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Abstract
Although the word psychotherapy, from the Greek (psyche + terapia) meaning soul healing, has multi-disciplinary roots, some of which date back to ancient Egyptian times, contemporary psychotherapy is predominantly aligned with health and healthcare. In response, the first part of the article interrogates the ideal of health and cure promoted by theories of psychotherapy; criticises the lack of critical practice regarding diagnosis; advocates a two continua approach to both sickness and health in psychotherapy; and argues that psychotherapy both is and is not a health practice. The second part of the article takes up the issue of the identity of psychotherapists and, by means of a review of different definitions of psychotherapy and of the more critical and radical traditions within the discipline and practice, argues that psychotherapists both are and are not health practitioners. The third and final part of the article offers a critical case study of the New Zealand Association of Psychotherapists' application for the state registration of its practitioners; and argues that such regulation and registration compromises the profession of psychotherapy, and thus that psychotherapy both is and is not a health profession.

Keywords psychotherapy; health practice; health practitioners; health professions; regulation

Psychotherapy practice, the practitioner, and the profession – In sickness and in health

KEITH TUDOR

Introduction

In the phrase "In sickness and in health", the conjunction "and" both juxtaposes and invites a dialectical consideration of the relationship between the two nouns "sickness" and 'health". Inspired by the original call for papers for the 8th International *In Sickness and in Health* Conference (held in Auckland, Aotearoa New Zealand), and the call for papers for this special issue of Aporia, this article discusses the sickness and health of the profession of psychotherapy. It discusses psychotherapy as a practice, with regard to its practitioner, and to the profession. It offers a critical perspective influenced by Marxist analyses of and perspectives on psychotherapy (Holzman & Newman, 1979; Parker, 2007; Sève, 1978; Tudor, 1997/2017), as well as post-modernist, deconstructive views of the practice and profession of psychotherapy (Burman 1994/2017; House, 2003, 2010; Parker, 1999; Parker et al., 1996), and indigenous critiques on what is, in effect a Western (and Northern) tradition of psychology and its therapies (see Shepherd & Woodard, 2012; Woodard, 2003). The critique offered in this article is theoretical, practical, and personal in that it draws on literature about the practice and profession of psychotherapy, it discusses the implications of such critique for practice, and it's personal in that, having long-argued for the professional regulation of psychotherapy, the author, who lives in a country in which the title "psychotherapist" is protected and regulated by the state (Aotearoa New Zealand), and practices psychotherapy chooses not to be a registered psychotherapist.

The purpose of the article is to question the positioning of psychotherapy as a health practice and, academically, a health science, as distinct, say, from a discipline in humanities and/or social science; and, therefore, to question the positioning of the psychotherapist as a health practitioner; and, finally, the

profession of psychotherapy as a health profession – all from a dialectical "both…, and…" perspective. Finally, it is hoped that the critical analysis advanced in this article is applicable not only to the practice and profession of psychotherapy internationally, but also to other professions situated in and beyond health and social care.

Psychotherapy practice

Although psychotherapy, from the Greek (psyche + terapia) means soul healing, and has multi-disciplinary roots, some of which date back to ancient Egyptian times, contemporary psychotherapy is predominantly aligned with health and healthcare, which, ironically, generally refers to ill-health and illness and the care of illness.

It is commonplace to date psychotherapy back to 1896 when Sigmund Freud introduced the term "psychoanalysis" (e.g., Norcross et al., 2011; Paris, 2013). There are, however, two problems with this particular carbon dating: firstly, that it equates psychotherapy with psychoanalysis, which is problematic as there are traditions of psychotherapy which are not psychoanalytic; and, secondly, it ignores other traditions that predate Freud. These include:

- Healing traditions – early Egyptian papyrus (c. 1550 BCE) refer to dementia and depression; in ancient Greece, Hippocrates of Kos (c.460–c.370 BCE) taught that melancholia has a biological cause (Kourkouta, 2002); and, thoughout the world, there are different and diverse traditions of indigenous healing. In their recent book, A Critical History of Psychotherapy, Foschi and Innamorati (2023) acknowledge the(se) ancient origins of psychotherapy, and the existence of mental health care from antiquity.

- Medicine – in the Western tradition, this includes the mental healing practices of Paracelsus (1494–1541), a Swiss physician; Franz Anton Mesmer (1734–1815), an Austrian physician who first developed a concept of what he called animal magnetism, which later came known as mesmerism, and later still as hypnotism; and the work of the English surgeon and writer, Walter Cooper Dendy (1794–1871) who, in 1853, introduced the term "psycho therapeia".

- Psychiatry – from the work of Philippe Pinel (1745–1826) who, as director of the Bicêtre and Salpêtrière asylums in Paris initiated a nonviolent and non-medical moral treatment which has been described as cultivating "a warm and trusting familial environment in which [patients] could feel that their mental condition did not in any way preclude participation in normal human activities." (Grob, 1966, p. 11)

- Academia – from 1811, when Johann Heinroth (1773–1843), the German physician and psychologist, who was the first to use the term psychosomatic, was appointed as (the first) Professor of Psychic (Psycho) Therapy.

- Lay practitioners and consumers – including, from the mid 19th century, spiritualists, the mind cure movement, and the mental hygiene movement (see Beer, 1908; Cautin, 2010; Tudor, 1996).

- Ministry – formally, from 1904, in the work of Elwood Worcester (1862–1940) who, as Minister of the Emmanuel Church in Boston, Massachusetts, developed a programme that "fused religious faith and scientific knowledge" in the treatment of functional nervous disorders (Caplan, 1998).

- Psychology – from work of Heinroth and of William James (1842–1910) who, amongst other things, investigated different levels of consciousness; of Lightner Witmer (1867–1956) who, in 1896, established the first psychological clinic, at the University of Pennsylvania, to assist children with educational impairments, and was the first to use the term clinical psychology to denote a distinct profession; and of John Watson (1878–1958) who claimed psychology as "a purely objective experimental branch of natural science [and i]ts theoretical goal [as] the prediction and control of behavior." (Watson, 1913, p. 158)

- Social work – from 1909 and the establishment of the first child guidance clinic in Chicago (although the term "Child Guidance Clinic" was not coined until 1922)

Reclaiming this multi-disciplinary history is important not only for historical accuracy, but also in order to challenge unitary thinking that views psychotherapy as (only) a health discipline (see Manning in Manning et al., 2017/2020).

In this context, it is interesting to note that, as psychoanalysis was finding and claiming its place and Abraham Brill, an American psychiatrist and early exponent of psychoanalysis, was arguing for this to be in medicine, Freud (1927/1959) argued that:

> Psycho-analysis is a part of *psychology*; not of medical psychology in the old sense, not of the psychology of morbid processes, but simply of psychology. It is certainly not the whole of psychology, but its substructure and perhaps even its entire foundation. The possibility of its application to medical purposes

must not lead us astray. Electricity and radiology also have their medical application, but the science to which they both belong is none the less physics. (p. 72, my emphasis).

Moreover, Freud (1926/1959) was strongly against prohibition and restriction of the practice of psychoanalysis, arguing that, "If [such] prohibition were enacted, we should find ourselves in a position in which a number of people are prevented from carrying out an activity which one can safely feel convinced they can perform very well". (p. 234)

The differences between Brill and Freud regarding the question of analysis and lay (i.e., non medical) analysis was to become key in the development not only of the practice of psychoanalysis but also of the discipline, profession, and professionalisation of psychotherapy (see pp. 13-14 below).

In the hundred years since these debates – let alone the nearly 4,000 years since the Egyptian references to dementia and depression – Western psychotherapy comprises a multiplicity of different approaches (now over 1,000) drawing on very different influences. Some of these forms and influences encompass critical and radical perspectives, namely: Marxist psychoanalysis, mutual analysis and co-counselling, anti-psychiatry, Marxist humanism, radical psychiatry, feminist therapy, red therapy, social action psychotherapy, pink and queer therapy, social therapy, ecotherapy, anti-oppressive practice, process-oriented psychology, indigenous therapy, and power-sensitised counselling (see Tudor & Begg, 2016). However, notwithsanding such traditions (about which most psychotherapists know very little, primarily as this critical perspective does not appear in the curricula of their education/training programmes), mainstream psychotherapy is strongly aligned to the medical model of health and illness and to framing its work in terms of diagnosis, treatment, and cure – and, indeed, despite the best endeavours of Carl Rogers who emphasised the client (Rogers, 1951) and the person (Rogers, 1961), to referring to the people with whom they work as "patients". One example may be found in the history of the New Zealand Association of Psychotherapists (NZAP) (since 2024 the Association of Psychotherapists Aotearoa New Zealand [APANZ]), with regard to the establishment of which, Manchester and Manchester (1996) made the following observation:

> The setting of the membership fee at "one guinea" may have been a reflection of the [then] current acceptance of a strong limkage between psychotherapy and medical and psychiatric practice and that the linkage with medical practice was seen to be necessary to promote legitimacy and public acceptance. (p. 21)

Here, as part of the wider, interdisciplinary project of deconstructing the terms "diagnosis", "treatment", and "cure", and of separating psychotherapy from the medical model of health, I offer a brief sketch of some objections to each of them, as well as some alternatives that do and could further influence psychotherapy practice.

Diagnosis

The English word diagnosis come from the Greek words dia (= apart) and gignōskein (= to recognise or know) which, together, gives us "to distinguish or discern". In its different forms psychotherapy has numerous ways of distinguishing what people present as causes or sources of concern or distress; of discerning between different states of being, self, and personality; and of knowing. Yet, when it comes to "diagnosis", most training courses in psychotherapy teach trainees the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (APA) (now in its fifth edition [APA, 2023], justifying it as what they (the trainee/practitioner) need in order to be able to work with psychiatrists. In the same vein, the Advanced Clinical Practice qualification offered by the APANZ requires its candidates to include "clinical diagnosis" as part of its written work assessment (NZAP, 2020). Apart from the fact that there are a number of criticisms of the *DSM*, one of which is that its increasing number of diagnoses is pandering to the insurance industry (e.g., Ede, 2021), this strategy represents a serious own goal in the education and acculturation of psychotherapists as it prioritises psychiatric knowledge over psychotherapeutic knowledge with its own, theories, concepts, and models of diagnosis; and colludes with a social level power play (Steiner, 1974) in which psychiatry (and, similarly, psychology) is seen as superior to psychotherapy. As Duncan et al. (2004) put it (some 20 years ago):

> It is time to dethrone diagnosis as the flower of mental health and stop using the excuse that we misdiagnosed to get paid. The only reason we use it for reimbursement is because we haven't articulated the pitfalls of diagnosis to funding sources, nor have we offered anything different. (p. 30).

Rogers (1951) offered a different perspective:

> Therapy is basically the experiencing of the inadequacies in old ways of perceiving, the experiencing of new and more accurate perceptions, and the recognition of

significant relationships between perceptions.

> [Thus] In a very meaningful and accurate sense, therapy is diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than the intellect of the clinician. (p. 223, my emphasis)

Treatment

Similary, the word treatment is used across different traditions in psychotherapy, extensively and largely uncritically, e.g., Freud (1912/1964), Rogers (1939), Berne (1966), Rangell (1985), Arroyave (1986), Donner (1991), and Arden (2008). In transactional analysis, one of the requirements for its qualifying written exam is to have a "treatment plan" (ITAA, IBoC, 2022, Section 8.5.3.10, p. 14). As with diagnosis, from a critical perspective, it's important to think about and use different words such as "therapy" or even "psychotherapy"! Rogers (in Rogers & Russell, 2002) put this well in an interview recorded in the last year of his life and published posthumously:

> Too many therapists think they can make something happen. Personally I like much better the approach of an agriculturalist or a farmer or a gardener: I can't make corn grow, but I can provide the right soil and plant it in the right area and see that it gets enough water; I can nurture it so that exciting things happen. I think that's the nature of therapy. It's so unfortunate that we've so long followed a medical model and not a growth model. A growth model is much more appropriate to most people, to most situations. (p. 259)

So, rather than "treating" people prescriptively, I suggest that it is important to consider what soul healers actually do, and that our methods may include; listening, analysing, directing, touching, empathising, confronting, minding (Tudor, 2018) – and much more.

Cure

Whilst the word and concept cure is also more often associated with the medical model (e.g., Berne, 1961/1975), interestingly, it was also used by radical psychiatrists to emphasise the aspiration of and their commitment to facilitating change – "therapy means change, not adjustment" (The Radical Therapy Collective, 1975) – in the context of their critique of interminable analysis that, while encouraging and/or providing insight, doesn't necessarily result in any change. Nevertheless, the word cure carries a certain idealised view of health and the promise of a permanent resolution of a condition, and the concept carries the implication that the medical or medicalised practitioner decides what constitutes cure. Concepts which reflect other purposes and outcomes of psychotherapy, include insight, connection, authenticity, liberation, and social purpose (see Tudor, 2018).

Finally, on the question of the nature of the practiceof psychotherapy, Totton (1997) has long argued that psychotherapy is "a spiritual and political practice" (p. 129); and Aron and Starr (2013) reminded us that "for a long time psychoanalysis was as much a social movement, a movement for reform in education, social policy, and culture as it was a treatment method" (p. 28). Thus, psychotherapy is not a de facto health practice (i.e., from the fact) but rather ex contextu (from the context). Moreover, as long as health practice is dominated by the Western allopathic medical model, if psychotherapy has any ambition to reach parts of the person – and parts of the world – that other therapies don't reach, it needs to remain open to other descriptions of psychotherapy or soul healing and embrace the reality that psychotherapy both is and is not a health practice.

The psychotherapy practitioner

Following on from the first part of this article, this second part turns its attention to the issue of the identity of psychotherapists, specifically as health practitioners, which I argue has been influenced by three forces: firstly, the early splits in psychoanalysis and differences and divisions within psychotherapy; secondly the small but articulate critical and radical tradition within psychotherapy; and, thirdly, the increasing professionalisation of the discipline, part of which has led some countries in the world, including Aotearoa New Zealand, to legislate and restrict the use of the term "psychotherapist".

Early splits

As with many disciplines, psychotherapy has both suffered and developed from splits between founders, followers, and subsequent proponents. Freud himself had a number of close associates, including Alfred Alder, Carl Jung, Otto Rank, Wilhelm Reich, and Sándor Ferenczi, all of whom split from Freud in some way, and all of whom Freud rejected (see Grosskurth, 1991). At one point, as Makari (2008) reports it: "Freud declared Adler's ideas as too contrary, leading to an ultimatum to all members of the [Psychological Wednesday] Society (which Freud had shepherded) to drop Adler or [themselves] to be expelled, thereby disavowing the right to dissent."This dynamic has continued not only in psychoanalysis – see Kirsner's (2009) study of what he refers to as Unfree Associations – but also in the wider field of psychotherapy in which there are disciples who generally want to consolidate what they consider to be the core principles, theories, and practice of the original approach, and to exclude those who don't adhere to these (see, for example, Steiner et al., 2003); and other colleagues who, as a result of theoretical and/or personal disagreements, break away from a parent institute and/or organisation, and found their own branch or school of psychotherapy and/or professional association(s).

These splits have led to psychoanalysts and psychotherapists identifying with their different theoretical orientations or modalities, not least to distinguish themselves from others. Add to this, practitioners who associate themselves with the different forces in Western psychology, i.e., psychoanalysis, behaviourism, and humanistic psychology, and the schools and modalities within each of them, and we have a plethora of practitioner identities. What also interests me is how this has become quite personal and individualised. For instance, when I qualified as a transactional analyst in the mid-1990s (as that was my qualifying training), I registered with the professional body in the United Kingdom as a transactional analysis psychotherapist. One of my close colleagues, who had undertaken exactly the same training, registered as a relational psychotherapist as that's how she wanted to identify and be identified. I notice a similar tendency with graduates from the psychotherapy programme at Auckland University of Technology (AUT) which, technically is a generic programme based on a broad approach to relational psychotherapy, who identify themselves variously as arts and creative therapists, body-mind therapists, gestalt therapists, and integrative therapists, but, predominantly as psychodynamic and/or psychoanalytic psychotherapists, not least, I suspect, as these identities have higher status in the eyes of the main professional associations in this country.

Critical and radical perspectives

Earlier, I referred to a number of critical and radical perspectives (Marxist psychoanalysis, mutual analysis, and so on), each of which have also spawned associated identities, thus: radical psychiatrists, feminist therapists, and so on. Indeed, one of the radical aspects of radical psychiatry was that its proponents were not psychiatrists but, by claiming that identity, were reclaiming the definition of psychiatry also as soul healing. Interestingly, Freud (1926/1959) himself wrote approvingly of "peasant healers"; and, in the same spirit, Southgate and Randall (1976/1978) coined the term "the barefoot psychoanalyst".

Critical and radical perspectives offer an alternative to an over-adaptation to norms of identity. In Aotearoa New Zealand, when the state registration of psychotherapists came into force in 2009, those of us who chose not to register with the psychotherapists' registration Board had to choose another identity. These encompassed: analyst, counsellor, family therapist, kaiwhakaruruhau, minister, psychodramatist, transactional analyst, traumatologist, and wahine Māori social and mental health care provider (see Tudor, 2017/2020b). Although some registered psychotherapists criticised the use of these terms, I would argue that they represented – and still represent – a conscious and conscientious objection to state control of professional identity.

In their book *A Psychotherapy for the People*, Aron and Starr (2013) note the significance that:

> Freud and the early analysts were at the margins of their society. Being at the margins gave them the edge and allowed for the intervention and development of psychoanalysis. Being at the margins is what allows for reflexive self-awareness, the ability to look at oneself as both subject and object, without being caught up in one pole or another. (pp. 8–9)

One example of this independent thinking with regard to the practitioner concerned a colleague who was training as a transactional analyst. She had had a lot of personal therapy but thought that she had to do more in order to fulfil a requirement that she had to undertake personal therapy during training, to which she was also somewhat resistant (her word). What she actually wanted to do was to work with a spiritual director (which represents a different identity). Checking the requirements as outlined in the international Certification and Examinations Handbook (ITAA IBoC, 2022), this was – and is – entirely possible as the Handbook neither specifies "personal therapy" or that personal work has to be undertaken with a psychotherapist. The colleague was mightily relieved and subsequently appreciated a period of personal work with a spiritual director.

Professionalisation

The third influence on the identity of psychotherapists has been the increasing professionalisation of the field and its practitioners.

Caplow (1966) identifies four steps in professionalisation, which here, I apply to the changing identity of psychotherapists, specifically in Aotearoa New Zealand.

The first step – which is marked by "[T]he establishment of a professional association, with definite membership criteria designed to keep out the unqualified." (Caplow, 1966, p. 20)

With regard to psychotherapists in Aotearoa New Zealand, this took place in 1947 with the establishment of the NZAP, whose founding constitution provided that:

> Membership shall be open to persons of either sex, medical or lay… who are engaged in psychotherapy of an approved form… which is scientific in the sense that… [its] methods are based on a knowledge of psychopathology. This provision is made notwithstanding the fact that psychotherapy is as much an art as a science. (quoted in Manchester & Manchester, 1996, p. 21)

The second step – which is marked by "[T]he change of name, which serves the multiple function of reducing identification with the previous occupational status, asserting a technological monopoly, and providing a title that can be monopolized" (Caplow, 1966, p. 20)

Two examples of this in Aotearoa New Zealand are the founding of the New Zealand Society of Physiotherapists in 1950, to distinguish themselves from masseurs, and following regulatory legislation (see Tudor, 2017/2020a); and the NZAP, which has changed its nominal identity over the years from its initial title (in 1947), to (in 1974) The New Zealand Association of Psychotherapists, Counsellors and Behaviour Therapists (Incorporated), to (in 1981) The New Zealand Association of Psychotherapists and Counsellors (Incorporated), back to (in 1987) the NZAP. This last change appears especially significant as, in this country, psychotherapists appear particularly concerned to distinguish themselves from counsellors. Most recently (last year), the Association changed its name to the Association of Psychotherapists Aotearoa New Zealand, a move that was prompted by its commitment to a bicultural perspective on psychotherapy (see Green & Tudor et al., 2014; Hall et al., 2012).

The third step – which is marked by "[T]he development and promulgation of a code of ethics which asserts the social utility of the occupation, sets up public welfare rationale, and develops rules which serve as further criteria to eliminate the unqualified and unscrupulous." (Caplow, 1966, p. 21)

With regard to the NZAP (now the APANZ), this may be dated to 1986 when, some three years after a preliminary report of A Code of Ethics for the Association was first circulated, the NZAP Council adopted a Code of Ethics (Manchester & Manchester, 1996). With regard to the public welfare rationale, this was first hinted at by Ernest Beaglehole, a founding Fellow of the Association and Professor of Psychology at the University of New Zealand in Wellington who wrote that "we may safely say that New Zealand at the present time could absorb well over ten times as many psychotherapists as are at present available." (Beaglehole, 1950, p. 41). I use the word "hinted" as Beaglehole actually wrote about the low numbers of psychotherapists in private practice. It wasn't until this century that the public welfare rationale for the registration of psychotherapists was made more explicit by Paul Bailey (2000, 2004a, 2004b), who led the charge on behalf of the then NZAP for state registration of psychotherapists, for a critical perspective on which see Bailey and Tudor (2017/2020) and Tudor (2017/2020b). It is at and in this stage that professions provide safety for the public through codes and/or frameworks of ethics and professional practice, including complaints procedures; establishing training standards; and so on – but, significantly, as a self-regulated profession.

The fourth and final step – which is marked by "[A] prolonged political agitation, whose object is to obtain the support of the public power for the maintenance of the new occupational barriers." (Caplow, 1966, p. 21)

Again, with regard to the APANZ, this agitation may be seen throughout its history – see Manchester and Manchester (1996) and Carson et al. (2006), and is critically summarised by Dillon (2017/2020).

As something of an antidote to these inexorable steps to professionalisation through the state registration of psychotherapists, I note that Freud (1929/1956) referred to the practitioner as characterised "by good training and supervision, by certain qualities... and by… being a decent human being which, fundamentally, cannot be legislated for or regulated" – and the fact that in most countries of the world, psychotherapists are not state registered and not necessary identified as health practitioners. Thus, we may say that psychotherapists both are and are not health practitioners.

The psychotherapy profession

In most countries of the world, including Aotearoa New Zealand, psychotherapy as a field or discipline is regarded as a health profession. The final part of the article offers some critique and deconstruction of this perspective and position.

Firstly, in a rare and interesting article discussing the question of whether psychotherapy is an autonomous scientific discipline, van Deurzen-Smith and Smith (1995) suggest that what characterises an autonomous discipline is that it "1)... must be theoretically distinct from any adjacent discipline... [and] 2)... must possess a theory which is irreducible to any adjacent theory". To this I would add a third criterion: that it must also have practitioners and theoreticians who identify primarily with the discipline. In other words, psychotherapy can be – and is – a profession in its own right rather than being apologetic that it is not psychology or psychiatry – and the same stands for its practitioners. Unfortunately, this is not the case in a number of countries in which training as a psychotherapist is restricted to medical doctors or psychologists. Moreover, if it were to take inspiration from Freud, Beer, Totton, and Aron and Stark, psychotherapy might even position itself as a social movement for reform in education, social policy, and culture, and/or a profession that has something to say about the spiritual and political. I look forward to the day when, in response to a social crisis such as an earthquake, a mass shooting, or an election, the media interview a psychotherapist with some expertise in the field, rather than a psychologist simply because they're

a psychologist; and I look forward to the day when the All Blacks (New Zealand's national men's rugby team) employ a psychotherapist to deal with group relations (about which psychotherapists and group analysts have some expertise), rather than a sports psychologist (who hasn't necessarily undertaken their own personal therapy let alone their own group therapy). With regard to psychotherapy being more of a social movement, this is reflected in initiatives and organisations such as:

- Psychotherapists and Counsellors for Social Responsibility (https://www.facebook.com/PCSocResp/)
- The Radical Therapist (https://www.theradicaltherapist.com/)
- The Radical Therapist Network (https://www.radicaltherapistnetwork.com/)
- The Red Clinic (https://www.redclinic.org/statement).

Secondly, with regard to discipline, psychotherapy education/training programmes in the tertiary sector appear across the arts, sciences, and health. At AUT, the Department of Psychotherapy & Counselling was, for 30 years, located in the School of Public Health & Psychological Studies in the Faculty of Health & Environmental Sciences. In 2019 this School was disestablished, and the Department moved to the School of Clinical Sciences in the same Faculty. However, it could equally have been – and be – located in the new School of Public Health & Interdisciplinary Studies within the same Health Faculty or, looking elsewhere in the university, within the School of Education – Te Kura Mātauranga within the Faculty of Culture and Society, or the School of Communication Studies – Te Kura Whakapāho within the Faculty of Design and Creative Technologies. This is not simply a question of semantics but rather a matter of strategy. For instance, at AUT, in 35 years of being located in the Health Faculty, the discipline of psychotherapy has never enjoyed the same level of funding for its clinical papers or courses as has psychology (for its counselling psychology programme) or, in other New Zealand universities (for their clinical psychology programmes).[1]

Thirdly, there is the problem that health is, as noted earlier, at least from a Western allopathic perspective, framed in terms of and conflated with illness. Thus, those colleagues in the then NZAP who were keen to get psychotherapists regulated and registered under the Health Practitioners Competence Assurance Act 2003, were, in effect signing up to a medical model of health, competence, assurance, and regulation, some of the implications of which are only just being seen and understood (see Tudor, 2021).

Fourthly, there is the issue (if not problem), that, with state registration and statutory regulation, the profession has ceded its sovereignty. Now, the state decides what constitutes a psychotherapist, and, beyond that – and, I would say, beyond its purview – what constitutes a supervisor, a visiting educator, and a training programme. As a result of this and other factors, since 2009, in Aotearoa New Zealand, there are fewer psychotherapists working in the public sector, and fewer psychotherapy training courses. The good news (at least as far as this author is concerned) is that the one training course in the country that the Psychotherapists' Board did not previously recognise, and the one which has most incorporated spiritual and indigenous traditions and values in its curriculum, teaching, and learning, i.e., Hakomi, is the one of the few courses that has increased numbers of students.

Thus, we may say that psychotherapy both is and is not a health profession.

Conclusion: In sickness and in health

As I was finishing this paper, I remembered a short article I wrote nearly 30 years ago about the contribution that psychotherapy makes to positive mental health (Tudor, 1997). Looking across various psychotherapeutic traditions and modalities, I identified:

- Love and work (attributed to Freud by a number of authors, notably Erikson (1950), and by Alberini (2020) who writes that Freud them the "cornerstones of our humanness." (p. 38)
- Happiness, efficiency, and adaptation (from Jones, 1931).
- Co-operation, connectedness, and social interest (from Adler, 1933/1938).
- Emotional maturity – from Jung (1951) and Klein (1960) – and emotional growth and maturity (from Winnicott, 1988).
- Friendship (from Erich Fromm, 1956).
- Being fully-functioning (from Rogers, 1959), and the capacity to live life (from Guntrip, 1964).
- Self-actualisation (from Maslow, 1961/1993), and the self-actualising tendency (from Rogers, 1963).
- Autonomy (from Berne, 1964).

Reflecting on these concepts, I think many, if not all of them could be taken as criteria for describing and assessing the

1 In the time between this article being submitted and published, there has been another reorganisation of the Faculty of Health & Environmental Sciences at AUT and the Department has been moved to another School, that of Community & Public Health.

health, ill-health, or sickness of psychotherapy itself. So, as a final reflection or reflexion, I ask and answer a series of questions related to this:

1. Is psychotherapy itself happy, efficient, and adaptive?

   I would say not entirely. With regard to its sense of (it) self, psychotherapy and psychotherapists can appear anxious, and somewhat apologetic in relation to its older siblings in the "psy" professions (psychiatry and psychology). It doesn't always know how efficient or effective it is (for instance, in presenting itself as based on research); and, if anything (as I have argued), it is over-adaptive to external forces and systems.

2. Does it express social interest through co-operation and connection?

   I think it tries to, but that this is expressed more internally (i.e., within the profession) than externally in relation to the public, the media, government, and other professions.

3. Is it emotionally mature?

   I would say yes, though with occasional exceptions.

4. Thinking about psychotherapy in terms of friendship with other disciplines and professions, I would say that, too often, we're on the back foot, and, as it were, waiting to be picked for the team, rather than actively making friends and influencing people such as policy-makers and politicians.

5. Is psychotherapy fully-functioning?

   Certainly not!

6. Does it have the capacity to live life?

   Certainly, but with more confidence in itself than engagement in life outside therapy.

7. Is it self-actualising?

   Absolutely, though I would question what "self" or aspects of itself it is actualising (see Tudor & Worrall, 2006).

8. Is it autonomous?

   No, as, for the most part, it's far too concerned to adapt to others and, in some countries, to other "psy" professions and the state

I have been involved in psychotherapy for just over 40 years, firstly as a client, then as a trainee, a practitioner, a supervisor, a trainer, and an academic (see Tudor & House, 2019). Insofar as my relationship with psychotherapy is one of co-habitation if not marriage, I have certainly experienced it for better and for worse, for richer and for poorer, in sickness and in health, and something that I love, cherish and profess (and of which I am critical), and that this will probably continue till death do us part.

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