FAMILY PROCESS

Editorial: The Cocreation of Crazy Patchworks: Becoming Rhizomatic in Systemic Therapy

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In the field of systemic therapy, there has been much discussion recently about the narrative self. This concept refers to the idea that the self is narratively constructed in and through the stories which someone tells about him/herself. The story is thereby not only viewed as a metaphor for selfhood: Selfhood is not compared to a story, it is a story. But what kind of story are we talking about here? If the self is a story, what does that story look like? These questions are explored in this article. Starting from the possibilities and limitations of traditional and postmodern visions on the self as a story, an alternative vision is illustrated. By considering the self as a rhizomatic story, we not only create a useful view of the way narrative selfhood is constructed within a therapy context, but we also stimulate therapists to coconstruct—together with their clients—patchworks of self-stories. By using story fragments of our own practice, we illustrate the rhizomatic thinking and its possibilities in therapy.

Keywords: Narrative Therapy; Rhizomatic Thinking; Coconstruction of Selfhood

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Last decades, the "narrative turn" in humanities and social sciences found expression within the field of counseling and psychotherapy in the form of an emerging narrative approach. McLeod (1997, 2003) distinguished three quite distinct lines of development in relation to the evolution of narrative approaches in therapy. The three theoretical orientations that have been most involved in this development are the psychodynamic, constructivist, and social constructionist approaches. Psychodynamic writers and practitioners mainly viewed narratives as sources of information about unconscious dynamics and habitual ways of relating to others. They interpreted narratives as representations of a person's inner life and relational patterns, more generally, as representations of real life. On the other hand, constructivist and social constructionist approaches have considered narratives as life itself. As Freedman and Combs (1996, pp. 137–138), stated: "the stories that we act out with each other are not about our lives; in the domain of meaning, they are our lives." In contrast to the psychodynamic approach that evolved to practicing psychodynamic therapy in a narrative-informed fashion, constructivist and social constructionist approaches recently have led to the development of narrative-oriented or narrative psychotherapy.

Within the field of systemic therapy, the interest in social constructionism (Anderson, 1997, 2012; Anderson, 1998; Gergen, 1989, 1991; Gergen, 1999) and in the narrative turn

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(see Epston & White, 1992; White, 1995, 2000, 2007) created "a whole new approach in family therapy" (Dickerson, 2014) that went hand in hand with a growing interest in the concept of the narrative self. This concept commonly refers to the idea that the self is not an inherent given, nor a stable center, but rather something that is continually (re-)constructed in and through the stories that someone tells about him/herself (Bruner, 1986, 2002; Ricoeur, 1988, 1992). While traditional theories about the subject in psychology start from the existence of an essential core self with more or less stable qualities, a narrative perspective starts from the idea that people are not born with a core self. According to a narrative perspective, people derive their selfhood from the narrative activity of telling, interpreting, and applying stories.

Considering the self as something that is not given but is narratively (re-)constructed over time automatically affects the way we look at therapy. When we assume that neither individuals nor family systems contain an essence which can be objectively observed, measured, and changed from the outside and when we also assume that selfhood is developed in and through stories, therapy can be considered as a narrative space in which—in the dialogue between therapist and client—self-stories may be created. From this perspective, the aim of therapy was not to search for dysfunctional essences such as individual disorders or dysfunctional family structures nor to change these dysfunctional essences from the outside. On the contrary, therapy becomes a narrative space where different possible self-stories may be coconstructed. Coconstructed, because self-stories are always created in interaction with the Other, "the self is always relational" (Anderson, 1997; Gergen, 2009), and the creation of self-stories is always "a relational practice" (Weingarten, 2013). The Other refers here to concrete other persons but also to the social language and discourses people use when speaking. Consequently, the coconstruction of self-stories is not an individual matter but something that is always created in relation to others and to a broader linguistic, meaning generating system (Anderson & Goolishian, 1988). As such the word "system" refers to all the voices outlining the self-stories of clients.

When we accept this narrative perspective and assume that people derive their selfhood from the stories they tell about themselves in interaction with the Other, and when we consider therapy as a narrative space where self-stories are coconstructed, we can question what exactly we understand by "the co-construction of a self-story." From a narrative perspective, the story is not only viewed as a metaphor for selfhood: Selfhood is not compared to a story, it is a story (Ricoeur, 1988, 1992). But what kind of story are we talking about here? If selfhood is a coconstructed story, what does that story look like?

These questions will be discussed in this article. Drawing on the work of the French philosophers Deleuze and Guattari (1994, 2004), Deleuze and Parnet (2006), and Deleuze (1995), and more specifically on their concept of the rhizome, we create a possible "view" of the way narrative selfhood is formed within a therapy context, a "view" which can offer therapists a supporting framework in the narrative coconstruction work they do with their clients. As will become clear further, the work of Deleuze and Guattari seems to offer a number of exciting possibilities for experimentation. Their work has been adopted in the field of feminism (see Braidotti, 1994; Buchanan & Colebrook, 2001; Grosz, 1999), education (see Allan, 2004; Gough, 2004; Gregoriou, 2004; St. Pierre, 2001, 2004), and disability studies (see Goodley, 2007; Goodley, Hughes, & Davis, 2012). However, its application in the field of systemic therapy is rather embryonic (Barbetta & Nichterlein, 2010; Hoffman, 2008; Sermijn, 2008; Sermijn, Devlieger, & Loots, 2008; Walther & Carey, 2009; Winslade, 2009). By this article, we aim to contribute to further introduce the work of these philosophers in the field of systemic therapy.

NOTIONS OF STORY AND SELFHOOD: THE SELF AS A TRADITIONAL AND/OR POSTMODERN STORY?

Within our western world a story is traditionally viewed as "a linear, complete whole which is characterized by a plot, a unity which is spatially and temporally structured" (Ricoeur, 1988, 1992). From this viewpoint, we could see the narrative self as a traditional story which is, although it is temporally variable, characterized by the presence of a plot that turns the story (and the self) into a linear, structured whole. More specifically, this means that people would place all of their self-experiences into one linear, complete story about themselves, a story which—as a traditional (auto)biography—is spatially and temporally organized around a plot with a beginning, middle, and end (Sermijn, 2008; Sermijn, Loots, & Devlieger, 2007; Sermijn et al., 2008).

As systemic therapists, we are quickly confronted with the possible limitations of this dominant story notion. Clients mostly do not enter a therapy room with coherent and complete self-stories. While some parts of their story fragments do share some traditional story properties, there are just as many contradictory, spatially, and temporally discontinuous story elements present as well. Departing from these limitations, the postmodern story notion emphasizes the idea that "everything is a story," there is no need for structuring in an overarching plot for something to be a story (Currie, 1998). In postmodern stories, the story elements are not synthesized around one plot. There is no hierarchy in the story structure, but rather a narrative laterality of horizontal story elements and the acceptance of "untamed story elements" (Herman & Vervaeck, 2005, p. 114), which refers to all elements that do not fit in a traditional story structure (nonlinearly organized time, nonlinear cause/effect relationships). The postmodern story notion emphasizes everything that is excluded from the traditional story notion. It values the acceptance of everything that does not fit into a streamlined story.

Adopting this postmodern story notion, we can view the self as an untamed story which consists of a heterogeneous collection of horizontal and sometimes "untamed" story elements, unsynthesizable into one coherent story from which a person derives his/her selfhood. This vision of the narrative self can be related to the broader postmodern idea that the self is multiple, multivoiced, discontinuous, and fragmented (see Gergen, 1989, 1991, 2009).

This postmodern perspective on selfhood clearly fits better with the daily narrative practices of therapists and clients than the traditional notion of story and self. The stories that people tell about themselves are not traditional stories but rather heterogeneous collections of sometimes streamlined, sometimes untamed story elements. Considering both story notions, we may conclude that the postmodern notion creates space for alternative story forms. Yet, this does not mean that the traditional story notion should be completely abandoned. Its characteristics are not completely absent in the self-stories of clients. Without traditional story characteristics, client and therapist would get lost in a chaos of untamed story elements and would no longer be able to understand each other. It does imply, however, that the traditional story notion is too limited and must be expanded to sufficiently connect with therapy practice. We will therefore explore an alternative view of narrative selfhood, a view that departs from the postmodern notion, but also leaves room for traditional story aspects. By comparing narrative selfhood with a rhizomatic story, we experiment with a Deleuzoguattarian concept that can be helpful for therapists to think and act rhizomatically on the way selfhood is narratively coconstructed, and on their own positions in this construction work. Following Deleuze & Guattari we emphasize that a concept should not tell us how reality is organized but should rather create new perspectives that open up the way we look at the world. Concepts are "not given, they are created; to be created" (Deleuze & Guattari, 1994, p. 11).

BECOMING RHIZOME: SELFHOOD AS A RHIZOMATIC STORY

A rhizome is an underground root system, just as in strawberry plants, bamboo, ginger, etc. In contrast to the hierarchical and binary root structure of trees—one tap root splitting into two side roots which again split up—a rhizome has no clear structure but spreads around to all sides. As a dynamic, open, decentralized network, a rhizome can take very diverse forms: from splitting and spreading in all directions on the surface to the form of bulbs and tubers. The most important characteristic of a rhizome, as applied to the notion of the narrative self, is that it has multiple entryways. From whichever side one enters, as soon as one is in, one is connected. There is no main entryway that leads to a core or center. The existence of multiple entryways automatically implies a multiplicity that does not get reduced to a whole or unity. Within the multiplicity, there is no clear hierarchy, structure, or order. Each point of a rhizome can be connected with any other point in the rhizome (the principle of connection), and at whatever point a rhizome is ruptured or destroyed, it will always grow further, begin again, either where it was before or on new lines or connections (the principle of a signifying rupture) (Deleuze & Guattari, 2004; see also Sermijn et al., 2008).

How can we use the rhizome as an image for the narrative coconstruction of selfhood? How can this image help therapists in their narrative work with clients? To explore these questions, we take each of the principles of the rhizome (multiple entryways, multiplicity, connections, and signifying ruptures) and apply them to narrative selfhood. We illustrate these principles using story fragments out of conversations between Jasmina as therapist (Th), Isabelle (I) who comes to talk about "things that doesn't feel good anymore," and other relevant persons that were part of the meaning generating system. Adopting the idea of the system as a "linguistic, meaning generating system" implies that we create a narrative space in our therapy practice in which we invite as many voices as possible that are engaged in the dialogue about what the client(s) call(s) "the problem." So, Isabelle's husband Jean Paul (JP), their 11-year-old son Tim (T), and the family doctor (FD) were invited to join the conversation. We refer here back to the idea of "the co-creation of self-stories as a relational practice" (Anderson, 1997; Gergen, 2009; Weingarten, 2013). As self-stories are always created in interaction with others, we always engage relevant others into the conversational space, others that can be helpful in coconstructing alternative self-stories.

Multiple Entryways

The self as a rhizomatic story has multiple entryways and each entryway will lead to other constructions of selfhood. Deleuze and Guattari reject the idea of a fixed, conscious subject that can be seen as the ground for thought and speaking. They insist that thinking and speaking are "trans-individual possibilities of becoming" (Buchanan & Colebrook, 2001, p. 9). Following this viewpoint, speaking cannot be seen as an utterance of that which a subject thinks/experiences but rather as an event in a continual process of becoming. In the words of Davies et al. (2004, p. 365): "The birth of selves is coincidental with the speaking. We speak ourselves as multiple in the multiple stories we create of ourselves." So each time we speak, a new entryway in the rhizome is taken and a new self is born. In the therapy room, this means that each time a client tells something about her/himself, he/she takes a possible entryway which can lead to a temporary construction of selfhood. Which entryway a client takes can depend on many factors, but will be codetermined by the audience to whom he/she is speaking (in the first place the therapist) and the context wherein the speaking takes place (the therapeutic context and the broader socio-cultural discourse context). The questions asked by the therapist and the position of client and therapist (age, gender, objectives, ideology) will codetermine which entryway is

taken. As therapists, we become automatically part of the rhizome: As soon as you are in, you are connected. It is impossible to remain outside the rhizomatic story as "neutral observers": We are within the rhizomatic story, we are part of the dynamic narrative co-construction process. Or, as Anderson (2012, p. 14) emphasized: "As relational beings who mutually influence each other, our 'selves' cannot be separated from the relationship systems we are a part of."

This idea of "both being part of the rhizome" becomes clear in the following story fragment that shows how the entryway that Isabelle takes at her first encounter with the therapist cannot be separated from the relationship systems she and the therapist are part of:

Th: Can you tell me what brings you here today?

I: Lately it doesn't feel so good any more. . .

The opening question of the therapist automatically creates a conversational context eliciting some self-constructions more than others. The opening question—"What brings you here (to me as a therapist)?"—invites Isabelle to talk immediately about what she experiences as difficult. Therapist and client both start implicitly from the dominant discourse on therapy, supposing people go in therapy to talk about their problems. The entrance Isabelle takes, as a reaction to the question asked by the therapist, is an entryway triggering a certain self-construction, a self that experiences problems and needs therapy to solve these problems.

This example shows how every speaking, every manifestation of the self, is embedded in a specific discourse context, that makes the speaking possible but also shapes and limits what can be said in a particular situation (Davies et al., 2004). Consequently, it is important that we as therapists are aware of the fact that the questions we ask and the ideas from which we start implicitly constitute a great influence on the self-constructions that may or may not be created in therapy. Accordingly, Freedman and Combs (2002, p. 17) stated: "Each question we ask directs attention to a particular domain and away from many others." If Isabelle's therapist, following the work of Michael White, would have asked a totally different opening question (e.g., Can you first introduce yourself, apart from your problems?) the dialogue between therapist and client would probably have opened up other entryways in the rhizomatic story, which would have led to other versions of selfhood.

Multiplicity and Connections

When we consider the self as a rhizomatic story with different entryways, we assume that there is no right entryway or question to show the therapist the way to find "the truth" about the selfhood of their clients. The illusion that one could capture the real essential self of a person is abandoned. On the contrary, through the existence of different entrances we may consider the narrative self as a multiplicity of stories which cannot get reduced to a single unitary story within which a subject can place all his/her self-experiences, recognizing him/herself. There is a multitude of stories, each of them leading to different versions of selfhood. From the moment therapist, client, and other relevant persons are engaged in a dialogical conversation (Anderson, 2012), they are constructing a temporal, local, context-bounded self-story. Within the multiplicity of sometimes contradictory story elements, they are searching together for possible connections that create a temporal coherence and unity, offering them a framework in which they can describe and understand themselves and each other.

Th: You just told me that recently you are trying to live more from yourself. What do you mean by that?

I: I mean … Recently I am busy looking at myself, doing things I feel I want to do, without being controlled. … You know … a few months ago, I followed a sailing course, … I still remember that I sat in that boat and when you want to sail, you have to ease the rope, in a way you must surrender yourself and the only thing I did was controlling. I was in that boat and I felt the fear I felt all these years and that control. … This has to do with … when I was 18 I got the diagnosis of bipolar disorder…

This example illustrates how Isabelle, during a conversation with the therapist, creates a connection between the fear and control she felt for years and the fact that she got the diagnosis of a bipolar disorder at age 18. By creating this connection, a specific story line ("the fear and control I felt for years is a consequence of being diagnosed") is constructed that offers a temporal frame to counderstand specific experiences. Although rhizome thinking does not exclude this constant search for connections and unity within the multiplicity, it emphasizes that every unity is local and temporary. Unity is considered as the temporal takeover of one story with the result that other possible stories are excluded at that moment. From this viewpoint, a certain self-story may—at a specific moment and in a specific context—dominate creating for the client and/or therapist and/or relevant others the illusion that the story constitutes a unity which is the only possible story (a singular root).

In the following story fragment, Isabelle and her husband (who was invited to join the conversation) are telling how they and others in their environment have placed for years all Isabelle's self-experiences and behavior in one dominant story: the story of "the self-suffering from a bipolar disorder."

I: When I got that diagnosis I thought "ok, it's not my fault, it's something in my head, a cerebral sickness, I have to learn to live with it, live quietly, regularly and whenever I feel something in the direction of manic depression I should interfere in time." And my family should do the same, keep an eye on me in case I wouldn't feel it myself. And that's what we did all these years. Everything, really everything was permanently seen from the perspective of that diagnosis. For example, as a women you have every 4 weeks your menses, then that premenstrual period and soon you think "I don't feel well" and every time I had something like "oops, I feel a bit more difficult" … I couldn't feel good or too good because then I was thinking "I become manic" and I couldn't feel bad or immediately I was thinking "I will have a relapse." So, constant control, 20 years of control…

JP: I recognize this. When I met Isabelle in 1994, she quickly told me that she had a bipolar disorder. In the beginning I always kept an eye on her … when she talked a lot, when she was very active or a bit silent … I was always thinking that she could relapse. … I never saw her manic or depressed, never saw her doing strange things … but the fact that she told me she had a bipolar disorder and the fact that she took medication, yes that made me afraid.

Referring to Deleuze and Guattari (2004), such a temporary take over by one story construction could be interpreted as an operation of "rigidification" and "centralization." This refers to the idea that all story elements are forced into one story with a single center. The multiplicity of the rhizome becomes bounded and reduced and all a person tells and does "becomes concentric, definitively arborifies" (Deleuze & Guattari, 2004, p. 232). The rhizome becomes a tree, and the self becomes an old oak. In the case of Isabelle, everything she told and did became concentric around her "being bipolar." "Bipolarity" became a power center that resonated through her whole story with the consequence that she was bounded to a rigid, prescriptive story line, in Deleuzoguattarian terms called a "molar line." Molar lines are "lines of rigid segmentarity on which everything seems calculable and foreseen" (Deleuze & Guattari, 2004, 215–216). The diagnosis of a bipolar disorder is,

for example, connected with a variety of dominant social stories prescribing and predicting how persons getting this diagnosis should perceive, interpret, and behave themselves.

Even if the dominance of such a centralized self-story (i.e., story of "the bipolar self that has to be controlled") seems to be very strong, rhizomatic thinking highlights that each centralized unity is local and temporal, and that there are many other self-stories that can be created besides the story that dominates at a certain moment, "there is always something that flows or flees, that escapes [the centralised story]" (Deleuze & Guattari, 2004, p. 238).

Becoming rhizomatic means also that we—as therapists—have to stay permanently alert for what escapes, for all those elements that don't fit into the united story.

> I: All that fear & control … all these years … I really want to do now what I feel is good for me. … It's so difficult … I mean … for example, it's springtime, in springtime I usually cannot sleep very well, being so many hours awake in bed and it is the first time that I can say "ok this works," without having fear … the first time that I can just let it fly over me. Being awake can be a symptom of becoming manic but…

In the above story part, this would mean that we would highlight those elements that do not fit into the centralized story of the bipolar self that has to be controlled to break through the arborescent unity, creating space to explore other entries which can lead to other temporal manifestations of selfhood.

Th: I hear you say that this is the first time that you can be awake in bed in spring time and that you can say "ok this works that you can just let it fly." Can you help me understand that feeling of "ok it works, let it fly"?

I: That not everything I feel … for example if I'm not able to sleep well or when I'm worrying in bed … that not everything I feel automatically refers to a relapse. After all I'm somebody who is thinking hard about things, this has always been like this…

Th: So while before you experienced the fact of being awake as a possible relapse, now for the first time, you can let it fly … you don't connect it automatically to a relapse but rather to the fact that you see yourself as a person who is thinking hard about things. Can you give me an example what you mean by this? JP, maybe you can help her. … Something that shows that Isabelle thinks hard about things?

JP: *(laughs)* She is always thinking … my little hard thinking wife, her head is never silent. That has nothing to do with a disorder, that's just how she lives, always reflecting…

T: *(who was also invited to join the conversation)* my mum, I love her but sometimes I get tired of her. Yeah, you *(looking at mum)*. … She's *(looking at Th)* always thinking about everything and then she wants that I think also about everything. For example, when I have a fight with someone at school she always thinks about it and she wants to talk then with me about what went wrong, what I could have done differently. … Pfff.

This way of staying permanently alert, highlighting story elements which do not fit into the virtual unity of the centralized story, follows the thinking in terms of "unique outcomes." White and Epston (1990) describe a unique outcome as "an exception to the problem you wouldn't await from the problem story itself" (p. 15) or as "aspects of lived experience that could not have been predicted from a reading of the dominant story" (p. 41). What White describes as a unique outcome can be compared with the above described "untamed" story elements that do not fit in the virtual unity of the dominant story and that can serve "as entry points to alternative storylines" (Winslade, 2009, p. 338). By highlighting untamed story elements and by connecting them to other exceptional situations, narrative therapists try—together with their clients—to break

through the problem saturated story (White, 2007; White & Epston, 1990), creating space for new connections that may lead to richer or thicker stories.

Ruptures and Lines of Flight

Creating space for new connections implies that old fixed connections have to be broken down. With the principle of rupture, Deleuze and Guattari (2004) refer to the idea that connections between story elements can be shattered at any moment. In a rhizome, a rupture is never fatal, as lines of flight that create space for new connections and new self-constructions always arise. A line of flight refers to what escapes, including the desires, intensities, activities, thoughts, and actions that break through the centralized story. "It's not a matter of escaping 'personally', from oneself, but of allowing something to escape, like bursting a pipe or a boil. Opening flows beneath the social codes that seek to channel and block them" (Deleuze, 1995, p. 19). Lines of flight "never consist in running away from the world but rather in causing runoffs" (Deleuze & Guattari, 2004, p. 225). Runoffs escape the forces of subjectification that threaten to arborify the subject into an old tree. As Winslade (2009) stated: "lines of flight are shifts in the trajectory of a narrative that escape a line of force or power [. . .] creative shifts that give rise to new possibilities for living" (pp. 337–338).

The moment Isabelle tells the therapist it is the first time she can "let fly" being awake in bed, the fixed connection "being awake means becoming manic" is ruptured. Through this rupture new connections may be cocreated, such as the connection between being awake and "I am just a thinker." A line of flight emerges from the arborified story of "the bipolar self that has to be controlled" and creates space for new self-constructions (I am just a thinker), as also illustrated in the next example:

I: In the mean time I discussed with my family doctor if and how I could reduce my medication. . . . I was really surprised to hear that he would support me if I should decide to gradually reduce and finally stop the medication. To know this made me happy, something like "he supports me and he thinks that I possibly could live without medication."

FD: *(mail conversation between FD and Th, I in cc) Hi Jasmina, a few days ago I talked to Isabelle about the possibility to reduce her medication. I told her that if she wants to stop her medication, I will support her in that process. I know Isabelle now for almost 15 years and every year she got stronger, more confidential. I think she can find other ways to cope with difficult life situations. From a medical viewpoint it would be positive to reduce the medication, her kidneys are in danger . . . but we have to take into account the possible side effects of reducing medication, she takes this medication for a long time, so we will have to see how her body will react.*

The dominant story line "I am sick so I have to take medication for the rest of my life" is broken up and an alternative self-construction is cocreated: I am someone who could possibly live without medication.

These examples show how existing fixed connections may be broken at any moment and new connections can be coconstructed, creating space for a multiplicity of possible self-constructions: "the self who is a thinker," "the self that is possibly able to live without medication. . ." However, it is not always easy to break fixed connections and escape arborified stories. Some roots, like psychiatric diagnoses, are so strongly settled in our society that they threaten to bind subjects and their lives to old trees. Note for example that in seeking lines of flight Isabelle, her husband, and also her therapist do not completely escape dominant meanings or molar lines.

Th: Isabelle, you told me several times that you really want to reduce your medication. That you want to do what you feel is good for you and that you know that taking this medication for years is not good for your health. You take this medication

since you're 18, after you had, what you call "a psychic breakdown," and the diagnosis of bipolar disorder was specified. Can you help me understand what makes that, although the fact that you want for years to reduce your medication, you still didn't do it?

I: Yeah, I take this Lithium for 29 years now and I don't know what this medication really does. … My psychiatrist always said … Suppose, I am an empathic person, I tend to go along with things … Suppose that lithium helps indeed to keep it a little bit more serene, I don't know that, but suppose it is so, yes … I will go on with these pills for a while. I have the intention, but this has not to be done immediately, I take them already for so long, but in a time … I really want to stop with this medication, I know it's not good for me … for example taking this medication for years has really ruined my kidneys. … I was 18 when I took my first Lithium. … I am now 47, married, mother of a son of 11, studying, working as a freelance therapist … I am not that girl of 18 anymore. Do I really need this medication anymore? I don't think so. … But … in the last 2 years I already went to 3 psychiatrists, and they all—they don't know me—but they all are afraid to reduce the medication. Once bipolar, always bipolar. … So, I don't know. … Who am I to go against what they are saying?

Inner voices Th: 29 years of Lithium. … That's not negligible … yeah, of course she wants to reduce the medication, a medication she began to take after something happened to her when she was 18! She hasn't relapsed since then. … Isn't it absurd that nobody ever questioned the purpose of keep on taking these pills … all these side effects. … But … I'm not a doctor. … Suppose that I should support her in her wish to stop the medication and that it goes wrong … if all these psychiatrists continue to insist the necessity of this medication … who am I to go against that…

JP: I would support her, standing behind her choice to stop the medication but, yes, I am also afraid of the consequences … I'm not a doctor…

This example shows how powerful some molar lines may be and how difficult it is to create, out of such a centralized story, lines of flight to other possible territories. The idea "once bipolar, always bipolar with lifelong medication" became a dominant arborified story that creates a seemingly fixed truth which may be very restrictive for clients, therapists, family (and others who are part of the meaning generating system). In Deleuzoguattarian terms: Rhizomes face blocks, "social codes that seek to channel and block them" (Deleuze, 1995, p. 19), trying to reinstall the dominant order of significance (in the case here the dominant psychiatric discourse and its normalizing practices). So, however Isabelle, her family, and her therapist "let things fly," they can never completely break with the existing dominant discourses: Molar lines (blocks) are unavoidable. However, the concept of the rhizome stimulates therapists and clients to find ways of keeping their joint work rhizomatic rather than arborified. They can do this by being alert for ruptures and lines of flight that break through the hard, fixed connections to reopen the arborified self-story and to start experimenting with new, more helpful connections. Accordingly, Winslade (2009, p. 344) highlighted: "Lines of flight do not need to be 180○ turnarounds. They might be subtle shifts of direction. […] If we follow the trajectory of a line that is bent only to a small degree, over time the narrative trajectory takes us to a quite different place."

In our therapy example, to hit a line of flight means challenging, not totally escaping, the centralized story of the bipolar self. By creating, for example, a conversational space for Isabelle to talk with relevant others about her strong wishes to bring down her medication, without trying to rearborify her desire to escape (by reinstalling the dominant story of "the bipolar self that is sick and needs medication"), we bend the molar line, creating the possibility to enter new terrains of living (Walther & Carey, 2009).

> I: Just the idea that I am somebody who possibly can live without medication, that feels terribly good . . . that gives hope and perspective . . . maybe—not now immediately because I'm still too afraid—but maybe my wish can become true. That supports me to go on, searching further for things that are important for me. . .

Reopening the centralized story by bending the lines and creating little shifts does not mean that one dominant story is replaced by another dominant counter story. The objective is not to come to an alternative arborified counter story, but rather to create continually *temporal, local stories* from which people derive their selfhood. Important hereby is that clients and therapists, just like nomads, never settle for too long into one bounded story. Nomads move from one location to another, "they are always in the middle," always becoming (Deleuze, 1995; see also Braidotti, 1994; Goodley, 2007; Winslade, 2009). But they settle occasionally, they construct temporal, local stories, they can "be" for a short time to continue again, to become further. . .

BACK TO THERAPY: THE CREATION OF CRAZY PATCHWORKS

Clients come to us with self-stories in different forms, measures, and colors. How can we as therapists deal with these stories? The way therapists look at self-stories will automatically influence the way they listen to the stories of clients and the way they will treat these stories in therapy. Therapists who start from a traditional story notion with a strong emphasis on aspects such as coherence, linearity, and unity will tend to offer the client a loom (Deleuze & Guattari, 2004, pp. 524–526). A loom provides clear, prescribed story lines in the form of warp threads which are vertically tightly applied in a frame. A psychiatric diagnosis forms for example a frame of prefixed story lines (warp threads). The client who gets a diagnosis will—together with the therapist—weave all his story elements horizontally like woof threads between the fixed warp threads until a tight close fabric is formed. Isabelle mentioned that she did this for many years together with her therapist and family members ("Everything, really everything was put into the story of the diagnosis"). This weaving together of separate story elements in a loom creates a top down ordering making the story of the client a closed structured unity: It becomes a fabric story. In the case a client enters the therapy room already with a tightly woven story, a therapist thinking from a traditional story notion will confirm this story or offer a new loom. Although this kind of fabric story creates unity, ordering, and clarity, the danger exists that everything will be interpreted and experienced starting from this one fabric. The creation of connections outside the loom becomes difficult and the self gets reduced to a centralized story.

A rhizomatic approach of self-stories tries to counter this reduction. Starting from a rhizomatic perspective means that a therapist tries to expand the fabric story to see the rhizome again. As described in this article, this may be done by highlighting untamed story elements and ruptures to enable the creation of lines of flight breaking through the hard, fixed meanings, opening up the tight fabric story and creating space to experiment with new connections and self-constructions. This constantly experimenting with the creation of temporal, local self-stories, makes that the self is not fixed into a fabric, but stays flexible and open without receding into a disconnected tangle of threads. Deleuze and Guattari refer in this context to the creation of "crazy patchworks." Crazy patchworks are created by putting at random different pieces of cloth in all sizes, shapes, and colors (Deleuze & Guattari, 2004, p. 526). There is no right manner or predetermined pattern defining the sequence of the threads or the pieces of cloth, there is only becoming. Becoming rhizomatic requires a certain creativity of the therapist and client as well as "a collaborative, not knowing stance" (Anderson, 1997, 2012; Anderson & Goolishian, 1992). By adopting a not-knowing stance, a therapist and client experiment together with threads and pieces of

cloth which may lead to various forms of crazy patchwork. In this way temporal, local self-stories are created, in different forms and colors, receptive to including changes constantly.

> She has been carrying with her a shapeless bag of dingy, threadbare brocade containing odds and ends of coloured fabric in all possible shapes. She could never bring herself to trim them to any pattern; so she shifted and fitted and mused and fitted and shifted them like pieces of a patient puzzle picture [. . .]. (Deleuze & Guattari, 2004, p 526)

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