exercise. This right is expressly enshrined in free and informed consent prior to treatment [15,23-25].

Respect for autonomy in seeking consent will, therefore, mean not only observing that the person does not suffer from any clinical condition that compromises their ability to understand and decide, but also to attend to the experiences of their condition and treatment that interfere with the expression of the self with autonomy competences.

The fear of stopping intake, relapsing or relying on the care relationship mobilized by personal condition and intensified by the relationship with people and situations, assigns meaning to how several patients respond negatively or develop erratic attitudes. These answers are ways to avoid painful feelings of insufficiency, self-devaluation, or guilt due to real or imaginary emotional losses, which end up affecting perceptions and more accurate judgments regarding their condition and treatment, including its future consequences [26-29].

More than the freedom to authorize possible complementary diagnostic tests and the freely and informed treatment modality, IC presupposes the autonomy that is enriched by imagining alternative paths and the autonomy that selects relational care encounters as an adequate way for satisfactory self-realization. This favors the empowerment individuals to master themselves and their relationship with the environment.

The view that places human suffering at the center of the addictive phenomenon thus calls for a relational and care ethic based on "concern" [30]—the therapist's dedication to listening empathically to the subjectivity offered by the other. The guiding compass of this relationship of reciprocity is the ability of a person to value themselves and the recognition of the autonomy of each individual in otherness.

Based on the idea that autonomy, rather than rationality and independence, is the subjectivity of the individual in human relations and interdependence, IC is seen as an empathetic dialogic process between patient and caregiver. Autonomy not only involves the cognitive but also the emotional, relational, and social aspects of decision-making, based on the mutual recognition of the self with autonomy competences as a constituent element of self-government and promoter of self-determination [31,32].

Coercion, anxiety disorder, or depression in the person suffering from an alcohol problem may be factors that interfere with decision-making regarding treatment. To the best of our knowledge, no Brazilian or international studies on this specific topic encouraged the design of research on the influence of such aspects on the decision to participate in treatment.

This study seeks to reinforce the practice of free and voluntary consent, based on the recognition and promotion of autonomy, as a way of obtaining the participation of the person in their treatment.

## Method

This prospective longitudinal observational study was conducted between April 2018 and June 2019 at the Alcoholism Unit of Porto, a unit of the public health care network for addictive behaviors and addictions, whose competence is to provide integrated care to users from the northern region of Portugal. The unit consists of different treatment teams, integrating different professionals of medical responsibility.

## Objectives

The general objective of the study was to assess whether IC in the person undergoing treatment suffering from coercion, anxiety, or depression influences participation in treatment.

The specific objectives were:

- Assess whether coercion is a determinant for participation in treatment;
- Assess whether anxious or depressive symptoms are decisive for participation in treatment;
- Assess the importance that the person attaches to IC for participation in treatment;
- Propose contributions with a view to valuing autonomy in IC practice.

Research

## Participants

All participants who received consecutive visits during the first consultation at the unit between April 1st and June 31st, 2018, were included in the study. People who consume illicit substances or who experienced acute alcohol intoxication, psychotic symptoms, and clinical deterioration were excluded.

## Information sources and instruments

All participants were characterized for their sociodemographic aspects (age, gender, education, cohabitation, professional status) and medical history (psychiatric history related and unrelated to substance use; physical, behavioral and psychological consequences, and socio-family consequences related to consumption and consumption patterns), as well as in terms of referral for treatment (self-referral, referral from the health area, and judicial referral) and the existence of a judicial process, using consultation of their clinical record.

To assess the study variables, the instruments described below were used.

### *Coercion perception scale*

This scale is used to assess the perception of coercion for treatment resulting from external pressures, referred to by Klag, O'Callaghan and Creed [16] as legal. The instrument was built by the researcher because no other instrument validated for the Portuguese population has been found in the literature, adapted to the clinical population under study and appropriate to the objectives of the study. The Coercion Perception Scale (CPS) was previously validated using exploratory factor analysis, whose results supported reliability using Cronbach's alpha coefficient.

The CPS is a self-administered instrument with seven items, which can be grouped as follows:

- Two assess legal coercion (when refusing treatment means facing the court system or imprisonment);
- Three, formal coercion (when the consequences of refusing treatment involve the threat of losing the benefit of social support, protection of minor children, or work);
- One, informal coercion (when the consequences of refusing treatment involve the threat of separation/divorce);
- The latter assesses the recognition of the problem and the need for treatment (based on the assumption mentioned by Molodynski, Turnpenny, and Rukga [17] that the perception of coercion can occur even when the person's will to be treated coincides with that of the coercion agent). The participant answers using a Likert scale with values between 1 and 5, where 1 corresponds to "I do not feel that way at all" and 5 means "I totally feel that way".

### *Hospital Anxiety and Depression Scale*

Used in the assessment of clinical anxiety and depression. The Portuguese version validated by Pais-Ribeiro and collaborators [33] was used, who consider that it measures the same constructs in the same way as the original scale.

The Hospital Anxiety and Depression Scale (HADS) is frequently applied to various clinical populations. This is a 14-item self-administered instrument: half measure symptoms of depression and half measure anxiety ones. Each item has a question that is followed by 4 Likert-style response options scored from 0 to 3.

According to Pais-Ribeiro and collaborators [33], the original scale manual indicates that, for each subscale, a score between 0 and 7 corresponds to a normal level; between 8 and 10, a mild level; between 11 and 14, a moderate level, and between 15 and 21, a severe level. Results with a value equal to or greater than 11 imply the probable presence of a mood disorder.

### *Informed consent scale*

The scale assesses the importance attributed to IC for participation in treatment. The researcher developed it, as no instrument was found in the literature to assess the importance of free and voluntary consent for participation in treatment.

The formulation of the Informed Consent Scale (ICS) was based on the assumptions presented by Beauchamp and Childress [15] to define autonomous action—namely intentionality,

understanding, and the absence of controlling influences. The ICS was previously validated using exploratory factor analysis, with results that supported the reliability using Cronbach's alpha coefficient.

The ICS is a self-administered instrument consisting of 5 items, each of which evaluates, respectively, the following aspects of consent to treatment:

- Recognition of the problem and the need for treatment;
- Understanding the information disclosed;
- Autonomous will;
- Free decision; and
- Opportunity to express oneself regarding the treatment.

The participant answers each item using a Likert scale with values between 1 and 5, where 1 corresponds to "not important" and 5 to "extremely important". More points indicate greater importance of free and voluntary consent to participation in treatment.

## Procedures

Data collection with the participants took place at two different times according to a previously structured evaluation plan.

First moment of observation: shortly after the first consultation at the unit, the participants were referred for an interview with the responsible researcher or with his substitute, when ethically and methodologically necessary.

Initially, written consent was obtained after presentation of the study, the reasons for its implementation, its time duration and observation phases, and its objectives. The understanding of the information shared was confirmed, including the right to withdraw consent at any time, without any consequences for usual therapeutic care. Subsequently, the CPS and HADS were administered.

Second moment of observation: one year after the first interview, participation in treatment was evaluated using the unit's electronic schedule. The observation period of one year was defined as the minimum time for the person to make their decision regarding treatment, based on the vicissitudes of the problem and the unit's care model.

Participants who were in follow-up were contacted for a second assessment interview, which took place after their regular consultation. After resubmission and revalidation of consent to participate in the study, the ICS was administered and information was collected regarding the intake of alcoholic beverages and medication.

With the participants who were not in follow-up, a telephone interview was conducted, in which the same procedures were followed. All information collected was measured using the clinical register and with the physician responsible for each treatment team.

## Data analysis

Sociodemographic, clinical history characteristics and referral sources were binary-coded and used as independent variables.

The dependent variable "participation in treatment" was categorized as "still in treatment/not in treatment": the first category included contact with the Alcoholism Unit (including hospitalization situations in the Detoxification Unit or Therapeutic Community) or with another Intervention Unit in the health care network for addictive behaviors and addictions after referral. Absence in person, after four or more consecutive consultations, or of any type of contact, after four months, defined the discontinuity of treatment, regardless of the reason.

The alcohol intake variable was defined by the categories "abstinent/non-abstinent"; the variable of medication adjunctive to psychotherapeutic support, by the categories "takes the medication/does not take the medication".

Continuous variables were described by mean and standard deviation, and categorical variables were described by sample *n* and relative frequency.

In the analysis of the association between the categorical variables, the chi-square test or the Fisher test was used, as most appropriate. To compare mean differences between two groups, the *t*-test for two independent samples or the Mann-Whitney nonparametric test was used. Non-parametric Anova was used for the comparison between three or more groups due to the small sample size of some groups and the lack of normality of the variables.

Data analyses were performed using the computer program IPSS (IBM 2011, IBM SPSS Statistics for Windows, version 23.0.). The significance level of the statistical tests was set at $p<5$.

## Results

The study sample consisted of 150 people with alcohol problems who underwent treatment at the Alcoholism Unit of Porto. Five participants were not chosen for the study and three were excluded: two due to death and one due to detention in prison. Of the final sample of 150 participants, 81.3% (n=122) are men and 18.7% (n=28) are women. The mean age was 50.47 years (standard deviation=10.64).

Regarding sociodemographic variables, 68% of the participants (n=102) were ≥ 45 years old and 32% (n=48) aged <45 years. Regarding schooling, 75.3% (n=113) have the basic level (1st, 2nd and 3rd cycles). Approximately 82% (n=123) of the participants live in a family environment, predominantly with a spouse/partner and/or with children. Of the total number of participants, 54% (n=81) are active workers and 37.7% (n=56) are earning some type of pension (retirement, unemployment benefits, social integration income). These data are in line with official data from the 2021 Addictive Behaviors and Addiction Intervention Service [34].

Regarding the referral for treatment, it was found that 52.7% (n=79) of the participants were referred by the health area (family physician or other health professional/institution) and about 24% (n=36) sought treatment on a self-referral basis (on their own volition or through friends and family members). Approximately 16% (n=24) of the participants were sent for treatment by the legal system (court and Public Prosecutor's Office), and 7.3% (n=11) by the social area (Social Security, Social Teams, Child and Youth Protection Commission, Employers).

Regarding medical history variables, it should be noted that most participants reported no history of problematic consumption of illicit substances (86%; n=129) or other mental disorder prior to substance use (78.7%; n=118). Vulnerability was found due to the prevalence of physical harm (83.3%; n=125), as well as behavioral and psychological changes (95.9%; n=142) related to consumption. About 52.7% (n=84) of the participants showed signs and symptoms compatible with a pattern of addiction, and 47.3% (n=66) with that of alcohol abuse.

The follow-up permanence rate was 54.3% (n=82) by the end of the observation. Patients who continued treatment tend to abstain from alcohol (78% *vs.* 26.8%; $p<0.001$) compared to patients who do not (38.2% *vs.* 61.8%, $p<0.001$). The association found between abstinence and age was significant ($p=0.015$): those who presented the most abstinence were over 45 years old (75.6%).

Regarding taking medication, patients who continued treatment are more likely to take the prescribed medication (73.2% *vs.* 26.8%, $p= 0,001$). Most patients who discontinued treatment did not take medication for alcohol problems (83.8%).

Results of the association between the dependent variable therapeutic participation ("still in treatment" vs. "not in treatment") and the sociodemographic variables indicate the absence of significant associations between the variables, with the exception of the association found between abstinence and age, mentioned above.

No significant associations between the variable of participation in treatment and the variables in the clinical history were found, but taking medication was significantly associated with the presence of behavioral and psychological alterations related to consumption and the pattern of addictive consumption ($p<0.05$).

Coercion was studied based on referral for treatment, the existence of ongoing legal proceedings, and the results of the CPS. The results of the relationship between the referral variable and the treatment participation variable ("still in treatment" *vs.* "not in treatment") did not show significant associations. On the other hand, a significant association was observed between therapeutic participation and the ongoing legal process at the end of the observation ($p=0.016$): those who continued treatment showed a lower frequency of ongoing legal proceedings at the end of the observation (80.5%) (Chart 1).

**Chart 1.** Relationship between participation in treatment and the variable ongoing legal process

| | Participation in Treatment | | | | |
|---|---|---|---|---|---|
| | Still in treatment | | Not in treatment | | |
| | *n* | % | *n* | % | *p* |
| **Ongoing Judicial Process** | | | | | |
| **No** | 66 | 80.5 | 64 | 94.1 | 0.016 |
| **Yes** | 16 | 19.5 | 4 | 5.9 | |

*Chi-square test or Fisher test for frequency comparison*

The results of the perception of coercion to enter treatment measured by the CPS show a 3.6 mean value, which is between the value corresponding to "I feel moderately like this" and "I feel very much like this" on the Likert scale. Almost all participants (90.7%; n=136), in response to item 7 of the CPS, reported recognizing the problem and the need for treatment.

No significant association was found between participation in treatment and the perception of coercion to enter treatment as measured by the CPS. Participation in treatment was also not associated with recognition of the problem and the need for treatment. However, it was found that the mean value of perceived coercion upon admission to treatment was significantly associated with taking the medication ($p$=0.003) and was lower among those taking medication ($M$=2.8 *vs.* 5.0).

The analysis of the relationship between participation in treatment and depressive and anxiety symptoms (Chart 2) showed that, in the group that remains in follow-up, normal and mild anxiety symptoms were prevalent compared to the presence of moderate and severe symptoms (73.2% *vs.* 26.8%).

**Chart 2.** Relationship between participation in treatment and anxiety and depressive symptoms

| | Participation in Treatment | | | | |
|---|---|---|---|---|---|
| | Still in treatment | | Not in treatment | | |
| | *n* | % | *n* | % | *p* |
| **Anxious symptomatology** | | | | | |
| Symptomatology at a normal and mild level | 60 | 73.2 | 50 | 73.5 | 0.961 |
| Moderate and severe symptoms | 22 | 26.8 | 18 | 26.5 | |
| **Depressive symptomatology** | | | | | |
| Symptomatology at a normal and mild level | 66 | 80.5 | 54 | 79.4 | 0.870 |
| Moderate and severe symptoms | 16 | 19.5 | 14 | 20.6 | |

*Chi-square test or Fisher test for frequency comparison*

The mean value of responses in the ICS was 25.4, considering a score range between 0 and 32, indicating the tendency towards a high value of the importance of IC for participation in treatment.

On the IC scale, a statistically significant difference was found between the two groups participating in treatment ("still in treatment" *vs.* "not in treatment"). As shown in Chart 3, on the IC scale, the mean number of answers regarding the importance of IC for participation in treatment was significantly higher in those who did not continue to follow up than in those who continued to be treated (26.4 *vs.* 24.4; $p$<0.001).

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**Chart 3.** Relationship between participation in treatment and the importance of informed consent

| | Participation in Treatment | | | | |
|---|---|---|---|---|---|
| | Still in treatment | | Not in treatment | | |
| | M | SD | M | SD | *p* |
| ECI value (M, SD) | 24.4 | 3.8 | 26.4 | 3.4 | 0.001 |

*T-test for comparison of averages; ECI: Informed consent scale; M: mean; SD: standard deviation*

## Discussion

The treatment of a person with alcohol problems generally involves participation in a continuous care process related to long-term recovery [5,6]. This process, adjusted to the individual situation and to the stage of the clinical condition, involves different phases, including the stopping of harmful consumption, prevention of relapse, and maintenance of abstinence.

Clinical evidence and research indicate that individuals refuse or leave treatment early [7-9]. This is a reason for ethical-clinical questioning within treatment teams, aware of the individual, family and social suffering that may result from the maintenance or possible exacerbation of the problem.

Informed consent, as a way of guaranteeing involvement and obtaining participation in treatment, is an integral part of the therapeutic approach [10,11], based on the promotion of autonomy as a primary ethical value within the care relationship between the professional and the patient [15,23-25].

Respect for autonomy in seeking consent constituted an additional ethical challenge for the treatment of people with alcohol problems who are suffering from coercion, anxiety, or depression. In the hypothesis that the experience of coercion and anxiety disorder or depression would interfere with the expression of the self with autonomy competencies, a prospective longitudinal observational study was conducted using a sample of 150 people who underwent treatment at the Alcoholism Unit of Porto.

This study aimed to verify whether consent to participate in treatment lead by coercion or anxiety and depression symptoms was decisive for one's participation in treatment. The results obtained indicated that permanence in follow-up is a significant measure related to the quality and effectiveness of health care, in line with the literature [6,35-36]. People can abstain from alcohol more when they continue to be treated ($p$<0.001).

We found that continuity of treatment was not determined by sociodemographic variables, and the results of previous studies [37,38], which indicate that being older and living on income from work are factors of permanence in follow-up, were not confirmed.

Given the characteristics of the sample, namely the fact that: a) most of the participants are professionally active (54%; n=81) and 37.7% (n=56) receive some type of pension (retirement, unemployment benefits, social integration income); and b) most participants have family support (82%; n=123), this result suggests the importance of getting a deeper insight into the alcohol problem and participation in treatment as a way to ensure the health and well-being of the person and those around them and, at the same time, of relief from fear of relapse and commitment to trust in a care relationship.

The finding that older people abstained more compared to younger people ($p$=0.015) points to the importance of developing and strengthening health education strategies regarding the impact of consumption on the development of disorders, particularly among the youngest. This is a way of providing them with knowledge that helps them make choices and take appropriate decisions for the health and well-being of themselves and those around them.

Regarding the variables of medical history, there were no significant associations with participation in treatment, and alcohol addiction was not observed to be a factor of permanence in follow-up, as indicated in the study by Elbreder and collaborators [37].

The fact that the physical consequences and the presence of behavioral and psychological alterations related to the use of alcohol prevalent in the sample were not related to the permanence of follow-up may indicate their limited perception, due either to low health literacy, possibly associated with the low level of education in the sample (75.3%; n=113 with a basic level of education),

or to the mobilization or intensification of denial or devaluation mechanisms explanation of the problem and of these consequences.

Interventions aimed at increasing literacy in this area of health may promote understanding of the impact of alcohol on the development of harm to physical and mental health, in addition to helping identify the values and attitudes that are consistent with health and quality of life, as well as in training for the decision-making that most enable them.

The tendency of people with ongoing legal proceedings (13.3%; n=20) to not continue follow-up ($p$=0.016) was confirmed, in line with a recent study by Wild and collaborators [39]. Since almost the entire sample reports recognizing the alcohol problem and the need for treatment (90.7%; n=136), this result seems to show that, even if treatment under legal orders is not *per se* involuntary, there may be marked movements in the therapeutic context to externalize the critical reflection that supports insight.

This psychic mechanism can be mobilized as a defense in the face of anxieties reactivated or intensified by and in the relationship with professionals and treatment, interfering with the appropriation of personal and relational values and with the perception of the negative consequences resulting from the refusal or abandonment of treatment. In general, it was found that the perception of coercion for referral, as measured by the CPS, was not related to the permanence in follow-up.

The fact that the mean value of the answers obtained on the scale indicates that the person feels moderately or very coerced when undergoing treatment may justify the appearance of erratic answers. People who felt more constrained accepted taking medication more often, but did not remain in follow-up, despite suffering from mental/behavioral consequences and alcohol addiction ($p$<0.05).

The combination of these results seems to indicate that coercion, rather than resulting in a perception of control of voluntariness on the part of another entity, seems to correspond to the scenario of the fluctuating cleavage of the self through its outsourcing movement with autonomous skills, which, according to Rhodes [18], opens up the field of correlation between perceived coercion and other variables, such as the subject's mental functioning and the prevalent type of anxiety, the phenomena of the relational field and the insight into the health condition and the need for treatment.

Moderate/severe anxiety symptoms presented lower prevalence among people who continued treatment compared to those who did not remain in follow-up (73.2% *vs.* 26.8%), in line with previous studies [40,41]. This result points to the importance of recognizing the impact of a possible anxiety disorder on a person's ability to transform their desire to be treated into effective action.

Against the background of anxiety, fears of stopping consumption, relapsing, or relapsing trust in a care relationship may appear unresolved and generate impulsive responses that compromise the most accurate perceptions and judgments regarding their condition and treatment [26-29], reflecting the role of alcohol as self-medication [14] and the relevance of integrated treatment for people with this comorbidity [41].

The methodological choice was made to assess the importance attributed to IC for participation in treatment at the end of the observation period, as it was considered that could continue over time – either due to the nature of the addiction or because of the characteristics of the unit's care model and its usual therapeutic procedures. Informed consent was valued in the total sample, but it was observed that it was more valued by the group of participants who did not continue treatment ($p$=0.001).

A first reading of this result suggests that those who did not participate in the treatment viewed CI as a place where the right to refuse was affirmed. However, the fact that the vast majority of participants recognize the alcohol problem and the need for treatment (90.7%; n=136) suggests the hypothesis that those who did not remain in follow-up did not find in IC the opportunity to appropriate the self with skills to transform the desire to treat themselves into effective participation in the therapeutic process.

Thus, it will be emphasized, among other aspects, the importance of meeting the impact of judicial coercion and anxious symptoms in the decision-making process. These factors, when mobilizing and/or intensifying reactions of fear of stopping consumption, of relapsing,

or of surrendering to trust in a caring relationship, may be associated with responses of refusal or abandonment of treatment that reflect the limitation of the self with autonomy competencies.

## Final Considerations

In an ethic of care centered on people with alcohol problems, the refusal or early abandonment of treatment cannot be separated from the relational encounter of care attentive to the experiences of personal condition and relationships with others and/or with situations involved in treatment, from respect for human dignity understood as an expression of relational autonomy [42-44], and from the recognition that the participation of the person in the therapeutic process is fundamental to the success of the treatment [45].

Thus, and in addition to strengthening the strategies in the field of health promotion and education mentioned above, contributions are made to reinforce the practice of free and voluntary consent based on the recognition and promotion of autonomy as a way of obtaining participation in treatment:

1. With the person under judicial coercion, it will be important to:
   - **a.** Overcome the confusion between treatment and punishment by creating a relational environment that is not critical and excusable, but attentive to the movement to externalize the autonomous self in response to emotional reactions mobilized and intensified by the relationship with professionals and treatment, with a view to alleviating the suffering of stigmatization and promoting self-esteem and the cohesion of the self;
   - **b.** Deepen the insight into the alcohol problem and its consequences on the health and mental well-being of oneself and others, the stages of treatment, and the reasons for accepting or refusing treatment, affirming the therapeutic process as a way of reassuring the person of their capacity for autonomous self-care;
   - **c.** Increase clarification about fundamental rights and freedoms in the therapeutic context and, specifically, knowledge about the timing and nature of the information to be shared legally, avoiding morally irrelevant breaches of confidentiality [15];
2. With the person undergoing treatment disturbed by anxious symptoms, it will be important to:
   - **a.** Strengthen the understanding of the relevant information about possible therapeutic interventions, disseminated at an appropriate dose and in sufficient relational time, so to find the person in a state of greater psychological preparation;
   - **b.** Promote a person's ability to identify and reframe their fears and consider therapeutic alternatives, including the possibility of integrated treatment of clinical conditions in person, available as feasible and valid for them [41];
3. It will be important to reinforce the practice of IC as a place for an ethical care process:
   - **a.** Spread throughout time and the relationship, providing an opportunity for a person to appropriate the self with skills to transform the desire to treat themselves into effective participation in the therapeutic process, based on the person's ability to value and self-care for themselves;
   - **b.** Guided by the sharing of relevant and adequate information about the problem, the therapeutic alternatives, and the treatment process, provided at a dose appropriate to the psychological capacity to metabolize anxieties reactivated or intensified by personal condition, and contact with professionals and treatment, with attention to intellectual, sociocultural and health literacy levels;
   - **c.** Based on empathetic listening developed in a non-critical and excusing affective context, and on attention to the dynamics of intersubjective responses, particularly in the person undergoing treatment suffering from coercion and anxiety;
   - **d.** With respect for the person as a partner in the relationship and participant in the therapeutic process aimed at repairing the physical and psychological integrity of both the person and those close to them,

as well as the quality of relations with others and institutions.

In addition, an action to promote IC aimed at people with alcohol-related problems was developed in the form of an information leaflet. This brief booklet, constructed in the form of a question/answer — with the concern of making it easy to read and understand considering the level of education of most people undergoing treatment — had the following objectives:

- To promote autonomy as a central ethical value within the clinical interaction that supports the search for consent to participation in treatment;
- To mitigate the anxieties called for and intensified by and in the relationship with professionals and treatment, through the affirmation of the self with autonomous skills to transform the desire to treat oneself into effective action, regardless of the usual sources of external pressure;
- To encourage the dialogic process that leads to decision-making regarding the treatment, including its execution, modification, or possibility of interruption.

This information leaflet can be accessed by contacting the author.

One can see the generalization of the meaning of associations obtained in this study is limited to the national clinical population, as well as the use of instruments that have not been validated for the Portuguese population. Direct biomarkers were not systematically used to assess alcohol intake. This methodological choice would not be compatible with the therapeutic approach model of many professionals, and was considered to be ethically discouraged among participants who discontinued treatment.

This research reinforces the importance of developing further studies on the subject of free and informed consent in the area of treatment of disorders related to substance use.

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