CHAPTER 3

Politicizing Therapy with Older Adults Experiencing Urological Distress

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Many older adults in therapy tell their practitioners that growing older is synonymous with struggle. This common statement elicits questions about the complexity and multiplicity of these struggles: Where are they located and how are they felt, experienced, and survived? Who are these difficulties to be felt with and how can one voice them? What about growing older must be suffered alone and what can be shared? This chapter reckons with these complex questions about vulnerability and marginalization.

Ageism is a "form of discrimination and prejudice, which limits the value of a person through definitions and stereotypes of old age" (Estes & DiCarlo, 2019). It is both an ideology and structural force that normalizes the experience of older age as a time of decline—processes of physical and cognitive deterioration as erosion of one's personhood. Clinical therapeutic work has the power to engage assumptions about what growing older entails and to recognize the realities of the body. The client and therapist (or "therapeutic dyad") navigate a complex matrix together of what ostensibly becomes "aging issues"—multiple and mounting physical and social difficulties, compounded losses, and economic constraints. Perceived and disclosed inequality in the therapeutic dyad threatens our ability to name and share experiences with others, feel fully seen, and play with new ways of being in the world.

Offered in the chapter are three case examples of how the experiences of disability and abjection that older people face can be politicized, demonstrating the clinical work with older adults has the potential to go beyond negotiating decline and the inevitability of death. We center our discussion of treatment around a similar impairment shared across three cases—urinary distress. We chose to focus specifically on cases in which older clients experience urinary distress because of its prevalence, psychic and interpersonal consequences, correlation with other determinants of health and well-being, and association with adversity over the life course. Through these cases, we aim to illustrate strategies for bridging emotional states with bodily realities, giving new meaning to ideas of "holding on" and "letting go."

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1 Literature Review

1.1 *Materialist Theories of Debility, Disability, and Visibility*

The social model of disability has critiqued defining disability as an individual impairment to prevent, cure, or rehabilitate (Berger, 2013). The social model distinguishes impairment from disability by situating it as a creation of the social, political, cultural, and spatial forces that interact with a person with an impairment (Oliver, 2004). However, the social model has been critiqued for neglecting both the embodied experiences of disabled people and the nuanced ways medical impairment and social formations of disability are intertwined (Shakespeare, 2006). Materialist theorists have asserted that the body cannot be ignored, but that a comprehensive analysis of disability cannot be limited to the body, neglecting the experience of contexts, communities, identity, and experiences across the life course (Siebers, 2012). As stated by Puar (2016), "[d]isability is not a fixed state or attribute but exists in relation to assemblages of capacity and ability, modulated across historical time, geopolitical space, institutional mandates, and discursive regimes" (p. xiv). Bodies and identities are mutually shaped through political, economic, and cultural forces (Omansky, 2011). Processes of structural violence and our relationships to structural violence shape disability (Kazemi, 2019). The gendered experiences of osteoporosis and osteoarthritis are prime examples of this convergence. Women are at higher risk for bone density and cartilage loss with limited scientific explanation as to why (Litwic et al., 2013). However, the gender disparities in the prevalence of these debilitating conditions may be rendered more legible when considering social policies that negatively affect women's health outcomes (Abramovitz, 2017), the volume of uncompensated care work performed by women (Bozalek & Hooyman, 2013), barriers to healthcare access women face (Mitra et al., 2017), and the perpetuation of diet culture and ideals of thinness that rob the body of nutrients needed to thrive in older age (Pickard, 2019).

Invisible disability has been concisely defined as "non-apparent impairment" (Evans, 2017). Impairment that is intermittent or difficult for others to detect often allows for the most options about disclosure, care and access assistance, or identity as disabled. The choice to not disclose a disabled identity or impairment can be viewed as an adaptive technique for survival, an outcome of the stigma one experiences or expects, or an act of reclamation and resistance (Evans, 2017). Materialist understandings of disability offer insight into the tensions of visibility and invisibility. Commonplace, intermittent, and covert acts of violence inflicted by institutional forces creates a process of debility across the life course. The frequency, size, and fuzziness of state-sanctioned trauma can allow it to go missing as a part of one's health and mental health

contexts. Further, the lived experiences of older people experiencing multiple forces of oppression (e.g., racism, classism, ableism, transphobia) can be more easily erased and co-opted with time. For example, life expectancy discrepancies (Miller et al., 2006) and the emergence of chronic illnesses earlier in the aging process (Janssen et al., 2015) for those with mental health diagnoses are well documented. As evidenced by the landmark Kaiser Adverse Childhood Experiences study, one of the largest longitudinal investigations into how interpersonal and environmental hardships in early life extend into adulthood and later life, the feedback loop of social degradation, physical disablement, and psychological coping responses can accelerate outcomes we associate with aging and frailty (Felitti et al., 1998). Not only is state violence obscured as a debilitating force, but this violence is *embodied*, allowing the source to be made even less visible within medicalized treatment systems.

Studies and treatments that do not examine or reflect on the failures of social policy and center discussions of human rights, restorative, and anti-oppressive practices inevitably end up promoting false visions of the state's benevolence rather than grounding the welfare state's efforts in accountability. It is essential to acknowledge the ways in which health and mental health institutions exert the power to define and determine disability, assess need, and conceptualize treatment. Using medical terminology can decontextualizes symptoms, alienates individuals and communities from an understanding of illness, and advances disempowering narratives of pathology abound with preconceived notions of (dis)ability. For these reasons, we use terminology in this chapter such as "distress" over "illness" or "diagnosis" to center one's embodied experience over an externally-generated label.

2 Urological Distress

Urological distress is known as a "geriatric giant," one of the main chronic health experiences common in older age that has an impact over multiple domains of daily life (Puvill et al., 2016). Urinary incontinence becomes more prevalent in older age in all genders (Chu & Lowder, 2018). There are four types of incontinence: stress, urge, overflow, and functional. Stress incontinence is when movement or activity prompts urinary leakage. Urge incontinence refers to bladder spasms or contractions that prompt the sensation of urinary urgency. Overflow incontinence refers to an involuntary release of urine without a prior urge to urinate. Functional incontinence refers to the inability to recognize the need to urinate or locate or access a place deemed appropriate for urination. Other subtypes of incontinence include voiding insufficiency,

when the bladder is not adequately able to expel urine (National Institute on Aging, 2017). This typology is not mutually exclusive, and many people experience co-occurring symptoms (Shaw & Wagg, 2017). Many forms of incontinence are either predictive of or a consequence of urinary infection (Bojd et al., 2018). Urinary tract infections (UTIs) are double in prevalence among women over 65 than they are in younger women and are most often associated with healthcare-acquired infection such as stays in the hospital or skilled nursing facility (Medina & Pino, 2019). There have also been well-evidenced associations linking urinary infection with the onset or exacerbation of neurological and psychiatric distress, including mood changes, disorientation, memory loss, and psychosis (Chae & Miller, 2015).

The dominant medical discourse depicts incontinence in a somber light—it is a warning sign for a drastic decrease in quality of life over time (Pizzol et al., 2020), a predictor of other signs of "decline" among older people, such as mobility impairments (Moon et al., 2021), sexual dysfunction (Gomes et al., 2020), dementia and delirium (Bail et al., 2013), and renal dysfunction (Musso-Enz et al., 2021). While engaging in common treatments for incontinence like pelvic floor strengthening, biofeedback, timed voiding, and cognitive behavioral therapy have been evidenced to give patients greater sense of familiarity and control (Smiles et al., 2019), it seems likely people may internalize messaging that their body is faulty, leaky, and bad and something to be managed, or that incontinence is the first marker of their demise. Many of the frameworks that guide psychotherapy, too, assume that loss and universal lack are central to psychic suffering (Braidotti, 2006).

When considering urological distress from a critical materialist perspective, we think about the social construction of the distress: how it is experienced, recognized, and responded to and the relational consequences it engenders. Many older adults feel they must hide involuntary urination. When carers respond to involuntary urination, a speedy rush to reassure an individual might come across as dismissive, and a hasty intervention to direct urination to the "appropriate" place (e.g., toilet, incontinence pads) prevents any learning about how to tolerate the experience of the body's change in control. Disability theorists engaging in psychology assert the need for frameworks to celebrate the ways disabled and older people affirm their selves and bodies and resist cultural understandings of disability as loss—joy can be transgressive (Goodley & Runswick-Cole, 2013).

As practitioners, we must recognize the destabilizing nature of both acute and chronic medical events, particularly for those who associate healthcare institutions with historic cultural or personal trauma (Giesbrecht et al., 2018). Policy events, such as administration changes and subsequent shifts to laws

funding and support for healthcare, housing, caregiver pay, and LTSS (Long Term Services and Supports), community-based services, what is covered in healthcare and protected in housing and community services, can replicate traumatic experiences of past institutional and interpersonal harm. The contemporary political environment and the historical life events one has survived shape how the general experiences of being sheltered or exposed to risk enters the therapeutic relationship. Laws and regulations can replicate the violations that occur on an interpersonal level; the overlap of the psychological, political, and material realities of trauma are present in clinical work. How do therapists contend with how and where we are in this landscape? Answering this question provides an opportunity for us to help patients contextualize and name experiences that are often muted by outside forces or ignored through shame and embarrassment. This chapter examines the role of psychotherapy in naming, working in and working through the hidden role of institutional violence in working with older adults with co-occurring experiences of psychic and urological distress. The aim of raising these cases we introduce in this chapter is to question the formations of aging, mental distress, and physical impairment—how are they shaped? How do they intersect? How do they obscure and/or reveal one another? What can be said about the margins of invisibility and visibility through an exploration of therapy with older adults experiencing urological distress?

3 Methods

3.1 *Type of Inquiry*

In this chapter, we present case studies of older adults who have sought mental health treatment. To locate and illustrate the embodiment of state violence against this population, our case studies focus on clients who experienced urological distress during our work together. Case studies are frequently used to provide depth in understanding a particular phenomenon (Creswell & Poth, 2016). Using this case study approach is part of a long-standing tradition in psychology. A practice-relevant case study approach is useful for informing mental health practice because it mirrors a process of analytic generalization used in treatment. Practitioners are taught to access past clinical experience and relevant theory into therapeutic interactions as the process develops, instead of imposing generalizable knowledge to formulate a predetermined trajectory for treatment (Gilgun, 1994).

According to guidelines for formulating case study research (Stake, 2006) we generated these case studies inductively through consultation and conversation

with one another. The organizing presentation of urological distress was identified after discussing the topic of invisibility as it related to construction of aging and disability. In our process of helping each other reassemble and remember these cases through inquiry and idea-sharing, we also accessed our own personal archival notes as clinicians, discussed these former cases with our current consulting supervisors, and considered sources of information (e.g., documentation of historical events) to clarify how to appropriately contextualize the cases.

In presenting case study research, we have introduced the conceptual framework of materialist notions of disability, have accessed cases at various points and settings in both our careers as mental health providers, and provided contextual details that help frame these cases within the larger ecological context, particularly in understanding the relationship of the client and the work to debility at the hands of the state (Yin, 2015). Our discussion of these cases present a cross-case overview asserting tentative answers and more questions in response to the question of how the ever-shifting formations of aging, mental illness, and disability dictate what is visible and invisible in the experiences of older adults seeking mental health support.

4 Positionality

Both of us have a comfort and familiarity with the body and the role of caregiving through personal experiences of working in various capacities with aging bodies and minds. We have both engaged in care processes as hired care workers, informal caregivers with loved ones, and as therapists with older people. We both identify as queer as a description of our sexualities as well as an indication of our non-compliance with gender expectations—queerness as a social identity honors our own acts of personal and interpersonal resistance, as well as an alignment with a lineage of political dissent. This resistance is its own enactment of care for self, community, queer ancestry, and queer futurities.

Neither of us occupy the typical caregiver body as white citizens assigned male at birth. Immigrant women of color do much of the care work in the United States (Institute for Women's Policy Research, 2018). It is also immigrant women of color in formal carer roles who are treated as less valuable than family carers and are labeled as incompetent and abusive in discourse about formalized and institutionalized aging care (Boodman, 2019). Largely, our experiences as formal carers have been met with neutral confusion or positive accolade. Responses we receive—like "was that part of your training?" or "you've got such a big heart!"—conceal the realities of each of our financial

necessity at precarious times in our lives, and our experiences of finding meaning in unfairly-compensated work in a feminized and racialized field of care.

Essential to our argument is acknowledging that care workers, including mental health professionals, risk ability and privilege in combating violence from the state. In our own ways, our experiences as carers are often rendered invisible in new roles—educated, clinical and scholarly roles that often represent power in systems of violence. These stories are told from our perspectives as clinicians and carers who have embodied madness and rage, but also have the privileges that allow us to embody these roles of power within the therapeutic dyad and elsewhere. These case studies were written without client co-authorship and only come from the limits of our interpretation and perspectives, which can never fully depict the value and wisdom of others' stories or do justice to clients' pain.

5 Findings

5.1 *"Diapers Are for Babies": Infantilization as Disablement*

Ian: I met Shirley while working on an interdisciplinary home-visiting nursing and mental health team. She was in her early 70s at the time and had been living in a supportive housing program for almost thirty years, moving there at the height of the deinstitutionalization movement after long-term stays in institutional settings since adolescence. According to her case file, she had a diagnosis of schizophrenia and was believed to have an intellectual disorder, though had missed the diagnostic window that sorts children into the intellectual and development disorder service world. Throughout her tenure in supportive housing, she spent several days a week at a nearby mental health day program.

Shirley was referred to me by the day program after the social workers on staff noticed that Shirley was using the restroom frequently and urgently, and how she had had "several accidents on the furniture," according to the referral form. Staff decided that she would need to be suspended from the day program because of the disruption caused in groups and the damage caused to property. In the referral process, the day program disclosed that they have seen many of their long-term participants grow older and that they needed to promote "retirement" or "aging out" of the program because the format of the program couldn't support changing needs.

During our initial assessment, Shirley vacillated between being angry with the director of the day program and telling me she had been "bad." She vehemently refused the nurse's suggestion to be referred to a urologist or gynecologist. When I noticed an expression of fear on her face, I asked her if she was

afraid of the doctor. She responded by saying "I don't like being touched." During this visit, I also asked about using incontinence pads, to which she responded by stomping her feet and flailing her arms, saying repeatedly "diapers are for babies and I'm not a baby." Her apartment was on the ground floor and had a window that overlooked the sidewalk, and she reported that she felt watched by passersby. When checking with residential staff and day program clinicians, Shirley had not presented with active psychotic symptoms in several years.

It was evident to me that Shirley's incontinence was taking away her adulthood. The experience of losing control of one's bladder may evoke memories of being a child and cultural narratives about normative development. Her refusal to seek medical care and fear of "being touched" was reflective of the inherent and possible abuse and neglect in institutionalized settings, where not getting enough touch or receiving invasive and violent touch seems a likely experience. Psychosis can be aggravated by bodily experiences, including urinary infection, and her experience of being watched by people on the sidewalk mirrored an experience of surveillance that is both reminiscent of being an infant and being institutionalized. Her refusal to embody the imagery of an infant in a diaper by wearing protective undergarments felt like an assertion of her womanhood. I could imagine and appreciate how Shirley, who had been a "ward of the state" for much of her life, may experience an urgency to assert her independence.

This same driving force of urgency, embodied in rushing to leave groups to make it to the bathroom, was what she was receiving punishment for. This punishment was something she was of two minds about—a part of her absorbing the perspective that her rebellion is bad, a part of her betrayed by her community for enacting the patterns that community living was supposed to be a resistance of. The goal of the referral wasn't just to address her urinary incontinence, but to render the intersections of her aging and psychiatric survivorship invisible.

There was a nonchalance about the onset of her medical issue and a belief that her physical decline was an inevitability of aging—whether about willingness or capacity, the program was not equipped to be adaptive or enabling of health through the life course, and now that those who were "deinstitutionalized" were aging, they were preparing to discard them. Further, there was no dialogue about Shirley's life course experience or what access the day program meant to her. She had broken the rules, and there was no question or concern for how the rules were breaking her.

A social work intern I supervised began working with Shirley after our initial assessment, at first to visit weekly and socialize with Shirley, given her loss of social ties and recent breaks in trust. As a woman, the social work intern

was positioned to build rapport and create safety in discussing medical issues. The interning clinician brought the idea to neutralize the association between protective undergarments and diapers by wearing them herself to a visit with Shirley. She showed Shirley the waistband of the undergarment in a conversation and explained that it can create peace of mind for adults and allow them to engage in and enjoy life activities more fully. Shirley agreed to begin wearing them, and the intern helped Shirley organize them in her clothing drawer to further separate the experience of infancy from their use.

With reassurance that Shirley would not damage furniture or create a stir with other participants, she began attending the day program again, albeit on a reduced schedule. Several weeks later, our intern accompanied Shirley to a gynecologist exam, after thoroughly educating her on what to expect using pictures. Our team's nurse arranged with the doctor in advance to reduce the amount of disrobing required for examination. Through connection with treatment, Shirley's medical team discovered her incontinence was related to a benign tumor blocking her urinary tract, which she agreed to have removed.

5.2 *"The Grave Was Reaching for Me": Urine Retention as Vigilance*

Ian: Early in my tenure as a social worker in Brooklyn, I worked with a man named Sam, a working-class secular Jewish man in his 70s. He was referred to the agency by his daughter, who exasperatedly described him as incompetent at many tasks—balancing a checkbook, rationing his groceries, preparing meals, caring for himself medically, cleaning the apartment. Sam had an ex-wife and an older brother who had very limited contact with him. Sam's wife left him for another man 25 years prior, leaving their daughter as his reluctant companion and carer.

Our agency offered home visits, but Sam insisted on walking several blocks, past a cemetery, to meet at our offices. He often wore a baseball cap and striped shirt. He called me "sir" and "doctor" whenever he spoke. In addition to calling me "doctor," he perceived my first name to be Yin, and asked regularly if I was of Japanese ancestry or had been adopted into a Japanese-American family. Before he sat down in session, he first would lay down a newspaper in the chair. Throughout our early sessions, he would sit and wring his baseball hat as we talked about the regret that had filled his life. His daughter reportedly berated him over the phone and would punish him for overeating by making him go without groceries. He had a sensory experience that he was falling every time he passed the cemetery on the way to session, which he described as unique to this specific location and time, saying "the grave was reaching for me." Whenever he left, he would leave behind a sweat-soaked newspaper on his chair for me to clean up.

Early on, I asked him how he was feeling about coming to therapy, hoping it would provide an entry point into discussing the newspaper. He described being so nervous to talk that he was fearful of wetting his pants. His imagined outcome was that he would urinate and feel ashamed that I'd need to help clean up after him, and that in response, I would ban him from attending services. He would sweat so profusely that it created a manifestation of his fear, one that he ended up leaving for me to clean up.

Sam was also fearful that his physiological symptoms of anxiety—heart palpitations, excessive sweating, frequent urination—were symptoms of a medical problem. When I referred him to a social group to supplement our sessions, he experienced obsessive thoughts about the other man in the groups' recent treatment for prostate cancer, asking me regularly if I thought he had prostate cancer, too. An enlarged prostate could in fact cause urological distress, and I encouraged him to realistically assess his anxiety and take medical actions he felt necessary. In this conversation, he disclosed that he had a lifelong avoidance of doctors because he had been sexually assaulted as a young boy by a family friend and found medical exams frightening. I saw myself included in his transference toward doctors, since he continued to dub me with the credential despite my attempts to inform him otherwise. Jewish and born in the mid-1930s, Sam's associations with Japan were one of cultural trauma. Not only was he afraid that I would shame him and reject him, but he also feared on some level that I would inflict invasion or extermination. Yet, he continued to turn to me for care, in what I imagine was similar to the relationship between Sam and his daughter, a relationship that generated fear and required a wartime alertness. In his attempts to conserve food, he would reach a level of hunger that prompted him to binge. There was a similar holding pattern with his urine in session—he created wetness in his efforts to hold his bladder despite an urge to urinate. There were other fantasies about what would happen if he allowed his body to release, too; if he let go of the tension that carried him on his walk to the office and fully succumbed to his vertigo in the graveyard, he believed he would surely die. This constant vigilance seemed both incredibly isolating and distancing, prompting a cycle of avoidance and conflict with his daughter and preventing Sam from developing new relationships or connecting safely with his environment.

In our work, Sam was able to relax into individual sessions and develop relationships in the therapeutic group. He got a referral to a doctor from a woman in his group who had shared sexual assault as part of her experience surviving the Holocaust. The doctor was a quite tender geriatric specialist, and her gender presentation eased Sam's fears. She ruled out prostate cancer and prescribed Sam a beta-blocker for blood pressure that had ancillary

effects of reducing his anxiety. I allowed him to use the newspaper as a buffer between him and his seat, but also encouraged him to dispose of it himself. This allowed for the newspaper to become a symbolic object in Sam's treatment, through which he could observe the declining severity of his anxiety through the gradual decrease in wetness. Through other Jewish people in the therapeutic group, Sam began to verbalize a more politicized identity, in which he discussed his failed pursuits of the American Dream, his attachment to an expression of masculinity that he could never manifest, and the fear he felt and took on from his family and community about pervasive anti-Semitism. We engaged in a process of re-telling his personal narrative, in which Sam realized that the self-hatred and fear he had lived with his entire life was inherited, and not generated by his unique individual failings. In frequently addressing his misidentification of my race and ethnicity, we were also able to discuss how anger and blame is misplaced in a political sense. This created a space for him to begin undoing his own fear of and racism toward Asian people and created an allegory for his relationship with his daughter. I referred Sam to both a meal delivery program and a neighborhood congregate meal site to address insufficient resources contributing to the conflict with his daughter. While they continued to have a contentious relationship, the combination of therapy, medical treatment, and community referrals offset the triggers for abuse and neglect.

5.3 *"I'm So Glad You Pissed Yourself": Incontinence as Release of Obsessional Anxiety*

Nicholas: I'm reluctant to share any details about this person, who I suppose I'll call Patient X, as so much of his own conundrum in life has been trying to figure out how to show himself to others without being destroyed. He recalls hiding as a child in the drapes, full of terror. He's in his seventies now, and for much of his life he had swallowed a terrible schoolyard experience that involved involuntary exposure and humiliation. That disclosure was an important turning point in our work. The Sisyphusian weight of the boulder Patient X felt condemned to tediously lug has shifted, but it's a lifetime obligation to carry the weight of what has happened to us and our people (The patient himself introduced the myth of Sisyphus, the Greek King of Corinth who after cheating death twice is condemned by Hades to forever roll a boulder up an underworld hill. Specifically, through Camus' adaptation *The Stranger*, in which a man is condemned because he does not weep for his mother's death).

In desperate early moments of our work he voiced feeling completely hollow, as if he were a shell, or had become the curtain. Embodiment came in fits and spurts. Pain was terrifying and demoralizing. He worries constantly about others seeing past the charade of what he believes is a performance of

sanity. His private masochistic process escalates mostly when others are away. He seems to enjoy me watching and what he calls "diagnosing" what he does to himself. With a strange mix of subdued glee he expresses his fantasy that it makes me very sad and must be too much to watch. Really, I just try to recognize what is happening so that he has more awareness of the consequences, and after years of work I think it appropriate he hear more about the bind he places me in: watching him do these things to himself instead of reckoning with what others have done and are doing to him. And how lonely the misery is. How eager is he for company. He expressed dismay one time when he encountered me smiling on the street an hour before our session, how could I possibly relate to him?

How confusing that so many don't really know him, and how fitting with the "logic of despair," a psychic framework geared towards proving others to be failing and rejecting (Green, 1986). Winnicott (1965) elaborates on the dilemma, we all face: "It is a joy to be hidden but disaster not to be found" (p. 187). Patient X does not let himself be known out of abundant caution that others cannot withstand his internal world, except in moments where he spills over and expresses himself in ways that are indeed overwhelming to himself and others.

When he begins to know and show the depths of his despair, is he ignored or punished by himself or others? Growing up entails becoming responsible for the ways one contains and reveals themselves, and how one is held accountable for the sadistic impulses to overwhelm and the masochistic maneuvers to be in charge of the pain. Can we bring awareness to the pleasure and relief he experiences in trying to overwhelm me? He really does care. He weeps a few times into our third year of work when I see his sweetness, but now in our sixth year and in the midst of so much in our world being difficult and worsening—anxieties and contempt for the limits are brewing strong.

The disclosure about the urinary incontinence came after an enjoyable gathering with his family after much pandemic-driven separation and isolation. He had forgotten to go to the bathroom. He was almost home. He was blindsided. The release of urine—incontinence—was a moment where the loss of control coincided with the patient lowering his defenses and enjoying himself. He forgot to manage himself with the usual obsessional anxiety about "behaving normally" and relaxed into the enjoyment of community with friends and family. He was having such a good time, he forgot to use the bathroom. He felt embarrassed, yet also felt some strength in being able to relate the episode to his clinician. He had considered swallowing the episode. I felt a flood, no pun intended, of associations about letting go. The important reality that relating is messy and that to contain ourselves so rigidly comes at quite a loss of the self. On the other hand, I see how afraid he is to lose control in a world which

frames his aging body as failing, not just changing in its capacity, but failing to meet its obligation to perform. We can only imagine how the sadistic schoolyard would have responded to an unexpected, public emission.

6 Discussion

These three clinical vignettes demonstrate the range and variability of what urinary distress embodies and symbolizes. Medical events invariably destabilize psychic realities—not only can they call into question the integrity and reliability of one's own ability to contain and filter their own experiences, but they also can alter the availability of dependable and reliable others. This destabilization can bring up attachment traumas, concerns about one's survival or preservation of self, and new contact with parts of one's existential experience that has been protectively avoided, denied, and projected in the past (Kristeva, 1982).

However, approaching crisis and death can also have a clarifying focus of needing to be real, using the vulnerability as an opportunity to mourn and make meaning. There is a freeing potential realized in putting language to what's never spoken—things we don't have words for until we have work for the words to do. One way to see the therapist's role is to provide space for discovering the multiplicity of what a word means, not collapsing or forcing an interpretation, but instead holding deep appreciation for what is said and cannot yet be said. A therapist can proffer authentic responses and working theories, but a great deal of one's experience as a clinician is privately musing or engaging in our own linguistic explorations with supervisors or peers, so as not to burden the client without invitation or consent. The cases presented also offer a caveat—that our holding patterns can become dangerous when informed by our structural and interpersonal traumas, another retention that can cause infection.

There are lineages of psychoanalysis that makes the medical and the bodily a symbol and a symbol only. However, encouraging people to have a narrative sense of their bodies is an essential part of clinical work. As psychotherapists, we also tasked with considering how impairment or disability can materialize through neuropsychological responses; for example, evacuating the bladder before leaving the house out of habit or routine dread that one will not find a bathroom can prompt the bladder and pelvic floor musculature to forget its capacities and increase the risk of developing or worsening urge incontinence. Therapeutic subfields on trauma have led the charge in acknowledging that the physical sensations, experiences, and pain we can experience is a result

of our personal experiences and experiences of our family lineage and communities (Rothschild, 2000; van der Kolk, 2014). Counter to a medical model, somatic and embodied approaches encourage relating to these sensations as worthy of attention, informative, and even functional. This body of literature historically has not explicitly recognized the associations between structural forms of disablement and embodied affective experience, though a growing number of psychotherapists engage with structural marginalization in their somatic work with trauma (Kidron, 2012; Linklater, 2014; Menakem, 2017). This chapter adds to this lineage by encouraging therapists to relate to the body as an ever-changing sociopolitical artifact.

Too routinely written off as a kooky old lady, Shirley's case illustrates how the societal and interpersonal expectations placed on her due to her disability predicates her failure to find a place in this world. The logic of the carceral state is that one's value is determined by labor and obedience to hierarchy. In the U.S. and throughout much of the world, big business and government colludes in creating social policy where workers are used for their labor, exploited through precarity, and then discarded when there is no more labor to extract (Gross, 1980; Estes & DiCarlo, 2019; Estes, Yeh, & DiCarlo, 2021). There is little room for the perceived waste generated from bodies and minds that are non-compliant with the needs of the state, so it was fitting for her urine to take on such significance. She faced "aging out" of the program for causing property damage. Urine becomes a dangerous and damaging thing that must be managed. Her late diagnosis of the tumor was a consistent theme throughout her life. Receiving a timely diagnosis is one requirement of many in the gauntlet of disability certification and can offer individuals limited but crucial opportunities to apply for disability benefits and programs. If she had been identified with an intellectual or developmental disability before early adulthood, she would've had access to a different, richer set of resources that could've prevented or reduced her time in institutions. Her urinary distress was a perpetuation of a cycle of neglect, confinement, and expulsion present throughout her personal history.

Sam received services due to others' concern over his ability to manage what are called "activities of daily living." Even though services were primed to come to him, Sam advocated for himself to be in the world, even if it meant exposing himself to the evocative clutches of death in his walk through the graveyard. Struggling with financial management should be a political event for any working-class person, and the retaliatory act of withholding groceries to punish over-eating speaks to his lack of autonomy, a lack of respect, and an abusive articulation of control. Even without the event of incontinence, the newspaper became a representation of his anxiety. Being present in his body

and with a fuller set of his sensations assumed a risk that he would be punished or intruded upon. Through careful, curious questions inviting him to not carry this anxiety alone, a path of words more substantial than the newspaper led Sam to explore the impact of growing up experiencing sexual trauma and bearing witness to cultural violence. Sam had previously never found an opportunity to politicize his identity, buying into nationalist fantasies and fear of an Asian Other. The lack of supports he faced in developing a critical social consciousness magnified his isolation from care resources and disrupted his relationships with a diverse local community. The constant vigilance to keep oneself separate from death or harm is perhaps the same vigilance that robs us of our vitality and mutuality.

Whereas Shirley may have needed to assert her adulthood, Patient X may have needed to make contact with a more infant experience. There was relief in the therapeutic dyad as it became possible for him to genuinely lose control and experience care. The experience of incontinence came at a chapter in his work where he had noticed babies in the world being held and expressed his own longing and concern for getting enough.

The work with patient X also included naming racialized objects and processing political terror, past and present; but these feel too potentially identifying and exposing to name explicitly. On one level this is part of the transference of hiding, but there's a reality that such details increase the risks of this vignette being potentially identifying. However, it is important to allude to them as they are relevant to how sadism and control have asserted themselves as paradigms of mastery and domination. These hegemonic and oppressive realities relate strongly to how I sense the patient experiences the degradation and precarity of aging in our society. Alongside these, and again without going into specifics, are family factors of illness, immigration, chronic mental duress, and premature traumatic death that inform the patient's level of terror, flightiness, and greater contextualize his lack of exposure to aging and dying as understandable events, able to be processed and made meaning with, rather than terrifying realities to avoid.

7 Conclusion

Relational care, psychotherapy included, primes us to see and be seen with more depth. However, the politicization of the body and of aging and disability processes is largely absent from psychotherapeutic discourse, an erasure that deeply complicates our capacity to construct and sustain healing relationships. Through case examples of older clients who have faced urological distress, this

chapter urges clinicians and carers to hold the complexities of patients' social identities—we must allow individuals to have their own holistic personal understandings of aging without dictating care or medicalizing experiences, while simultaneously working to name and describe disability as an outcome of structural violence across the life course and the continued inequities that prevent adequate care. When we as service providers collaborate with older patients to provide care centered around their identified needs, we must also consider the symbolic and material value of bringing the historical, political body into our work to facilitate security, connection, and agency that counter dominant narratives of aging.

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