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REFLECTIONS ON THE ETHICAL CHALLENGES OF INDIVIDUAL PSYCHOLOGICAL INTERVENTION

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psychological intervention
models and asymmetry of helping relationships
work ethic

Summary

The article presents reflections on helping in psychology and selected ethical dilemmas that accompany it: paternalism, and partnership. Psychological counseling is based on overt consent to violate the rights of the individual, which is a consequence of the asymmetry of the position and the competence, and responsibility of the participants. The helping relationship is built on personal trust and practice based on empirical evidence. Changes in the understanding of the relationships between the helper and the client/patient result, among others, in the creation of a better model of communication. A pitfall and threat to psychological intervention is the doubt about whose definition of "good" will be accepted as a criterion for its evaluation. Dialoguing about the solution to the client/patient's problem seems the best and safe antidote to the potential danger.

Introduction

The text presents a psychologist's reflections on helping in psychology as well as selected ethical dilemmas that accompany psychological support: paternalism and directiveness. Psychological interventions are based on the individual's explicit consent to the violation of his rights, which is a consequence of the asymmetry of the position as well as the competence and responsibility of the participants, which is an element of social knowledge about such interventions. As a result, psychological helping raises various types of problems and ethical dilemmas. After determining the essence of individual psychological intervention addressed to individuals and their types, I discuss the forms of relationships between paternalism and partnership, referring to the asymmetry of position and competence. The reflections end with indications of the pitfalls and threats of psychological intervention.

The considerations presented are not the result of an analysis of ethical codes or other normative texts. These reflections were inspired by questions raised by students during classes titled, "Ethics of the Psychology Profession"[1] as well as by practicing psychologists.

[1)] I have been conducting these classes since 2012 at the Faculty of Psychology and Cognitive Science of the Adam Mickiewicz University, as part of the psychology major.

It is then, I think, that the true context of code postulates appears more clearly. My article does not contain a diagnosis of the state of helping in psychology or a normative proposal for helping, but it points to the main themes of personal experiences and reflections on the implementation of the professional role of a psychologist in the field of psychological helping and summarizes them.

The essence of individual psychological intervention

Psychological intervention is an action undertaken to induce change in people, planned by a person educated to perform such tasks and based on his operational (theoretical) and pragmatic (from experience) knowledge. The essence of individual psychological intervention is the use of various forms of psychosocial interactions within interpersonal relationships, using verbal and non-verbal communication. The aim of the intervention is, mainly at the request of the individual(s), to change (also for preventative purposes) the mental processes and functioning [1], to better adapt to a given situation, and thus to optimize their personal resources. This intervention is used in many areas: education, upbringing, advertising and propaganda. The one that interests me here is the relationship of psychological support built on personal trust[2] and practice based on the results of empirical research. The change is intended to enable the implementation of behaviours, using regained skills or, more often, behaviours that were not previously included in the individual's repertoire and which he is not capable of on his own, or solely based on existing capabilities [2, 3].

The adjective, psychological, defines a specific form of intervention – based on knowledge about mental processes, motives of human behaviour, experience of the world, emotions, the content of an individual's mind, etc. It is based on a psychological diagnosis, which allows, among others, the discovery of what may be hidden even from the individual and therefore violates his privacy. This intimacy is protected by shame, which does not allow the revealing of what should be hidden. The need for privacy is strongly felt by people and its appeasement has important psychological functions. Nevertheless, the violation of intimacy is an inherent element of psychological diagnosis [2, 3].

Types of psychological interventions addressed to individuals

When we talk about types of psychological interventions addressed to individuals (as opposed to, for example, organizational psychological interventions), we assume that psychological intervention (like psychotherapy) also causes changes in brain connections and brain functioning [6]. Psychological intervention is a way to change the mind, primarily through words in a relationship built on personal trust. A professional triggers this change, but it is mainly the result of the subject's own activity [1]. The initiator of establishing a helping relationship is the person undergoing psychological intervention,

[2] This trust is an important element of the so-called therapeutic alliance (working alliance) that is, the co-realization of the agreed upon goals and tasks of therapy, in conditions of empathy and unconditional acceptance [4, 5].

motivated by the experience of discomfort. The source of this discomfort may be a mental disorder (illness) or the need to improve psychosocial functioning, as well as a perceived lack of something necessary, or an excess of something, which constitutes an individual obstacle to a subjectively meaningful and satisfying life [2, 3].

A person seeking help comes to the meeting with his problems, needs and goals, as well as with his life history, in which this contact is only a moment. Making the decision to seek help is an important life event which people take part in of their own free will and in which they try to cooperate with a professional, but in such a way and to such an extent that they achieve their goals. A professional brings professional knowledge, professional tools and procedures, as well as his value system and preferences for a specific helping style to the meeting. He not only provides a professional service, but also plays a specific social role, the content of which is providing help (benevolence – doing good), and the service and role of which are understood and accepted by the people seeking help [2, 3][3]. Professional knowledge allows one to notice the danger of the negative side effects of helping for both the recipient of the help and for his social environment. Specialist knowledge is also needed to recognize the limits of helping, when it becomes harmful or even takes the form of violence. Vigilance is important both for people seeking help and for those providing it [7].

Jerzy W. Aleksandrowicz [1, 8, 9] proposed – due to the blurring of the boundaries of the term "psychotherapy" – a clear division into psychological interventions addressed to people suffering from mental disorders (accepting the social role of a sick person and a patient) and help addressed to people without such disorders[4] [cf. also 10, 11]. Each of these forms has its own specific features.

The first type of intervention is a form of treatment of health disorders using non-pharmacological means (talking therapy), the aim of which is to remove the symptoms and causes of the experiential and behavioural disorders [1]. The areas of focus during psychotherapy (also called medical or clinical), as the method of choice, are the treatment of mental health disorders [11], including: neurotic, somatoform, personality, addiction, affective as well as psychotic disorders, described in diagnostic manuals (ICD, DSM). It can be said that this is a narrow understanding of the concept of psychotherapy, but it allows us to more clearly highlight the specificity of psychological help.

The second form of intervention for people without mental health disorders (also called "development-oriented psychotherapy", "psychological psychotherapy"[5]), includes helping people in difficult life situations, with their self-development or to gain a greater knowledge about themselves, or to improve their psychosocial functioning and increase

3) It is worth emphasizing that this is a service, not a favour, although from the perspective of the psychologist's clients it may sometimes seem like one, because meetings with a psychologist often resemble a conversation with a friend, although in fact they are task-oriented.

4) "Formulating such a definition requires, first of all, a distinction between psychosocial interventions aimed at treatment and those aimed at providing help. The name 'psychotherapy' is appropriate only for the former, in accordance with the meaning of the word 'therapy'; for the latter, the term 'psychosocial help' seems more appropriate" [1, p. 22].

5) Aleksandrowicz [8, p. 6] emphasizes that the connections between psychology and psychotherapy are mainly of a historical, not substantive ("theoretical") nature.

their coping skills [1, 8, 9]. In a satisfactorily organized society, life does not require daily sacrifice, heroism or an extraordinary level of competence, so few people seek help in this area [11, 12]. In the case of helping healthy people, the psychological problem of the individual is either that he is unable to satisfactorily meet the developmental tasks set for him [11, 12] or that he perceives the ineffectiveness of his actions in the face of his own expectations and is concerned about this due to a feeling of discomfort [2, 3]. It may take various forms [7, 9, 12–15]: psychological counselling in solving normative reactions to crisis or making important life decisions, identifying personal and social resources, diagnosing interests and predispositions, caring for people who need support in improving their close relationships, crisis intervention, resocialization, psychoeducation (especially in the field of knowledge about typical developmental problems or the course of an illness), psychopedagogical help, sociotherapy, participation in self-help groups, coaching, training of cognitive functions, assertiveness or interpersonal skills training, coping with stress, etc. Psychosocial interventions are also used to prevent health disorders (promotion of healthy behaviours and prevention) and to support the treatment of somatic and mental illnesses.

It is worth noting that both of the above forms of intervention differ in the intensity of asymmetry in the relationship [1, 9]. In the case of psychotherapy, a stronger asymmetry results from greater medical knowledge of one of the parties. It can, therefore, be said that the patient's compliance results more from his faith than his knowledge. The situation is different when providing help to people without mental health disorders. The client's needs and wishes[6] play a greater role here. In the case of helping, it seems correct to believe that decisions regarding the method and scope of helping should always rest primarily with the client, because his motivation and level of cooperation more strongly determine the effects of the help provided. When giving/receiving psychological help, the expected and actual asymmetry is smaller.

Models of the psychologist-individual relationship: between paternalism and partnership

Describing the authoritarianism of psychoanalytic psychotherapy, Jeffrey Moussaieff Masson[7], in the preface to his book [16, p. 25] writes: "my main goal is to demonstrate that the very idea of psychotherapy is bad. The structure of psychotherapy is such that no matter how nice a person is, when he becomes a therapist, he engages in activities whose goal is to diminish the dignity, autonomy and freedom of the person who comes for help" (cf. also 17). Elsewhere, he writes [16, p. 192]: "violence, regardless of its form, is built into the structure of psychotherapy." The views expressed by this author are not only controversial, but also one-sided, but they nevertheless draw attention to the problem still experienced today by patients and clients of psychological help – the violation of their right to autonomy.

6) There are also exceptions: career counselling is definitely more directive than other forms of helping.

7) J. M. Masson has a PhD in Sanskrit. In 1970, he began his psychoanalytic studies at the Psychoanalytic Institute (Toronto), completing the full clinical course 8 years later. In 1980 he was appointed director of the Freud Archive project and after publishing texts critical of psychoanalysis, he was dismissed from this position and stripped of his membership in psychoanalytic professional associations.

A form of limiting an individual's autonomy is that the therapist bases his actions on an arbitrary definition of the well-being of the individual (paternalism). The second form of domination is the specialist's imposition of solutions, a plan for their implementation and justifications for these actions, as well as external motivation (directiveness). Both of these aspects of violating autonomy are often referred to by the synthetic term "paternalism".

There may be different models of the relationship between a psychologist and his client or patient [18], and these models can be placed on a dimension ranging from paternalism to partnership. There is the legalistic model, i.e., a relationship based on compliance with applicable prohibitions (what is good is what is legally permissible). The scope of interference is determined arbitrarily by the creator of the law, a figure external to the specialist and his client. The law, like a contract, allows for the institutionalization of a lack of trust [16]. Another relationship model is the economic model (consumer or business), when the essence of the relationship is the sale of psychological services. The specialist informs what he has to offer (knowledge or conscience have nothing to do with it; the "hired gun"[8] attitude), and the consumer either buys it or not. In this model, the client's autonomy prevails over the psychologist's. There is also the negotiation or contract model in which what is favourable and what is unfavourable is determined as a result of negotiations. The negotiated procedures completely determine the understanding of this relationship and the appropriate principles of operation, beneficial to each party. The result of the negotiations is the construction and enforcement of a contract and the institutionalization of the relationship (although the assumed equality of the parties is superficial). In this approach, the negotiation seems more important than its effect (contract). There is also the religious model in which the essence of the relationship is the realization of a mission: a kind of obligation with the characteristics of a promise as well as that of a moral and religious obligation.

There is a group of professions that are socially perceived as a service or sacrifice. The basis of a professional relationship here, is the personal commitment and sharing of resources by one of the parties in order to improve the difficult situation of the other person. In this understanding of a relationship, it is easy to ideologize it and adopt the worldview of the stronger party in the relationship as a criterion for assessing the method and purpose of helping.

The issue of providing help can also be analyzed from the perspective of attributing responsibility for the problem (for a past event) and for solving it (who is to control future events), and this in turn will influence the goals and forms of providing help. In this approach, we can point to four alternative models of providing help [19, 20, pp. 22–23]: the medical, enlightenment, compensatory and moral model.

In the medical model, the individual is not responsible for creating the problem or for solving it. It is believed that the problem was caused by external factors, and the specialists helping must apply the appropriate procedures to solve ("cure") the problem. The problem and its solution are understood here in a deterministic way, independent of the will and capabilities of the individual. In fact, it is expected that the individual will not solve the problem on his own. It is the expert or specialist who takes full responsibility for

[8] As in an expert hired to do a specific and often ethically dubious job.

solving it. In the medical model, people with problems see themselves, and are perceived by others as sick and incapacitated[9].

In the enlightenment model, the individual is considered responsible for the problem, but the solution of the problem is left to specialists in a given field or authority (authorities, "professionals" or other social control factors). The emphasis is on making participants aware (enlightenment) of the true nature of their problem and their responsibility, which they may not recognize. In this model, people must submit to strict discipline and formal and informal social control, because only this ensures a credible and effective solution to the problem (an example is the Association of Alcoholics Anonymous). Sometimes this help is accompanied by conversion of others and proselytism, and sometimes by labelling and stigmatization.

A model in which people are not responsible for causing their problems but for solving them is called the compensatory model. Compensation refers to an individual taking responsibility for compensating for his shortcomings or lack of resources through effort, ingenuity or cooperation. Collaboration with others empowers (empowerment) the action of the individual, and he is responsible for recognizing the opportunity to solve his own problem. Responsibility understood in this way does not encourage blaming oneself or others and allows one to concentrate on the task of coping with the issue.

The model in which people are assigned responsibility for creating and solving their problems is called the moral model. According to this model, it is the individual who metaphorically "chooses" the problem (e.g., due to weakness of character or risky behaviour) and can change it if he wants to – this is determined by his self-motivation.

Yet another classification that can also be applied to the relationship between the person who helps and the one who is helped, is proposed by Ezekiel J. Emanuel and Linda L. Emanuel [22]: the paternalistic, informational, interpretive and joint consultation model. These four models of doctor–patient interaction take into account different understandings of its goals, the doctor's responsibilities, the role of patient values and the concept of patient autonomy.

Paternalism, etymologically, refers to the attitude of the father of the family who, realizing that children are not capable of conscious and rational choices, cares about their well-being without taking into account their opinion on this matter [18]. Such concern is widely accepted and is treated as a character virtue. However, when such actions are taken against people capable of making decisions for their own good, they are assessed negatively, regardless of the positive effect. Of course, the importance of kindness, the concern for well-being, the protection of individuals or the act of freeing an individual from difficult decisions is not denied, but acting on these aspects without the acceptance and even against the will of a given person, sometimes under conditions of coercion, is criticized [18]. Fruitful upbringing means allowing children to grow up to be independent.

In the paternalistic model (sometimes called the parental or priestly model), the specialist independently decides which method of treatment is most appropriate, and then provides the patient with selected information and convinces him to consent. In the

[9] It is also indicated [16, 21, p. 23] that treating the illness instead of treating the patient may lead to an unintentional indictment and stigmatization of the sick person.

information model (sometimes called the scientific, engineering or consumer model), an expert-professional shares his knowledge about treatment methods, providing problem-relevant information about the nature and probability (uncertainty) of the risks and benefits, so that on this basis, the patient can make an informed choice regarding the medical interventions that best realize his values and interests[10]. It can be said that the specialist provides the facts and the patient is guided by his own well-being.

The interpretive model, like the previous one, involves the doctor providing the necessary information. The subject of the interpretation are the patient's values and goals and providing him with related information about his health condition and the risks and benefits associated with various treatment methods, as well as assistance in making decisions that bring him closest to realizing his values. This requires the patient to engage in a shared process of understanding.

The last model is the model of joint consultation, in which the specialist supports the patient in the decision-making process, jointly analyzing all the consequences of using various methods and selecting the most appropriate diagnostic and treatment methods. The doctor does not negotiate values, but only informs how the disease and treatment may affect the achievement of the patient's goals. In the deliberative model, the doctor serves as an advisor or guide, engaging the patient in dialogue about the best course of action for him. This allows the patient to autonomously evaluate alternatives.

As I mentioned, the models of relationships between a psychologist and his client or patient can be, simply put, described on a paternalism-partnership continuum[11]. From a psychological point of view, a better term would be monologue-dialogue, with an emphasis on empathetic listening and sympathetic consideration of arguments during dialogue. It is difficult to imagine relationships based solely on the patient's or client's autonomy, or solely on cold professionalism. A dimensional approach is better than a categorical one, because helping must include both directive and non-directive[12] forms. Closer to the paternalistic (monologue) end, we can place the legalistic or religious models, the medical model, the enlightenment model, or the paternalistic model. On the other side, closer to the partnership (dialogue) end, we would see the economic and contractual models, the compensation model and – to some extent – the moral, informational, interpretive and deliberative models. Relationships that are closer to the paternalistic end can be described as based on prohibitions and punishment, relationships in which diagnosis and treatment are based on the knowledge of a specialist-expert, in which the problem and its solution are independent of the will and capabilities of the individual, and even where they are considered guilty because of their inability or unwillingness to solve them. The transfer of knowledge is

10) Aleksandrowicz [23, p. 18], however, points out that in this respect, the situation of a psychotherapist is different than in the treatment of somatic diseases, because knowledge about mental disorders is less universal and more contextual.

11) According to Kazimierz Szewczyk [24], we are dealing with an acceleration of the process of moving away from the paternalistic model of the doctor-patient relationship, towards anti-paternalistic approaches as well as from an individualistic approach, towards understanding relationships in the psychosocial context (cf. also [21, p. 25, 28 et seq.]).

12) Different paradigms in psychotherapy, just like different forms of psychological help, differ in their level of directiveness. Patients or clients, therefore, also differ in their search for and acceptance of paternalism.

more persuasive than educational and mainly serves to induce the individual to agree to the professional's actions. The specialist assumes that the person under his care does not distinguish between "I need" and "I want" and that it is his prerogative to determine what the well-being of the individual is.

Partnership relationships, on the other hand, assume the equality of the parties in the relationship. The specialist presents an offer, and the recipient of the service chooses one of the options – the selection criterion is based on his interest: profit or well-being. The parties can negotiate the final shape of the offer and are obliged to implement the contract to its letter (spirit?). Analyzing the problem from various perspectives, taking into account the values and goals that guide the person and the obstacles the problem creates, allows to find the best way to solve it. There is no atmosphere of blaming anyone in this relationship, because finding the culprit does not bring the parties any closer to solving the problem. The specialist complements the person's resources with his competence and helps him find a solution to the problem. Specialized knowledge makes it possible to indicate the pros and cons of an individual's subsequent choices.

Asymmetry of relationships and communication processes

The asymmetric nature of the specialist-client relationship, especially in terms of knowledge and skills, is an inherent element of professional interactions. There are, however, professions in which this asymmetry and the resulting specialist domination, are accompanied by inequalities in other areas. The profession of a psychologist is widely considered to be a profession of social trust. It is a profession whose practice is associated with a social contract resulting from the special role played in society by professionals performing a given profession. At the same time, service recipients require special protection because they entrust specialists with, among others: information about their private lives, with the belief that it will be used for their benefit. The service recipient most often, openly relinquishes some of his autonomy and puts himself in the hands of the specialist.

The professional relationship between a psychologist and his client is, in fact, asymmetrical, both in terms of competence, responsibility for actions taken by both parties (consequences) and control over the content of the relationship (it is the client's emotions, experiences, memories that constitute the main topics of the relationship) as well as formal and social position (power), which creates a situation of an inequality of rights [7]. The asymmetry also concerns the position: it is the service recipient, not the specialist, who suffers and seeks help; therefore, it is the specialist who takes responsibility for the relationship. The professional role of a psychologist includes social consent for his unauthorized interference in the existence of another person [25]. Formal and institutional asymmetry is reflected and reproduced in interactional asymmetry [26]. Communication may then be more of a field for negotiating power and creating an interactive identity for participants than for building interpersonal relationships [26]. An element of the implementation of the professional role of a psychologist is, to a greater or lesser extent, the unintentional violation of an individual's personal rights: his right to intimacy, privacy,

confidentiality, personal secrecy, secrecy of correspondence[13], self-decision and autonomy [27, 28]. People using the services of a psychologist usually consent to it because they are either forced to undergo an examination as a result of certain regulations or, they hope to obtain help – which, however, should never exempt psychologists from using it prudently and minimizing the violation of these rights [27]. As Mario Bunge wrote [30, p. 159]: "Do your job as best as you can and do not profit from the weaknesses (physical, economic or cultural) of people using your services."

A model example of limiting the autonomy of one of the parties, is medicine. Traditional principles of medical conduct reflected in old deontological codes, minimized the patient's role in the treatment process. The ancient Hippocratic Oath says much about the doctor but nothing about the patient. It was assumed that the doctor knew what was best for the patient and had the right to decide on his behalf about the entire diagnostic and treatment process, without even asking for his consent. In practice, this reasoning expressed an extremely paternalistic attitude. There was, however, nothing strange about this, because this model of relationships had widely been used in society for a long time, not only in medicine. For centuries, paternalism, resulting mainly from the asymmetry of competence and power, has been widely accepted and even expected in medicine, education and bureaucracy.

Today, the asymmetry of competence is smaller than before. In the case of a doctor-patient relationship, using the Internet (including forums for people with a given illness) allows the patient to access information. On the other hand, the level of the complexity of medical knowledge is increasing. It seems that both these processes are irreversible: the Internet gives access to many sources of information and at the same time the level of knowledge is growing. Using the services of specialists is not an easy decision: visits to a psychologist or psychiatrist cause embarrassment, shame, stigmatization and discreditation [7, 27, 29]. Taking into account the psychological aspect of the helping (treatment) relationship and the adoption of the primacy of the patient's autonomy as a fundamental ethical principle, the asymmetry in this aspect has shifted towards the patient (client) [14]. Reducing the asymmetry (distance) is also facilitated by the creation of regulations such as patients' rights or the establishment of the Office of the Patients' Rights Advocate[15] [31]. What limits asymmetry in psychological interventions is the requirement by code, to sign a contract: the client must be informed about all relevant circumstances of the psychological service, such as the scope, duration, confidentiality and its limitations, etc[16]. However, the formalization of mutual expectations may cause a contractual relationship to become the opposite of a relationship based on trust, duty and obligation. The contract becomes a formalized expression of a lack of trust. As a result, instead of implementing the postulate of beneficence towards the client (beneficence-in-trust), the psychologist may strive only for the literal fulfilment of the signed contract, at the expense of the client's

13) They are a tool for realizing the right of an individual to dignity, which is the basis for constructing the meaning of life, and an indicator of this need being met is, self-esteem [28].

14) This is more due to the efforts of patients (clients) than to specialists, although more depends on the latter.

15) The first Patients' Rights Charter was based on the Declaration on the Promotion of Patients' Rights which was established in Amsterdam in 1994.

16) It is worth noting that in many countries, professions that are related to, generally speaking, helping, lack ethical codes with a strong emphasis on the dialogic form of creating a contract.

well-being. The only moral evil is then considered to be insufficient compliance with the accepted contract, not a lack of help [27]. Nowadays, the asymmetry of responsibility is also changing – on the one hand, patients (clients) understand that part of the responsibility for the final effects also rests with them and depends on the level of their cooperation. On the other hand, the responsibility of specialists providing the help (treatment) is often codified in the relevant regulations, and breaking them may, to the maximum extent, result in the withdrawal of their right to practice the profession.

It must not be forgotten that the person helping also bears the costs of the burdens resulting from the performance of their professional role. Jörg Fengler [32] describes examples of personality deformations as a consequence of fulfilling the professional role of a psychologist. First of all, he indicates the professional burnout of helpers and the violation of the work-life balance: emotional exhaustion, a reduced sense of self-competence and effectiveness, and the depersonalization of patients/clients. In addition, he draws attention to excessive identification with the professional ethos and patients/clients, selective perception of reality mainly from a professional perspective, falling into routine and schematic thinking, theatricalization of emotions and behaviour, loss of empathy and mechanical acceptance of patients'/clients' statements, or the compulsion to interpret the behaviour of loved ones and friends.

Perceived pitfalls and dangers of psychological interventions

Based on an unwritten social contract, it is assumed that the essence of the mutual relationship between a psychologist and his client is trust in the knowledge and professional skills of the psychologist and trust that the client's well-being will be the basic criterion for assessing the psychologist's actions. It is assumed that this well-being can be gradable: from the minimalist principle of "do no harm" to the paternalistic limitation of the autonomy of the client of the psychologist "for his well-being" [27]. Therefore, in a sense, the term "well-being" is treated as a primary concept. In 2013, the journal "Roczniki Psychologiczne" published a discussion on the understanding of well-being in various areas of the professional activity of psychologists. The issue opens with the voice of Katarzyna Sikora [33, 34]. After analyzing the content of various codes of professional ethics for psychologists, she states that "well-being" is defined as being both subjective and objective, a good quality of life, the development of individual resources or benefits as well as the respect for individual rights. In this discussion, Małgorzata Toeplitz-Winiewska [35] draws attention to the need to indicate who is to determine the "client's well-being" because there is a risk that it will be decided by the psychologist (specialist). Whenever possible, we should include our clients/patients in the decision-making process and put more trust in dialogue rather than monologuing. Maria Boratyńska [36] points out that prior information from the service recipient on how he defines his well-being and entrusting a specialist with the professional implementation of this well-being does not in itself ensure protection of the patient's/client's autonomy. The mere indication of the code that the recipient of psychological services has the right to their own understanding of their well-being [25] is also insufficient. The person seeking help should be able to cognitively

control the realization of this well-being. The mere intention or obligation to provide professional help is not sufficient, because the assessment of the value of help depends on its usefulness and expected effectiveness[17]. The usefulness is assessed by the person in need of help, not by the person giving it [37]; the assessment of its effectiveness is based on specialist knowledge. It is also better to link "well-being", in codes of professional ethics, to the psychologist's duties rather than to the rights of the individual (client), because this makes them less declarative.

Just as a psychological diagnosis, by definition, violates a person's privacy and intimacy, psychological intervention violates their autonomy. Autonomy means self-reliance, self-determination, self-management, independence, one's own way of life, freedom. Autonomy also involves making choices and responsibility. Paternalism is its opposite. From the perspective of developmental psychology, autonomy is the basic goal and essence of the entire process of human development. For individuals, it is a search for the individual meaning of life and a source of new experiences that influence the shape of identity.

We can talk about a weak (soft, moderate) and a strong (hard, radical) form of paternalism [38]. In the first case, we act without the consent of an individual who, in the light of the data, does not have the mental capacity to understand and transmit information, and to make, on this basis, a decision regarding his participation in the psychological service. We talk about the second case (strong paternalism) when the decision made by the service recipient is conscious and based on knowledge, and yet it is not taken into account by the service provider. Two forms of "strong" paternalism are indicated: authorized and unauthorized [36, 39]. Authorized paternalism occurs when a patient or client consents to the actions of a specialist (assuming his actions are *bona fide*), but does not want to be informed in detail about his condition or the form of help provided. Authorized paternalism may also take the form of a specialist's presumption that his client or patient trusts him based on a general knowledge (stereotype?) and on this basis he would grant authorization and/or actually has granted it. An element of this general knowledge is also the awareness of who to expect specific help from and the very fact of seeking it justifies the specialist's belief that the individual has, in a sense, consented to providing it.

Unauthorized paternalism is an action without the person's explicit consent as to the form of help provided to him, or even against his consent, even though he is fully aware and capable of making independent decisions. This action is taken regardless of the ac-

17) An example of the fact that when it comes to helping, the road to hell is paved with good intentions, is the case of a bear cub described in the media. In the Bieszczady Mountains, near Teleśnica, foresters from the Ustrzyki Dolne Forest District found that his mother had left him and gone away with her second bear cub, and that he was being tracked by wolves, so, they "captured" him. He was weak, thin and sick, but it was believed that he could be saved and he was transferred to the Rehabilitation Centre for Protected Animals in Przemyśl. He was named Ada (after the name of the Foundation that took care of him). There, treatment for tick-borne diseases was undertaken but unfortunately, the neurological symptoms did not subside. After a week of treatment, the bear cub was euthanized. Presumably, his mother had left him to die naturally for fear of infecting his sibling. Dr. Robert Maślak, a biologist and bear specialist, comments on the bear's euthanasia in the following way: "If we attribute dignity to animals, this bear had it taken away before it died. The prolongation of agony, called treatment, lasted for almost a week. He could have died sooner without being a 'teddy bear' and the circus that was organized around him." https://m.facebook.com/MaslakRobert/photos/a.297459031052974/1098381674294035/

ceptance of the degree of (ir)rationality of this decision. It is often rationalized by the specialist's assumption that there are circumstances excluding the need to ask for consent (higher-order reasons). In practice, it may be difficult to distinguish between authorized paternalism and unauthorized paternalism.

In a sense, psychological help limits autonomy more than psychotherapy. According to Aleksandrowicz [9], reaching content repressed into the subconscious (insight) is more important in psychological help than in psychotherapy[18]. On the other hand, the similarity of the experiences of the person helping and his client, who is without a disorder, is generally much greater than that of the psychotherapist and his treated patient [9]. Compatibility of value systems and views in helping promotes effectiveness, unlike in the case of psychotherapy [23]. This similarity and the lack of insight in the interpretation of diagnostic data may encourage people to impose their own solutions (directiveness).

Additionally, treatment and helping differ in the intensity of asymmetry in the relationship [1, 9]. In the case of psychotherapy, the specialist has scientifically grounded medical knowledge and individual experience, so he has a better position in the therapeutic relationship. However, in the case of providing help to people without mental health disorders, specialist knowledge is less empirically grounded, its content often resembles everyday language, so the experienced inequality between the parties seems to be smaller. At the same time, giving up autonomy in favour of the specialist seems more difficult. Taking all this into account, it can be concluded that, on the one hand, the asymmetry during psychotherapy is greater, but psychological helping limits the clients' autonomy more. The legal protection of patients' autonomy is quite clearly defined, but psychological help is poorly established in law, so the situation of a doctor's patient is better than the safety of a psychologist's client.

Is there any progress in the asymmetry of the relationship between the helper and the client/patient? Are we keeping up with the contemporary challenge on the paternalism-self-determination dimension? If we understand progress as an improvement, development or refinement of the psychologist-client/patient relationship, we may have justified doubts. The implementation of the postulate of replacing the specialist's autonomy with the client's/patient's autonomy may have negative consequences. If knowledge is to be the criterion for making decisions, it cannot be a patchwork knowledge of "Doctor Google" or artificial intelligence. It is a fact that the monopolization of specialist knowledge is becoming less than in the past, but on the other hand, truth is not determined in a referendum! Categorization and going from one extreme to another is not a solution to the problem either. The postulate of increasing the knowledge of potential recipients of psychological services and the competence necessary for critical thinking is undoubtedly right, but it also means that professionals are relinquishing responsibility for solving an ethical dilemma. I think that joint, reflective movement on this dimension is a good way to search for a contextually optimal solution, as in the deliberative model of joint consultation.

[18] The opposite view on this matter is presented by Czabała [11, pp. 526–527].

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