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'Unlocking the cage door': the spatiality of counselling

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This paper examines the spatiality of counselling, focusing on ideas about positions, boundaries and spaces emerging from practitioners' accounts. Counsellors describe counselling as a practice within which the relative positions of self and other are explored and negotiated. To that end, counsellors adopt a contradictory position in relation to expertise, claiming to be experts in not being experts. Counselling transgresses bureaucratic boundaries between different forms of care, and normative boundaries of secrecy. In their place, counselling works with spatio-temporal, confidentiality and ethical boundaries, which are simultaneously concrete and specific, fluid and illusory. These boundaries create spaces within which the interplay of reality and fantasy can be explored. These spaces can be understood in terms of processes of exteriorizing the inner worlds of clients and interiorizing external spaces including those made available by counsellors and counselling services. The spatiality of care associated with counselling strategically invokes binary distinctions, for example, between reality and fantasy, but also disrupts dualistic conceptualizations of space in favour of an understanding of space as simultaneously real, imagined, material and symbolic.

Key words: counselling, positions, boundaries, spaces, spatialities, care, self/other.

Introduction

This paper contributes to geographies of care by considering how a particular group of caregivers—counsellors—mobilize spatial concepts in relation to the care they offer. Through this we seek to illuminate the spatiality of care at work within counselling. We situate the ideas deployed by counsellors in relation to geographical theorizations of space, and we point to their significance within a wider range of care relationships.

Counselling has so far attracted minimal attention from geographers (but see Bondi 2003a). There are, however, several reasons why this practice is of particular relevance to the developing field of geographies of care, of which we identify four. First, in the UK and many other contexts, counselling has become increasingly influential, as indicated by the

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growth in the availability and uptake of counselling services and of counselling training (McLeod 1993; Mulhern 2001), and by the attention it attracts in the popular media. Whether its increasing pervasiveness is welcomed or decried, a practice that is making its presence felt in these ways merits the attention of geographers.

Secondly, while commentators emphasize that counselling is difficult to define, they also converge around the idea that it entails providing a particular kind of relationship (see e.g. Feltham 1995; McLeod 1993). Because counselling emphasizes the relationship between care-giver and care-receiver, it helps to focus attention on the spatiality of care at the interface between carers and recipients of care. This interface is relevant to numerous other forms of care such as pastoral care (including that provided by educators), medical care, personal care and support work.

Thirdly, and related to the preceding point, in recent years, increasing emphasis has been accorded to interpersonal skills in many forms of care, including, for example, in the care offered by medical practitioners, nurses and residential care workers, and much of the associated training draws on ideas associated with counselling. For example, in Scotland, the COSCA Certificate in Counselling Skills, which serves as a first step towards counselling qualifications for some, is also designed for, and delivered to, many people working in other fields, including health care, education and community work, to name just a few. So, by examining the spatial concepts mobilized by counsellors, we hope to provide an analysis of relevance to a wider array of caring practices.

Fourthly, a richly spatial vocabulary is to be found in talk and texts about counselling: counsellors make extensive use of spatial concepts in their descriptions of counselling. For example, counselling is described by its practitioners as a practice that seeks to provide a kind of spatial liberation, a task encapsulated by one counsellor in the phrase 'unlocking the cage door', from which the title of this paper is drawn. The abundance of these spatial concepts, which include numerous references to positions and boundaries as well as spaces, prompts consideration of the significance and meaning of spatial metaphors in representations of counselling. As Gregory (2000: 771) has noted, one important theme in current theoretical discussion about space concerns 'the dualism between "real, material and concrete space" and "non-real, imagined and symbolic space" '. This paper examines conceptualizations of space deployed by counsellors in relation to this debate. We show how the ideas about positions, boundaries and spaces to which practitioners appeal simultaneously invoke and disrupt binary distinctions between 'real, material and concrete space' and 'non-real, imagined and symbolic space'.

Our analysis draws on sources of three kinds, namely in-depth interviews with practitioners, our own immersion in the field of counselling and some of the texts of counselling. We comment briefly on these sources and our use of them.

At the core of this paper lie accounts of counselling articulated in interviews conducted with approximately 100 people involved in voluntary-sector counselling in Scotland, including service managers, practitioners of varying lengths of experience and trainee counsellors.[1] We recruited interviewees in four different parts of Scotland (rural and urban) via counselling agencies and counselling training programmes, which were selected to ensure diversity (for an overview of voluntary-sector counselling in Scotland see Bondi, Árnason, Fewell and Kirkwood 2003). Interviewees ranged in age from their twenties to their seventies, included men and women, and came

from a range of social, racial and cultural groups. Some were white, middle-class, heterosexual and non-disabled; others were black, working-class, gay or lesbian, and/or disabled.

The interviews were designed to elicit narrative accounts, focusing either on the stories of agencies (in the case of service managers), or on autobiographical pathways into counselling (in the case of practitioners and trainees). In the context of these narratives, interviewees were asked about the meaning and purpose of counselling, and for their thoughts on some of the key issues facing voluntary-sector counselling in Scotland today. The analysis presented in this paper does not focus on the narrative construction of accounts but reads across the stories to examine the use of spatial concepts in talk about counselling. Because we are interested in discursive representations of counselling rather than personal narratives, we do not provide contextual information about individual interviewees, although the pseudonyms we use indicate gender.

Our reading of the interview transcripts is informed by our own participation in the field of counselling. One of us (Judith Fewell) is an experienced practitioner who has, for many years, been involved in the delivery of counselling training, and who has supervised the practice of a considerable number of counsellors. The other (Liz Bondi) trained as a counsellor in the mid-1990s, and for about five years has worked as a part-time, volunteer counsellor in a voluntary-sector counselling agency. This immersion has various effects, one of which is to prompt us to make connections between what is said in interviews and other representations of counselling with which we are familiar, including those arising in other conversations about counselling, and in texts about counselling. We use the interviewees' words to illustrate and examine commonly held views within the field of counselling, and, in so doing, we explore ideas that are often taken for granted or treated as unproblematic both within and beyond counselling. We draw selectively on representations of counselling found in widely used textbooks and in debates among practitioners to complement and set in context accounts offered by the interviewees.

In the sections that follow we examine ideas about positions, boundaries and spaces, respectively, within practitioners' representations of counselling. Our discussion begins by exploring conceptualizations of the relative positions of care-givers and care recipients advanced by counsellors, showing how counselling seeks to problematize relations of power at the interface between practitioner and client.

Positionings: counselling as inverted knowledge

Simon: Because the issues that counselling deals with are such human, everyday relational issues, the idea of being an expert in that seems somewhat ridiculous … [Anyone can say] 'I'm a human being, I know about relationships', whereas 'I'm a human being, I know how to diagnose your cancer and treat it' would be nonsensical. So I think there's some failure of assertion, some kind of failure to say that counselling is a hard skill as well, that actually you *do* have to know what you're doing to be any use to a client.

LB: I guess the concern with an emphasis on the counsellor's expertise would be … that it might change the relationship between client and counsellor.

Simon: Well I somehow think that's a confusion over that word 'expert'. I suppose 'expert' has come to mean somebody who knows—somebody who holds fort, gives advice, consults to, whatever, whereas 'expert' in terms of counselling means you do the opposite—you know to do all the opposite of

that, so your knowledge is kind of inverted knowledge—or apparently a negative knowledge.

This exchange articulates a tension within counselling about how to conceptualize the relative positions of practitioner and client. Simon begins by insisting that counsellors have special, hard-won, expert knowledge that differentiates them from others, to which the interviewer (LB) responds by referring to the idea that claims to expertise create unequal, hierarchical relationships, whereas the relationship between counsellors and clients is usually understood to be egalitarian. Simon then argues that counselling redefines 'expertise' in such a way that it is liberated from its association with the unequal, hierarchical positions typical of most client–professional relationships. Rather than relinquishing all claims to expert knowledge, he suggests that counsellors take up a different kind of position in relation to knowledge, which he describes as 'inverted' or 'negative'. In his account, practitioners are, paradoxically, experts in not being experts, their expertise residing in their capacity to 'invert' or 'negate' conventional claims to, and relationships associated with, expert knowledge, and in their capacity to hold the position of not knowing (cf. Árnason 2001).

In geographies of care, questions about positionings (or 'positionality') have surfaced primarily in debates about difference in research relationships, in which researchers have discussed political, epistemological and ethical aspects of the conduct of relationships between themselves and the 'others' with whom they interact (see e.g. Dyck 1997; Dyck and Kearns 1995; Parr 1998). In its engagement with questions about the relative positions of practitioners and clients, counselling speaks to these debates (also see Bondi 2003b), and to questions about the interface between carer-givers and care recipients within other kinds of care relationships. This section explores the positions and positionings claimed by counselling and counsellors. We show how the idea that counselling is an 'inverted' or 'negative' kind of knowledge troubles the distinction between 'professional' and 'lay', and we link this troubling to the development of counselling in the UK. In so doing we draw attention to some of the tensions woven into this development, and we highlight the contradictory spatiality of power in care relationships.

Simon's argument about the expertise of counsellors engages with two meanings of knowledge. One meaning equates knowledge with *what* is known—with matters of content. The other meaning is concerned with knowing *how*—with matters of practice. Different perspectives on the meaning(s) of knowledge generate different understandings of the relative positions of practitioners and clients. Professional expertise is often equated with the first meaning of knowledge, in the sense that lawyers or medical practitioners are assumed to know the content of the law or medicine, respectively, or at least about the specialist areas they name as their fields, such as family law or oncology. This understanding fosters professional–client relationships in which the professional occupies the position of knowing, in relation to the 'ordinary' person—or lay person—who does not. It sets up a hierarchy in which the professional knows more than the client, and which permeates the distinction between 'professional' and 'lay'. Knowledge as practice is often understood as embodied skill, like that of artistic performers or those with 'craft' skills, but in these examples the knowledge is not connected to relationships. Knowledge as relational practice is exemplified by the idea of the doctor's 'bedside manner'. In professional–client relationships, knowledge as relational practice is often regarded as a supplement to knowledge as content: it may be

considered important but only in the context of knowledge on the first meaning. Thus a doctor's bedside manner is supplemental to his or her medical knowledge.

In Simon's portrayal of counselling, this relationship between the two meanings of knowledge is radically different, as suggested by his use of the words 'inverted' or 'negated'. Counsellors, he suggests, take up a position of not knowing any more than their clients in relation to matters of content, and instead accord priority to relational practice, about which they do know more than their clients. In not knowing any more than their clients in the sense of knowledge as content, counsellors refuse to claim a position of expertise 'over' clients, positioning themselves instead as equals in the sense of belonging to the category of 'ordinary' or 'lay' people and therefore being 'at the same level as' their clients. But, simultaneously, counsellors profess expertise of another kind, which does differentiate them from their clients, and this is an expertise in the practice of counselling relationships.

In their descriptions of counselling, practitioners place considerable emphasis on attending to both their clients' and their own experiences of the counselling relationship itself, an emphasis also strongly evident in numerous counselling textbooks (see e.g. Jacobs 1988; McLoughlin 1995; Mearns 1994, 1997). These texts do not prescribe a position which the counsellor should adopt, but instead advocate that the positions into which client and practitioner find themselves drawn are explored in relation to the issues the client seeks to address.[2] Thus, counsellors need to be experts in understanding and negotiating the relative positions of self and other (whether the 'other' is the person of the practitioner or someone else), as they are imagined, experienced, and played out between clients and practitioners. Rather than envisioning counselling as a form of care in which clients necessarily experience counsellors as equals, this interpretation calls upon practitioners to maintain their commitment to non-hierarchical relational practice at the same time as engaging therapeutically with the positionings experienced by their clients, which are neither fixed nor necessarily easy to change. Counsellors must be capable of moving between different positions and, perhaps, occupying contradictory relative positions (Clarkson 1995). The contradictoriness arises because these positions are both 'imaginary' in the sense of being metaphorical representations of experience, and 'real' in the sense of drawing on tangible power structures. Indeed these aspects are deeply intertwined, suggesting that counselling works with a concept of positionings that unsettles a binary distinction between the 'imagined' and the 'real'.

In its focus on the relative positions of caregiver and care recipient as an integral part of what is offered, counselling troubles the distinction between 'professional' and 'lay', a claim we explore further by considering the trajectory of ideas that underpin it. In so doing we elaborate connections between the way counselling conceptualizes the positions within practitioner–client relationships, and the position of counselling within the wider domain of care provision.

Counselling is one of a number of practices made possible by the prior development and influence of psychoanalysis. There are important connections between the way counselling engages with the distinction between 'professional' and 'lay', and a European tradition of 'lay psychoanalysis'. In relation to psychoanalysis 'lay' means 'non-medical', and Freud himself endorsed the idea that people should be able to undertake psychoanalytic training without medical qualifications (Freud 1926 [1961]). In the early years of the twentieth century this was crucial to the entry of women into psycho-

analysis, whose access to medical training was either non-existent or very limited. Notable examples of female lay analysts include Anna Freud and Melanie Klein (Sayers 1991). This openness to non-medically trained practitioners has persisted in Europe but did not survive the journey across the Atlantic: in North America, psychoanalytic training has never been available except to those with medical qualifications, and usually as an addition to a psychiatric specialism (Schwartz 1999). Counselling draws on and extends the European tradition of lay psychoanalysis in the sense that neither medical nor any other professional qualifications have ever been prerequisites for training.

A key route though which counselling services developed was via the marriage guidance movement, which gathered pace in the inter-war period in response to concern about the institution of marriage. In the late 1930s and the 1940s the marriage guidance movement began to develop an institutional form in England and in Scotland through the establishment of local marriage guidance councils in the voluntary- (non-statutory) sector bodies, which offered services to members of the public (Lewis, Clark and Morgan 1992). Counselling swiftly became a core element within these services. The idea that those experiencing relationship difficulties might benefit from the 'counsel' of their peers was enshrined within the marriage guidance movement, which recruited 'ordinary' women and men to give a few hours a week as volunteer 'marriage counsellors'. As services developed so too did training for the volunteers, incorporating inputs from experts in a number of different fields, which were not designed to turn volunteers into 'experts' but were intended to widen the horizons within which they offered support (Lewis, Clark and Morgan 1992). Thus, counselling in the UK originated as an avowedly lay practice in the sense of being non-professional as well as non-medical. It did not explicitly set out to challenge the distinction between lay and professional, but it sought to offer high standards of practice without relinquishing the claim to a lay position.

This approach received new impetus during the late 1940s and 1950s with the arrival in the UK of ideas developed by the American psychotherapist Carl Rogers. Rogers argued that effective therapeutic work depends upon qualities of relating rather than bodies of expert knowledge, and he advocated an explicitly non-judgemental, non-hierarchical and egalitarian approach to the relationship between practitioner and client (Rogers 1957; also see Kirschenbaum and Henderson 1990; Rogers 1951, 1961; Thorne 1992). For the marriage guidance councils, Rogers' theory of 'client-centred' psychotherapy endorsed the logic of counselling as a practice in which counsellors are positioned as their clients' peers, rather than as expert professionals. Rogers' ideas also provided a robust rationale for insisting that counselling training was best served by the practice-based development and refinement of existing relationship skills, rather than by the extensive 'book learning' or academic study associated with training for overtly professional occupations. Another effect of the incorporation of Rogers' perspective into marriage counselling was to introduce an emphasis on self-development and personal freedom, which co-existed in tension with moral concerns about marriage breakdown (Lewis, Clark and Morgan 1992).

Alongside the use of Carl Rogers' ideas to underpin distinctiveness of counselling, the marriage guidance councils adopted a particular position in relation to the state and the private market. They were voluntary-sector bodies, and consequently counselling in the UK developed within this sector, extending into

other sectors only towards the end of the twentieth century. This contrasts with, and sets counselling apart from, psychoanalysis and psychotherapy, which have been much more closely integrated into both public-sector and private-sector forms of provision since the early twentieth century.

As psychoanalysis emerged as an occupation, practitioners established themselves within the private sector, charging fees for the services they offered. By contrast, fees played no part within marriage counselling relationships in that clients did not pay and counsellors were not paid. Neither did fees enter directly into counselling training, which was provided free at the point of delivery. In these ways, counselling was positioned outside of, and independent from, the market.

Unlike psychoanalysis and psychotherapy, counselling also positioned itself outside of the public sector. In the UK, the relationship between psychoanalysis, psychotherapy and the state was mediated by the psychiatry. The relationship between psychoanalysis and psychiatry has been far from straightforward or harmonious, not least because of suspicion of lay psychoanalysts on the part of some medically trained professionals. However, at the outbreak of the First World War some psychoanalysts developed strong alliances with members of the medical profession, and, in due course, psychotherapy secured a place in the public-sector health care system, primarily within psychiatric services (Pilgrim 1996). In contrast to psychotherapy, the marriage guidance councils, and other organizations that developed counselling services in the 1960s and 1970s, actively chose positions that maximized their independence from the state as well as from the private sector. This underpinned the commitment of counselling to dissociate itself from the relations of authority associated with professions, which secure their status partly from their recognition, as well as regulation, by the state. It also helped to maintain a distance between counselling and political debate on issues such as marriage and family life.

In summary, counselling in the UK developed as a lay practice, operating outside both the private market and the state. In eschewing professional hierarchies and state bureaucracy, it sought to underpin its claim to distinctive and egalitarian practitioner–client relationships. This contrasts with most client–professional interactions in both the private and public sectors, in which clients are widely understood to occupy lowlier positions than the practitioners from whom they seek expert treatment, advice or representation. But, while counsellors strove to avoid the relations of authority associated with established professions, they also undertook extensive (part-time) training, and developed frameworks for safeguarding standards of practice. They certainly did not claim to be un-professional. In negotiating the tension between rejecting the idea of authority 'over' clients, and developing a distinctive relational expertise, counselling took on the form of an 'inverted' or 'negative' knowledge.

Counselling in the UK has evolved since the middle of the twentieth century in ways that further highlight tensions connected to the positioning we have outlined. It is now offered in a variety of public-sector settings, including a substantial number of primary health care practices (Mellor-Clark, Simms-Ellis and Burton 2001), and by private-sector practitioners, as well as in a wide range of voluntary-sector settings. Although a good deal of voluntary-sector counselling continues to be delivered by volunteers, it is now possible to earn a living as a counsellor. Counselling training has changed too, with many courses now offered by academic institutions rather than voluntary-sector organizations, and others validated by universi-

ties. Although some courses are open to students who have no prior academic qualifications, for others a first degree is a prerequisite. The merits of the statutory regulation of counselling, which would establish a legally binding system of registration along with legal protection for occupational title, has been subject to considerable debate within practitioner circles and some influential counselling organizations have lobbied for this development.

Another aspect of the tensions surrounding the position of counselling concerns its ambiguity in relation to social norms. We have noted the tension between notions of personal liberation and moral concern in relation to marriage counselling, which can be experienced and understood as supporting people to resolve issues in ways that might tend to endorse or unsettle social norms. This is equally true of other forms of counselling, and practitioners give differing emphases to maintaining and disrupting social order in their accounts of the practice. For example, Maureen describes counsellors as 'upholding that which we see as good in society' whereas for Kenneth 'counselling is a liberating experience, so that people actually begin to say "well, I don't need to put up with this, I can do something about it" '. Throughout its history within the UK, counselling has encompassed such variations in emphasis. The current phase of professionalization may draw renewed attention to tensions between these positions, but we would argue that a defining feature of counselling is its commitment to accommodate ambivalence between them. This entails mobilizing different positions strategically, thereby working with a contradictory spatiality of power in which counsellors simultaneously seek to avoid exerting influence or authority 'over' their clients, and actively use their authority to encourage clients to explore their own experiences of the relational dynamics of power. The positionings counselling and counsellors adopt create a space in which distinctions between reality and fantasy can be explored, recast and sometimes dissolved. We explore the production of this space further in due course but first turn to the concept of boundaries.

Boundaries: reframing relations of care

As feminist scholars have observed, direct caregiving is strongly associated with women and is traditionally naturalized within informal, domestic, familial contexts (Gilligan 1982; Graham 1983). The growth of formal care services has done little to challenge the association between women and caring work (Bowden 1997; Tronto 1993) but has complicated expectations about where and by whom care is provided. The provision of personal care, involving assistance with bathing, for example, troubles bureaucratic boundaries of public-sector health and social care (Sutherland 1999), and normative boundaries of personal privacy (Twigg 2000). Counselling troubles the same boundaries, albeit in rather different ways. In this section we examine how counselling traverses some kinds of boundaries, and redraws others. We focus on the way it cuts across bureaucratic boundaries and transgresses normative boundaries of privacy and secrecy before exploring the boundaries designed to contain counselling relationships.

Counselling resists dominant categorizations of care. Is it, or is it not, a form of health care, a form of mental health care, a form of social care or a form of personal care? As we have noted, counselling in the UK originated as a social welfare intervention, responding to marital distress, and was offered in voluntary-sector settings. It can now be found in a diverse array

of public-sector health care and social care settings, and in the private sector, as well as in numerous voluntary-sector contexts. The proliferation of counselling services in such a wide range of settings has generated considerable unease among commentators, prompting Alex Howard (1999: 269), for example, to claim that 'the practice of counselling has moved ahead, beyond and out of sight of sensible definitions, discipline and demarcation of boundaries'. The capacity of counselling to challenge and transgress demarcations between different forms of care tends to be reduced when it is incorporated as an element of public-sector service provision, for example within primary health care, where access is controlled by medical practitioners (Mellor-Clark, Simms-Ellis and Burton 2001). Within the voluntary sector, however, where it originated, its position is more complex and its resistance to bureaucratic boundaries is more evident.

In the UK as elsewhere, the independence of the voluntary sector, within which counselling initially positioned itself, is relative rather than absolute (Milligan 2001; Wolch 1990). Flows of public funding into the voluntary sector are linked to contracts for the supply of services that address policy goals, and the voluntary sector has become an explicit arena through which public policy goals are addressed (Fyfe and Milligan 2003a, 2003b; Scottish Office 1998). These patterns are clearly evident in voluntary-sector counselling agencies in Scotland, which, for example, receive a steady flow of clients from a wide range of public-sector professionals and which draw a substantial proportion of their funding from public-sector sources, primarily Health Boards and Social Work Departments, responsible for ensuring the delivery of health care and social care, respectively, within specified geographical areas (Bondi, Árnason, Fewell and Kirkwood 2003).

Practitioners working in such contexts typically represent counselling as a practice that freely traverses boundaries between health care and social care. When asked whether she considers counselling to be a form of health care, Rachel, for example, replies 'yes, if you take health in the broadest sense'. She continues to exemplify her claim in the context of her work with people affected by alcohol issues:

> When people come to see a counsellor, for instance … let's say somebody has a problem with alcohol, their health is affected in many different ways. It's no' just their physical health, it's their emotional health.

She is equally insistent that counselling is a form of social care.[3]

> If you take it from the perspective of the person … let's say the woman whose husband or whose partner has a problem with alcohol, and she comes in to see a counsellor and she has a lot of different issues—stress, money worries, relationship issues. If she can feel confident about going … maybe to Citizens Advice and actually paying off some of the debt, that would, in turn, affect her social life … her wider life … I've seen clients going out and applying for a job, which again, in that sense, is enabling them to change their social way of being.

Some practitioners resist the labels 'health care' and 'social care' completely, arguing that they are not meaningful or relevant to counselling. For example, for Susan counselling is about helping people to 'resolve problems' and 'find what is best for them', and she firmly resists any suggestion that it might be seen as part of either health care or social care.

In these ways practitioners argue that counselling straddles the boundaries between health care and social care, or that it resists such territorializations of care (cf. Milligan 2001). Explicitly or implicitly they criticize the bu-

reaucratic and professional organization of care within the public sector, which generates lines of demarcation—between health care and social care, and between specialisms within health care and social care—which do not correspond to the realities and needs of everyday lives. Against the grain of these forms of provision, counselling is presented as a holistic form of care that responds to people's needs in flexible ways and plugs gaps between and within public-sector systems of health care and social care. For example, a leaflet sent to all those enquiring about the counselling service offered by one generic voluntary-sector agency opens as follows:

> The counselling service offers counselling to anyone who feels they can benefit from it. We recognise that an individual's wellbeing depends upon his/her spiritual, emotional, psychological and physical health. Our holistic approach offers healing through relationship and the opportunity to reflect in a safe, confidential setting. You can come when you need help or when you want to make changes in your life. Counselling may help you when other services have not been able to provide the kind of support you need.

Counselling is not, however, presented by practitioners as a panacea. Many describe it as a practice to which people are more likely to turn as a last resort than as a first choice, a tendency suggested in the final sentence of the excerpt above. Although counselling has become familiar in many western contexts through direct or reported experiences of the practice, together with the widespread circulation of representations in the popular media, those we interviewed drew attention to the ambivalence and unease of many of those who attend agencies as clients. For example, Pamela comments that

> the fact that everyone goes for counselling, or a very high proportion of people go for counselling, doesn't stop people feeling a bit shameful … Clients who come feel vulnerable, and they don't want people to know [that they are attending].

This ambivalence and unease arises from the fact that counselling addresses feelings, thoughts and experiences, which are frequently considered very private and intimate in the sense that they are otherwise not shared at all, or shared only with close friends or family members (Jamieson 1998). That is, these matters are usually guarded as secrets and protected by boundaries that counselling invites clients to transgress.

Counselling invites clients to transgress two kinds of boundaries of privacy and secrecy: those of families and those of selfhood. To elaborate, explicitly or implicitly families often guard their privacy and their secrets very carefully, instructing family members, especially children, not to tell anyone 'outside' the constitutive boundary of the family (Pincus and Dare 1978). At another level, an individual's sense of self also depends on boundaries, constituted at least in part through limits on (self-) disclosure, that is on what can be said (to anyone) about one's self (Winnicott 1965). Consequently, because counselling raises the possibility and perhaps the prospect of telling family secrets to someone outside the boundary of the family, and/or of rendering personal secrets into speech it is permeated with a sense of boundary transgression. Thus, practitioners describe counselling as enabling clients 'to express things that are often not easy to express' (John) or 'think the unthinkable or say the unspeakable' (Keith), or to embark on the process Fiona describes as 'unlocking the cage door'.[4] As Fiona's phrase suggests, the transgressive qualities of counselling entail movement across spatial as well as familial and personal

boundaries: counselling generally takes place in settings and locations that are separate from the spaces of clients' everyday family and personal lives, such as their homes (cf. Cresswell 1996; Staeheli 1993).

The resistance of counselling to being positioned within boundaries associated with the bureaucratic and professional organization of care, together with its transgression of normative boundaries of privacy and secrecy, might be taken to suggest that the practice disrespects boundaries in general. However, counselling institutes some very precise and explicit boundaries, which are designed to contend with the potential consequences of transgressions as well as to reframe the boundaries of care. The spatiality of counselling can therefore be understood in terms of a reframing of the boundaries of care.

Counselling operates within, and requires, highly specific spatio-temporal boundaries. It is typically offered in the form of meetings held at specified times (typically one hour in length at weekly intervals) in specified places (typically the same room in the same building for each session),[5] with contact between client and practitioner limited to these meetings and to the sole purpose of counselling (Jones et al. 2000). These arrangements are designed to offer clients clearly demarcated and delimited time and space, free from interruptions, external pressures and impingements, including those that might arise from contact with the counsellor in another role. In so doing, spatio-temporal boundaries mark a separation between a realm of ordinary everyday life, and another realm in which deeply private anxieties and concerns can be addressed.

While most counselling occurs in consulting rooms into which clients come, the need for well-defined spatio-temporal boundaries is further accentuated in circumstances in which it is provided in clients' homes. As in the case of intimate personal care, the intrusion of a formal carer into home spaces tends to heighten, rather than reduce, the transgressive qualities of the care relationship (Twigg 2000). Thus, discussions of counselling in clients' homes, for example, stress the importance of establishing the clearest possible boundaries of time and space to ensure that counselling sessions can proceed without interruptions or intrusions associated with everyday life (Sinason 1992).

Boundaries of time and space are closely linked to confidentiality, the provision of which is given a great deal of emphasis by practitioners, as, for example, in the leaflet cited above, which states: 'Our holistic approach offers healing through relationship and the opportunity to reflect in a safe, confidential setting'. Confidentiality is often conceptualized in terms of boundaries designed to place strict limits on the circulation of information about clients' identities and disclosures. These boundaries delimit an arena within which clients' disclosures are held: these boundaries set a limit beyond which disclosures, previously held by the client alone, cannot be transferred without the client's explicit permission (Bond 1993; Jones et al. 2000). Boundaries of confidentiality are a vital counterpart of the invitation to clients to share matters felt to be deeply private. They serve to protect clients in two distinct ways, concerned with safety in relation to self and in relation to others. First, boundaries of confidentiality offer a way of containing the experiential consequences of transgressing secrets of the self and the family, and reframe the boundaries within which secrets are held, so as to create a space safe enough for the issues the client brings to be spoken about and addressed, with a view to gaining new perspectives on their meaning and significance. Secondly, boundaries of confidentiality protect clients from harm that might result if information were transmitted to

others without their knowledge, and thus from sources of harm outside of their selves.

Many practitioners conceptualize boundaries of confidentiality as coinciding with spatio-temporal boundaries, and therefore with the walls of the room within which they meet with their clients, uninterrupted and undisturbed by external impingements. For example, Mike says

> I make really clear, you know, [to clients] the space between us … It's not—confidentiality for us isn't confidentiality within the team, it's between yourself and myself.

While the intention is to provide a safe space for therapeutic work, the idea that boundaries completely enclose practitioner and client, and thereby create a space that is just for 'you and me', is partly illusionary. Counselling does not seek to replace one form of secrecy, such as secrecy within the family, with another. Instead the work of individual practitioners and clients within carefully demarcated counselling sessions is framed by other practices and procedures designed to enhance the safety of clients. This wider context within which counselling relationships are situated can be thought of in terms of a series of three levels: supervision, other practices and procedures associated with the particular counselling service, and ethical and legal frameworks governing counselling in general.

Throughout its history the practice of supervising the work of individual practitioners has been integral to counselling. Supervisors do not meet with clients, but meet counsellors in regular, dedicated sessions designed to assist practitioners to reflect on their work with clients. Counsellors therefore bring material from their work with clients to their supervisors. One of the purposes of counselling supervision is to guard against the risk of abuse taking place within the boundaries of the counselling relationship, a possibility created precisely because those outside the counselling relationship do not witness exactly what goes on (Penfold 1998). The boundaries of confidentiality therefore always include the supervisor as well as the client and practitioner.

Supervision is often, but not necessarily, provided by the organization that runs the counselling service. Other practices and procedures at this level also condition the counselling work in ways that clarify and complicate the meanings attached to boundaries of confidentiality. For example, funding arrangements may lead agencies to explain to clients in some detail who may be told what, as the following account illustrates.

> For referrals [from a large employer] a letter [is sent] to the designated person saying 'so and so, after their first visit … has agreed to a programme of counselling'. They would then get a letter at the end saying that it's finished and how many appointments the person had had. What we have to make clear is that anything that actually happens in counselling is confidential … All that is discussed [with the client] on the first visit, so the client knows exactly what the nature of the confidentiality is, and it's their chance to commit to it or not, and if they choose to walk away, then fine. They can come back as a self-referral [in which case no one is informed of their attendance], we would have no problem with that. (Vivian)

In this account the idea that what 'actually happens in counselling is confidential' is maintained in order to ensure that clients are offered (the illusion of) sufficiently protective boundaries to enter into counselling at all. But there is also explicit acknowledgement that third parties may, under certain circumstances be notified of particular information. In this way, counselling works with ideas about

boundaries that are simultaneously very concrete and specific, and necessarily fluid and illusory.

Beyond the level of individual counselling agencies, ethical and legal frameworks for the practice of counselling have been developed to guide the way practitioners work, as well as to provide complaints procedures for members of the public. Ethical frameworks set out boundaries designed to limit the content of confidential relationships (Bond 1993; Jones et al. 2000). Mike, quoted above, for example describes counselling as

> a helping relationship within certain boundaries [... which] I tend to think of in terms of ethics. Ethics should inform confidentiality, safety, all those kinds of things.

These frameworks are also designed to guide practitioners in relation to circumstances in which the imperatives of client safety and confidentiality appear to conflict. Key examples are when practitioners (generally in consultation with supervisors and sometimes service managers) are concerned that clients are at serious risk of harming themselves (for example by attempting suicide) or that there is a serious risk of harm to others (especially children). Under such circumstances counsellors may choose, or be required, to break the normal boundary of confidentiality by drawing their concerns to the attention of third parties, notably general (medical) practitioners in the case of self-harm, and the police or child protection officers in the case of harm to others. Although such circumstances do not arise frequently, they add to the complexity of the boundaries within which counselling takes place. Moreover, when practitioners consider concerns about risk of self-harm or harm to others, they are likely to do so in relation to ideas about a boundary between fantasy and reality: fantasies, including fantasies of harm, such as thoughts of suicide, would not lead to the normal boundary of confidentiality being broken in the absence of indications of intent to inflict 'real' harm.

Taken together these features of the wider context within which counselling takes place demonstrate that confidentiality is never just between client and practitioners, or within the walls of the counselling room. The idea that client and practitioner work within a straightforward and impermeable boundary serves an important purpose in fostering a sense of containment and safety for work that transgresses other kinds of boundaries. But, paradoxically, containment and safety are enhanced by more complicated and flexible boundaries. In other words, counsellors strategically invoke firm boundaries between reality (everyday life) and fantasy (subjective experience), but also acknowledge the fluidity and blurring of such boundaries.

In summary, counselling can be thought of as a practice committed to redrawing boundaries. It seeks to offer a form of care, within which clients' most private hopes and fears can be shared, and it does so by traversing the boundaries of bureaucratized and professionalized practices of care, and by challenging normative boundaries of secrecy, while creating other kinds of boundaries that are both imaginary and real. By redrawing boundaries, in conjunction with problematizing relative positions within care relationships, counselling actively seeks to reframe relations of care and to contribute to a more widespread reframing (cf. Tronto 1993). Within the boundaries it draws and the positions it mobilizes, counselling aims to produce spaces of care that are sufficiently flexible and sufficiently safe to enable caregivers and the care recipients to enter into relationships within which relative positions

can be problematized, and it is to these spaces that we now turn.

Spaces: between outside in and inside out

Given the importance of boundaries in relation to counselling, whether transgressed or created, illusory or tangible, it is not surprising that spatial concepts abound within practitioners' accounts of what they do. In this section we discuss some of the most commonly used spatial metaphors in terms of processes of exteriorizing interior spaces and interiorizing exterior spaces. We argue that counsellors conceptualize the interface between client and practitioner as a dynamic space within which these exteriorizations and interiorizations can be explored, thereby enabling the boundary between inner and outer realities to be redefined and reshaped (also see Bondi 2003a).

Metaphors of travel and mobility figure prominently in counsellors' accounts of their work with clients, often in images of going on journeys. These metaphors illustrate attempts to exteriorize what is felt to be interior, which they do by representing inner experiences in terms of imaginary external worlds. For example, Brian explains that 'wherever someone is, we have a way of meeting them [clients] at that point and going with them on their journey', while Debbie points out that on these journeys 'you can wander all over the place; it's not about going in a straight line'. Derek elaborates the role of the counsellor on such journeys as follows:

> The client is taking you on a journey and you are walking alongside your client and sometimes you'll see things and you'll point things out—'look at that flower, isn't that pretty?' Sometimes your client can't see it but it's the client's journey, it's not ours.

The frequent appearance of these kinds of metaphors might be symptomatic of flight from situated, embodied and material realities. This is certainly an argument advanced by its detractors (see e.g. Howard 1996; Masson 1989; Weldon 1999). Geographers too have been highly critical of some of the uses to which metaphors of travel and mobility have been put. For example, Pratt (1992) has argued that these metaphors often express a refusal to situate knowledge claims, while Dorn (1998: 184) has lambasted feminist post-structuralist theorists in particular for privileging 'the capacity for movement and change' and fleeing from the 'messiness' of the material conditions of ordinary lives and identities. However, before dismissing counsellors' use of such metaphors as ungrounded and escapist, it is important to consider other metaphors that represent interiors in terms of exteriors.

Among the rich body of spatial metaphors practitioners use to describe counselling, ideas about 'inner spaces' are also very common. These ideas derive at least in part from the theories of what it means to be human that underpin counselling and related practices. Counselling in the UK is theoretically diverse, but two broad perspectives are especially prominent—the psychoanalytic/psychodynamic and the humanistic. The former focus on unconscious processes, which variously undergird, unsettle, displace and undo intentional action, while humanistic philosophies and psychologies emphasize the capacities of persons as agents (see Bondi 1999; Kahn 1991; McLeod 1993). Both draw on metaphors that invoke ideas about the interiority of human experience through images of exterior spaces.

The influence of psychoanalysis on counselling training in the UK is filtered primarily through the object relations tradition, which, as Cushman (1995) has elaborated, posits an understanding of the self as a container within

which an imaginary inner world or landscape exists, 'populated' by necessarily partial, subjective representations of persons and objects. Like other psychotherapeutic practices, counselling is conceptualized in terms of attending to the character of an individual's inner landscape, how it is peopled, and how the client relates to this inner world and its residents. The humanistic strand draws strongly on organic and ecological metaphors, in which the person is construed as a complex but unified adaptive entity that embodies the potential necessary for his or her own growth. The interiority of this potential is spatialized, often in terms of 'layers' and 'depth', for example when Nancy describes the aim of counselling as 'understanding deeper parts', or when Hilda describes what she does as attending to 'what's going on underneath'. These interiors are shaped by their wider, ecological context, so that growth may be distorted by the impact of a hostile, depleted or injurious environment (see Rogers 1951, 1961). Counselling aims to facilitate healing from such impacts, a task represented by Susan, for example, as 'tending plants so that they grow well'. In different ways these metaphors interiorize exterior worlds. Moreover, they implicitly problematize the boundary between interior and exterior, indicating that it is porous rather than impermeable.[6]

Woven into their accounts of imagined journeys and inner worlds counsellors often make reference to their clients' experiences of particular, material places and spaces. Having shown me a comfortably furnished waiting room bathed in natural light, Ruth, for example, expresses her desire for clients to

> experience that this is a safe place, that this is a place of peace or a place of hope or a place of healing, and it's a place where they will find rest. They might not go out better but the experience should be something that they can recognize has some of those elements.

She was delighted when she discovered that 'some people would come and sit in our waiting room … arriving about an hour early for an appointment, [saying] "I just like to come here and just sit" ' (cf. Kearns 1991). Debbie is much less happy with the environment in which she works, describing it as 'spartan and functional' as well as being affected by traffic noise and insufficiently sound-proofed internally so that clients may be aware of voices emanating from adjacent rooms. Thus, while imagined journeys transport clients and counsellors to other (psychic) spaces, practitioners keep their feet firmly on the ground in the sense of attending to immediate, material and embodied impacts and experiences of space.

In different ways, Ruth and Debbie illustrate how exterior spaces are absorbed into, or impinge upon, their clients' inner worlds. In Ruth's account, the space of the waiting room has the potential to provide clients with qualities—safety, peace, hope, healing or rest—they can interiorize. These spaces therefore have the potential to be therapeutic in and of themselves, and the effort taken to decorate, furnish and arrange a waiting room may be regarded as intrinsic to the care a counselling service offers (cf. Gesler 1993; Williams 1999). However, exterior spaces can also undermine the quality of care available. Kirsty, for example, who works in a cash-strapped agency, describes peeling paint as undermining attempts to make a consulting room 'more comfortable' and 'warmer' with a tablecloth and a lamp. When asked 'do you think it makes a difference to the work?' she replies 'yes, I think it does. I think it must do … I think there's something about having a space to do the work that shows that the work's valued.'

That particular kinds of spaces might carry

different symbolic values for, and impact differently on, different clients is also recognized by many practitioners in their comment on such things as meanings conveyed by a location in a well-heeled neighbourhood, or premises situated in a dark and dingy basement. For example, Simon, who manages an agency which occupies part of an attractive Victorian building in a city business district, is concerned that 'people walking about in hushed tones' creates an atmosphere like a 'mausoleum' which is likely to alienate some potential clients. Thus, the dynamic interplay between material environments and clients' inner worlds is contingent and variable. Moreover, in their discussion of the material qualities of consulting rooms, premises and locations—things like carpets, cushions, paintwork, stonework, street noise and levels of natural light—and the emotional experiences of clients—practitioners represent these spaces as exteriorizations of aspects of the interior worlds into which they invite their clients. For example, in describing the counselling service within which he works, Bob made the following statement.

> When I talk about space, I'm not just thinking about the immediate relationship between counsellor and client, but the space right from picking up the telephone and phoning the agency, you know—making an enquiry, then coming here, ringing the buzzer, waiting in the waiting area, being met by the counsellor … We work quite hard on providing an environment that is relatively safe, you know like a waiting area that's not full of people—we structure our appointments—put spaces between appointments, so you've normally no more than two or three people waiting at a time. It's a small thing but it's an example of how we try—like making sure the ash tray is empty when someone arrives. It's their space. It's their room. So this is our whole sense of providing the space.[7]

Bob thinks of the first moment of contact with a client or potential client as part of the service because of the way in which it creates a space that expresses something about the care that is offered. He links together and integrates what might be thought of as internal and external spaces, or symbolic and material experiences of space, as he imagines the client picking up the telephone, ringing the buzzer at the door, and sitting in the waiting area, where there might be other clients waiting too. He articulates an understanding of the spaces in which these experiences occur as replete with meanings that are 'felt' by clients (cf. Davidson 2000b), and he suggests that these spaces provide clients with evidence about the experiential worlds into which they are coming.

Bob's comments also illustrate a paradox at the core of these processes of exteriorization and interiorization. The waiting area is represented as a space produced by the agency and representative of the care the agency offers. But the space also belongs to the clients—'It's their space. It's their room'. This slippage between the agency's responsibility for the condition of the waiting area and the clients' ownership of it suggests that counselling spaces are exchanged and produced through interactions and relationships. Moreover, these spaces are simultaneously the medium and the substance of communication between client and counsellor.

Several geographers have argued that attempts to differentiate between 'real' and 'imagined' spaces, or between 'material' and 'metaphorical' spaces are misguided and unhelpful, emanating from the influential but flawed and limiting epistemologies of positivist, objectivist and masculinist science (Rose 1996; Soja 1996). Likewise, counsellors' deployment of spatial concepts exemplify a way of thinking about space which resists the analytical distinctions and separations associated with rational, scientific discourse. The care they describe

themselves offering actively synthesizes and integrates aspects of everyday experience that are widely (mis)represented as separable, such as physical and mental, outer and inner, rational and emotional, reality and fantasy.

Conclusion

The demand for, and supply of, counselling services and counselling training have grown rapidly in recent years. Consequently, while it remains a form of care the status of which is uncertain and contested, it is increasingly influential within people's lives and within wider systems of care provision. Counselling is an explicitly relational form of care, typically conducted face to face, and often described as a process that depends primarily on the quality of the client–practitioner relationship (Kahn 1991; Rogers 1957). As a practice characterized by a richly geographical vocabulary it therefore holds the potential to illuminate important aspects of spatiality of care relationships, and to inform theorizations of space.

We have argued that counselling in the UK emerged as a practice positioned outside of the hierarchical and bureaucratized relationships associated with much public-sector and private-sector care provision, and committed to challenging the widespread experience of disempowerment felt by clients in their dealings with professionals. We have shown how the position counselling takes up problematizes the relative positions of client and practitioner, in a way that seeks to 'invert' conventional forms of knowledge. The idea that care relationships entail positions that can be questioned and modified is of considerable significance for many other practices.

As a practice of care that remains at least partially outside the bureaucratized and professionalized structure of public-sector care systems, counselling traverses (and criticizes) lines of specialist demarcation. Moreover, counselling is a form of care that actively transgresses normative boundaries of secrecy. Counselling mitigates the risks associated with these trangressions by reframing care within distinctive spatio-temporal, confidentiality and ethical boundaries. As we have shown, the boundaries counselling deploys are paradoxical: in certain respects very precise and concrete, but turning out to be both illusory and fluid on closer inspection. This does not undermine their importance and utility but is a necessary counterpart of a practice that works with experiences through which distinctions between reality and fantasy are explored and reshaped. Other forms of care may not be concerned with the explicit exploration of issues at this interface, but the scope for framing or delimiting care on terms that are acceptable to both carer and cared-for is an issue of great importance to the quality and availability of care, and to the willingness and welfare of carers (Kohn and McKechnie 1999; Tronto 1993).

Boundaries exist and operate in relation to spaces. The spatiality of care described by counsellors is transformational in the sense of attending to fear in order to offer safety, and in acknowledging constraints in order to foster freedom. The spaces of care invoked by counsellors are ones in which relative positions can be questioned, disturbed, inverted, contradicted and redefined. These spaces are framed by boundaries which simultaneously contain and liberate. The spatial metaphors counsellors deploy exteriorize 'inner' experiences through metaphors such as those of journeys and travel, and interiorize the external world through metaphors of inner worlds and landscapes. Furthermore, the boundary between inner and outer is opened up for exploration by attending to the processes of interiorization and exteri-

orization. This conceptualization of space works to undo dichotomous conceptualizations of space in favour of an understanding of space as simultaneously real, imagined, metaphorical, material, symbolic and embodied. While the language of other forms of care may be less overtly spatialized, the relational dynamics of care-giving and -receiving are likely to foster similarly creative and productive geographies.

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Notes

1 The interviews were conducted between May 2001 and March 2002 in the course of an ESRC-funded research project (R000239059), and those cited in this paper were conducted either by Liz Bondi (LB) or by Arnar Árnason (AA) who worked as a Research Fellow on this project.

2 This description is intended to apply equally to the different theoretical orientations that inform counselling training. For example, the psychodynamic tradition uses the language of transference and countertransference to address these issues (Jacobs 1988; McLoughlin 1995), while the person-centred tradition eschews this language but refers instead to the 'unspoken relationship' (Mearns 1994) and 'meeting at relational depth' (Mearns 1997).

3 Her comment also draws attention to linkages between different scales of care: her work within a consulting room is imagined to play out in a client's daily life and hints at wider social impacts.

4 These quotations hint at other kinds of boundaries that operate within people, for example through self-censorship, and therefore point towards wider questions about the boundaries that constitute persons or selves (Bondi 2003a; Davidson 2000a, 2001).

5 This description assumes that counselling is conducted face to face. However, telephone counselling is well-established, with other forms of technological mediation (especially internet technologies and video-conferencing) attracting increasing attention. While these technologies transform some of the spatio-temporal features of counselling, the expectation of explicit and well-defined time, space and role boundaries persists (Goss, Anthony, Jamieson and Palmer 2001).

6 One way of thinking about the difference between psychoanalytic and humanistic perspectives is in terms of the 'nature' of this boundary. In psychoanalytic thinking, the boundary is actively produced through the creation of the infant as a separate being, and, therefore, at least partially de-naturalized. In humanistic thinking the potential for boundedness is naturalized through organic metaphors.

7 The reference to an ash tray in a waiting room merits comment. Smoking is not allowed in the spaces used by most counselling services. However, some services that work with drug users, such as the one where Bob works, do allow smoking in waiting rooms, partly to signal that it is for clients to make decisions about substance use.

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Abstract translations

'Déverrouiller la porte de la cage': la spatialité du service de conseil

Cet article examine la spatialité du service de conseil en portant une attention particulière aux notions de positions, de limites et d'espaces telles qu'exposées dans les comptes rendus de conseillers. Ceux-ci présentent le service de conseil dans son ensemble comme une pratique où les positions relatives du soi et d'autrui sont explorées et débattues. À cette fin, les conseillers choisissent une position contradictoire, dépendant de leur niveau de compétence, en prétendant à la fois d'être experts et non experts. Le service de conseil enfreint autant les limites administratives définies par les différents types de soins de santé, que les limites normatives fixées par le secret professionnel. En remplacement de ces limites, le service procède à l'intérieur de limites spatiotemporelles, de confidentialité, et d'éthiques qui présentent non seulement un caractère concret et spécifique mais aussi, de manière concomitante, fluide et illusoire. Ces limites sont à l'origine d'espaces dans lesquels peuvent être explorées des relations de réciprocité entre la réalité et l'imaginaire. Ces espaces peuvent à leur tour être saisis à la fois par les processus d'extériorisation des esprits intimes des clientèles, et par les processus d'intériorisation des espaces externes y compris ceux mis à leur disposition par les conseillers et par leurs services. La spatialité du bien-être humanitaire propre au service de conseil évoque de façon stratégique des distinctions binaires, à l'exemple de la réalité et de l'imaginaire, mais elle perturbe également les con-

ceptions dualistes de l'espace au profit d'un entendement à propos de l'espace qui tient compte à la fois de son caractère réel, fabuleux, matériel et symbolique.

Mots-clefs: Services conseillers, positions, frontières, espaces, spatialités bien-être, humanitaire, soi/autre.

Abriendo la puerta de la jaula: la naturaleza espacial de la terapia

Este papel examina la naturaleza espacial de la terapia y se centra en las nociones de posiciones, fronteras y espacios que surgen de los relatos de profesionales en este campo. Los consejeros describen la terapia como una práctica dentro de la cual se explora y negocia las posiciones relativas del yo y del otro. A este fin los consejeros asumen una postura contradictoria con relación a su pericia, y afirman ser expertos en no ser expertos. La terapia sobrepasa las fronteras burocráticas que existen entre las distintas formas de asistencia y también las fronteras normativas del secreto. En lugar de ellas la terapia emplea fronteras espacio-temporales, éticas y de confidencialidad las cuales son a la vez concretas y específicas, y fluidas e ilusorias. Estas fronteras crean espacios donde se puede explorar la interacción entre la realidad y la fantasía. Se puede entender estos espacios como procesos; el de la exteriorización del mundo interior del cliente y el de la interiorización de espacios exteriores, incluso aquellos espacios hechos accesibles por los consejeros y sus servicios. La naturaleza espacial de asistencia asociada con terapia invoca de modo estratégico distinciones binarias, por ejemplo, entre realidad y fantasía, pero al mismo tiempo afecta conceptualizaciones duales del espacio a favor de una noción del espacio como a la vez real, imaginado, material y simbólico.

Palabras claves: Orientación psicopadagógica, posturas, límites, espacios, lo espacial, asistencia, el yo/el otro.