The main interest in life and work is to become someone else that you were not in the beginning. If you knew when you began a book what you would say at the end, do you think that you would have the courage to write it? The game is worthwhile insofar as we don't know what will be the end.

Michel Foucault, *Technologies of the Self*

University of Alberta

Candida and the Discursive Terms of Undefined Illness: Ghostly Matters, Leaky Bodies and the Dietary Taming of Uncertainty

by

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This dissertation is dedicated to my parents—to my father who passed away years before I ever considered graduate school, and to my mother who saw me through to the very end.

Abstract

This dissertation examines the discursive terms upon which people come to understand their experiences with a yeast-related disorder known speculatively within biomedical practice as "Candida". Following the critical interrogations posed by feminist and poststructural theorizings, I aim not to prove or disprove Candida's etiological case. My aim, rather, is to question what can be learned about the social workings of undefined illness through attending to how people talk about their experiences with Candida. I am concerned both with people's experiences of Candida, and in how these illness experiences come to be structured in and through the wider discursive framings of biomedicine, gender and dietary discipline. As Candida continues to emerge as unintelligible—and thus disorienting—form of illness, the urgency lies, I argue, not only in representing these often nebulous illness experiences, but also in questioning how these illness experiences come to be shaped.

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CH. 1

A Double(d) Science:
Candida and the Discursive Terms of Undefined Illness

> Candida is very complex. It's got a life of its own, and it tries to out-fox me everyday and in every way it can.
> Sue

> The modern lifestyle of chlorinated water, bad diet, heavy stress loads, frequent use of antibiotics, steroids, chemotherapy, all sorts of other drugs, and probably also the bombardments of radiation from computers and microwaves, are taking a very heavy toll on our immune systems, and this is giving Candida a big, big chance to grow at the expense of our friendly bacteria.
> Diana

> There are no soft places to land with Candida. You have to be so on top of things just to be normal.
> Meena

> How do I understand Candida? It's difficult to define, really. I see it as a condition that affects the mind, the body and the spirit.
> Janine

> Candida is what it is and it's going to be what it is until it isn't what it is.
> Will

People often ask me what my research is about. I tell them it is about understanding the experiences of a largely undefined disorder known speculatively within medical practices as "Candida". And then they ask the inevitable question, a question with no simple or straightforward answer: *what is Candida?* While I detail the medical case of Candida in the following chapter, for now, I will say that Candida is a yeast-related disorder of vague symptomatology, classifiable under what Malterud (1992) terms "undefined disorders"—an illness with no objective pathological (biomedical) trace.

While some of my initial interests with this project stemmed from my own mystifying and maddening experiences with what I later assumed to be Candida, my interests in this project are not only about these experiences. I use the case of Candida to explore sociological questions concerning undefined illness, the body, and experience. I am concerned *both* with how people negotiate the complexities of living with Candida, as well as the discursive terms and limits which produce these (often undefined) experiences. Although illness—and specifically here, Candida—is experienced "in" the body, it also cannot be removed from the wider discursive limits in and through which we come to experience its effects. The question that frames this dissertation, then, is this: what can be learned about the social workings of illness through attending to how people talk about their experiences with Candida?

I am concerned with people's poorly defined experiences of Candida, as well as concerned with situating "the ill-self as part of historically-delineated systems of knowledge and meaning" (Fee, 2000, p. 9), and with emphasizing how the life of the ill-self is "implicated in knowledge-centered struggles" (Fee, 2000, p. 2). Because I ask after the ways in which people talk about and make sense of their experiences with Candida, I am not focused on whether the people I interviewed actually "have" Candida[1], or with whether Candida actually "exists". These questions are secondary given that I approach the reality of Candida as a social phenomenon—as that which is structured by wider discourses of

[1] In my call for interview participants, I asked for people willing to share their experiences with Candida. Given that it is very difficult to get a medical diagnosis of Candida, and that there is so much ambiguity concerning exactly what Candida is, it was sufficient for me that people self-identified as having Candida.

power/knowledge[2]—and not as a medical problem simply to be solved (or absolved). Rather than attempting to legitimize the case of Candida, or people's often delegitimized experiences with it, I confront "the ontology of illness from an interpretive framework" (Fee, 2000, p. 3). Following some of the wider interrogations posed by poststructural theories, I seek to reveal how the truths of Candida (or, more aptly, its lack of truths) come to be produced.

Emerging from, and as a critical reaction to, the modernist and enlightenment ideals of structuralism[3], poststructural critique proceeds from the ontological and epistemological assumptions that there is no single, inherent, or universal authority, and that all positions and/or claims to truth—including here, those concerning bodies and illness—are necessarily contingent upon the social, historical and political systems in which they come to be known (Belsey, 2002). My approach to this topic (for some) may seem surprising, even counter-productive, given that much of the existing literature on "chronic undefined disorders" (Malterud, 1992), "medically unexplained symptoms" (Nettleton, 2006), "non" or "illegitimate illnesses" (Cooper, 1997), "uncertain illnesses" (Dumit, 2006), and "chronic" or "medically unexplained pain" (Werner, Isaksen & Malterud, 2004), seek mostly to prove that these illnesses *do* exist and that they *are* real.

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[2] I use the written form of power/knowledge, like Foucault (1977), to signal the poststructural assertion that power and knowledge directly imply one and another. As he argues, "there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (p. 27).

[3] Most often associated with the fields of linguistics, anthropology and psychology, structuralism purports that language carries underlying and inherent structures (Hawkes, 2003).

According to Nettleton (2006), the growing body of work encompassed under what she deems "an emerging sociology of uncertain illness" (p. 1168), focuses predominantly on three themes: living with uncertainty, issues of legitimacy, and resistance to psychological and/or psychosomatic explanations. I have found that this field also concerns itself with changing attitudes both towards, and by, the medical profession (Cooper, 1997; Dumit, 2006; Greenhalgh, 2001; and Malterud, 1992 & 1999); the role of social networks (Espwall & Olofsson, 2002); and the gendered (if not feminized) aspects of these illnesses (Barker, 2005; Driedger & Owen, 2008; Greenhalgh, 2001; Malterud, 1992; Richman & Jason, 2001; and Werner, Isaksen & Malterud, 2004). Despite the emerging research area of the sociology of undefined illness, however, there are few studies that explicitly position people's experiences with undefined illness as being shaped in and produced through wider regulations of discourse (the exceptions I include are Cooper, 1997, Greenhalgh, 2001, and Fee, 2000). Unlike much of the existing research on chronic undefined disorders, I approach the case of Candida via an inquiry into the discursive frames of intelligibility that shape, limit and enable its murky construction.

Having said this, however, at this historical moment, I also think it is imperative to make more unambiguous the often uncertain experiences of Candida. I think it is critical to bring awareness to the experiences of Candida which are "systematically disconfirmed" by biomedicine (Ware, 1992, p. 347). I think it is necessary to move beyond persistent, largely insulting assumptions dictating that if an illness cannot be diagnosed objectively within the body then it

must—according to the logics of Cartesian dualism—be "all-in-your-head". A focus on the experiences of Candida becomes even more critical considering that there are no sociological, anthropological, or critical health studies to date on Candida[4]. Despite the emerging sociology of undefined illness, and despite Candida being listed as an undefined illness by Cooper (1997), Malterud (1992) and Ware (1992), it remains (at least within the English language) an un-studied topic via critical and/or qualitative perspectives. Wanting to circulate knowledge about Candida, alongside an urgency to also understand how knowledge about Candida is itself discursively constituted, my pursuits in this dissertation are inherently "double(d)" (Lather, 2007).

I seek both to give expression to the often un-told experiences of Candida, while also maintaining an awareness of how these experiences are constrained in and through the discourses which produce them. Writing at the uneasy edge between the desire to voice, and the desire to think critically about the structures of knowledge and power in and through which these voices come to be heard, I follow Lather in her assertion that a double(d) approach is both necessary, and productive. In order to detail more fully the two at-times contradictory lines of inquiry that inspire this dissertation, as well as the social and political investments associated with each set of knowledge practices, I turn to Lather's (2007) recent conceptualization of a "double(d) science". The point, as she argues, is not to reconcile the differences between the pursuit of experiential knowledge, on the

[4] This claim is based on extensive database research. I searched the term "Candida" across a variety of social health, sociology, anthropology, social science and humanities-based databases. While the word Candida registered a few results, these results were either scientifically or medically-related resources.

one hand, and discursively produced knowledge on the other, but rather to follow both strands simultaneously in an attempt to re-think the very stories (about illness, about the body and about experience) we want to tell.

A Double(d) Science[5]

In *Getting Lost*, feminist poststructuralist and methodologist Patti Lather (2007) explicitly calls for feminist efforts towards a double(d) science. Lather's call for a double(d) science is a methodological treatise on her and Smithies' earlier book *Troubling the Angels* (1997), wherein they negotiate the "politics and ethics of doing research on/for/to/with" women living with HIV/AIDS (p. viii), wrestling with the knowledge practices possible "after so much questioning of the very grounds of science" (p. viii). "Its starting point", Lather (2007) explains, "is the aftermath of poststructuralism, delineating the science possible after our disappointments in science" (p. 1). A double(d) science is not a mastery project typical of modernist or Enlightenment thinking, but rather, a project that engages "a methodology of getting lost", and a methodology "where the journey of thinking differently begins" (p. 9). Lather is proposing that by rejecting simple or straightforward explanations, and by engaging in what Pitt and Britzman (2003) term "difficult knowledge", we might "produce different knowledge and produce knowledge differently" (p. 13).

Difficult knowledge is knowledge that moves beyond what we think we want to find, and asks after the "necessary complicities" as well as the

[5] I use the term science in the same way that Lather (2007) uses it—to refer to the investigation of knowledge and knowledge practices, and not to empirical or positivist truths.

"inadequate categories" that frame a person's research (Lather, 2007, p. viii). It is knowledge that "disperses rather than captures meaning", and, as such, knowledge that "induces breakdowns in representing people's experiences" (p. viii). The pursuit of difficult knowledge is one way for Lather to approach the many complexities of exploring (as I also do) other people's illness stories from poststructural and anti-foundational perspectives. Because poststructuralism entails a questioning of why things are the way they are, how they come to be produced as such, and whose ideological interests they might best serve, it is a knowledge practice "characterized by the loss of certainties and absolute frames of reference" (Lather, 2007, p. 117). As Lather (2007) argues, "the most useful stories about science are those that interrogate representation" (p. 119). Poststructural approaches to experience have consistently encouraged a recognition that stories cannot exist in and of themselves—that stories about experience, about the body and about illness are inescapably shaped by the social, political, historical, linguistic, discursive and cultural practices in and through which they come to exist, and be told. As critical as this assertion may be, it also becomes quickly thorny in the face of ethnographic pursuits of human experience.

Like Lather (1995, 1997, 2000, 2001 & 2007), Deborah Britzman (1995) also engages the often-pointed question of what poststructural theories "do" to ethnographic research (p. 229). Britzman (1995) explains that ethnography is based on the methodological assumption that it can offer new information to the reader, that it can take "the reader into an actual world to reveal the cultural knowledge working in a particular place and time as it is lived through the

subjectivities of its inhabitants" (p. 229). In ethnography, experience is considered "the great original" (Britzman, 1995, p. 229). Experience is put forth as "the authoritative because seen or felt" (Scott, 1992, p. 401). And, because "the concept of voice is at the heart of claims to the 'real' in ethnography", it is often "privileged over other analyses" (Lather, 2007, p. 136). While the concept of voice has been important in moving away from scientific pursuits of objectivity and truth (Lather, 2000), for poststructural modes of inquiry it remains problematic. It remains problematic because it fails to take into account the ways in which "voice" is produced, and the ways in which discursively-produced identities are bound by the discourses that shape them. Confessional tales, personal narratives and experiential stories are flawed in their inherent attempt to represent that which cannot exist—"unmediated access to the real" (Britzman, 1995, p. 235), and the assumed a-priori of experience.

Given that "poststructural theories raise critical concerns about what it is that structures meanings, practices, and bodies, about why certain practices become intelligible, valorized, or deemed as traditions, while other practices become discounted, impossible, or unimaginable" (Britzman, 1995, p. 231), it is not enough to simply "voice" individual experiences. Poststructural approaches to ethnography must entail the critical recognition that wider constitutive forces are also at work. Poststructural approaches to ethnography, as Lather (2007) asserts, "shift responsibility from representing things in themselves to representing the web of 'structure, sign and play' of social relations" (p. 119). What is critically and necessarily re-worked in Lather's double(d) science, therefore, is the position

from which individual narratives come to be told. Personal narratives are removed from simplistic or straightforward or accessible assumptions that stories = truth, and are positioned as the byproducts of a system of "competing regimes of truth" (Britzman, 1995, p. 235).

Taking up Lather's (2000) quest "for a less comfortable social science" (p. 23), I use her double(d) approach as a way of producing much-needed, yet far-from-simplistic, knowledge about Candida and its lived experiences, while simultaneously maintaining an awareness of how these experiences come to be shaped. While I risk, as Lather and Smithies (1997) did, "walk[ing] a fine line between making a spectacle of [my participants'] struggles and wanting to speak quietly, with respect for all that it means to tell the stories of people willing to put their lives on public display in the hope that it will make it better for others" (p. xiii), I am confident that this fine line is exactly where this project needs to be. A double(d) science is precisely "a praxis of aporias and stuck places" (p. 7), and a shifting imaginary where "aporetic suspension is ethical practice" (Lather, 2007, p. 6). Veering away from "the impossible desire to portray [other people's stories] as they would portray [them] themselves" (Britzman, 1995, p. 233), I also do not entirely abandon these (impossible) pursuits. In my quest for a fullness of analysis that honours the stories of Candida and the cultural situatedness of these stories, I privilege both the experiences of the people with whom I spoke, and the poststructural critiques of these experiences.

To sketch more fully my double(d) approach, I begin by summarizing the roles of illness narrative, mapping their significance to the project at hand. Next, I

engage feminist poststructural interrogations of experience, de-centering humanist notions of experience. And finally, in putting Lather's methodology of getting lost to work, I detail the methods used to both present and explore experiences concerning Candida—experiences which simultaneously belong to others and don't belong to others, and experiences which at the same time, help people in their struggles for self representation, and bear the indissociable framings of wider discursive workings.

Illness and the Practices of Narrative Representation

One need not look very far for personal narratives[6] concerning illness. Examples of narrative and autobiographical accounts concerning illness can be found online (on health websites, and personal blogs), in community health magazines, and in both popular and academic literatures. The boom in illness narratives (a term popularized by Arthur Kleinman, 1988), or of what Mairs (1996) half-facetiously refers to as the "literature of personal disaster" (quoted in DeSalvo, 2000, p. 185), speaks to the many frustrations of diagnosis, the ups and downs of treatment, the dynamics of patient-doctor interactions, as well as to the many bodily ails encountered during illness. Lisa Diedrich (2007) remarks that the proliferation of illness narratives in the last 30 years can be partially explained as a result of the women's health movements of the 1970s, and the cancer and AIDS movements of the 1980s and 1990s, movements which have "politicize[d] patienthood" (p. 24). The politicized patient, according to Diedrich, is not only

[6] Like Williams (1984), I use the concept of narrative in a broad sense as a synonym for a 'story', 'account' or 'chronicle' (p. 177).

more publicly visible than in the past (consider, for instance, the pink ribbon campaign for breast cancer, or the red ribbon campaign for AIDS campaigns, which encourage people to wear their support for those suffering from these illnesses), but, the politicized patient is also encouraged to speak up about their illness experiences (consider also the ways in which personal stories are a common feature of public HIV/AIDS and/or cancer events).

Alongside the boom in illness narratives and of central concern here, is that there has also been a growing body of work that examines the uses and roles of telling one's illness story. As outlined by this wider literature, illness narratives are commonly used by sufferers to create an "illness community" (Frank, 1997a; Greenhalgh, 2001; Sharf and Vanderford, 2003); to help inform medical practice (Hydén, 1997; Kleinman, 1988); to provide counter-narratives to the dominant narratives of biomedicine (Butler & Rosenblum, 1991; Diedrich, 2007; Greenhalgh, 2001; Frank, 1991 & 1995; Lorde, 1980; Stacey, 1995; Wendell, 1997); and to create meaning for the body in pain (Broyard, 1992; Garro, 1994; Good, 1992; Hydén, 1997; and Kleinman, 1988). I briefly consider each of these uses of illness narratives in order to give a better sense of why I consider it necessary to speak to the experiences of Candida.

Because of the isolation commonly encountered during illness, illness narratives are used to create a community among sufferers. As Frank (1997) maintains,

> Stories are told as claims to membership in communities but the community is not already there, waiting for the story. Communities are

> formed out of stories; the story is a reflexive affirmation that a gathering of people is a community (p. 36).

Illness communities not only ally people with similar illness experiences; they also enable sufferers to access a wide range of information, and encourage supportive environments to learn from what others have experienced (Greenhalgh, 2001; Sharf and Vanderford, 2003). The creation of experience-based illness communities is evident in the case of Candida through such organizations as The National Candida Society, The Yeast Connection, and even the Canadian Women's Health Network where members exchange stories, and share product and treatment information.

Illness narratives are further considered valuable because of how they may be used to inform medical practice. In writing about her suspected bout with Fibromyalgia, Greenhalgh (2001) asserts that illness narratives provide valuable insights into the lived experiences of undefined and/or chronic disorders, especially given that these experiences are often so poorly understood within standard biomedical practices. Greenhalgh (2001) states that she "hope[s] most to reach the biomedical community" (p. 8). Based on twenty years of treating chronic illness, psychiatrist and anthropologist Arthur Kleinman (1988) also strongly supports the use of illness narratives to aid in clinical practice. He contends that attention to illness stories can make better doctors, and that listening to patients' narratives can bridge the growing gaps between patient and practitioner (p. 29).

Above and beyond the reasons listed thus far, illness narratives are perhaps most commonly used as a way of writing against, and *re*-writing, overly medicalized accounts of the body. Many of the authors who voice their personal stories of illness speak to the importance of writing "outside" exclusively medicalized accounts of their bodies. Writing extensively about the emergence of scientific medicine and the corresponding ways in which it treats the human body, Foucault (1973) explains that bodies according to the "anatomo-clinical method" (p. 4) (more commonly referred to as the clinical method or model), are considered stable and homogenous because they are thought to be examined in a pristine state and thus viewed as something disconnected from culture. While I detail the empirical discourses of the clinical model in Chapter 3, suffice to say here that it dictates how biomedicine approaches the sign, symptom and pathology of disease. In Foucault's (1973) words, the patient under the medical gaze "is only an external fact" (p. 8). Guided by the positivist belief that a single knowable and objective reality exists, biomedicine claims to see diseases that lie deep within the body, bringing them into knowable, treatable and curable forms, and, consequently, rendering the human body as the site and target of scientific manipulation.

Given the ways in which scientific medicine objectifies illness in the body, separating it almost entirely from the ill person, and denying ill people the authority over their own bodies, it is perhaps not surprising that many people want to write themselves *back into* their (ill) bodies. As Diedrich (2007) explains, the patient under medicine's gaze is "individualized as a body [but] not as the subject

of her own experiences" (Diedrich, 2007, p. 5). Greenhalgh (2001) similarly remarks that ill people need to reclaim their voices because "scientific medicine has too often silenced the ill" (p. 323). And likewise for Frank (1997), "in learning to tell my own story I began to learn, better than I ever had, what my own voice sounded like" (p. 32). Experiential stories concerning illness attempt to recover the person in the ill body, and seek to restore, as Garro and Mattingly (2000) state, "the human subject at the centre" of ill bodies (p. 8). For many authors, illness narratives provide "triumph over the alienation created by the institutional appropriation of the body through an official, medical discourse that interpolates that body in exquisite physiological detail but denies the voice of the person in the lived body" (Frank, 1996, p. 63). The use of illness narratives in the case of Candida enables individuals to voice that which is often systematically disconfirmed—yet still also still medicalized—by dominant biomedical practice (a point of analysis I engage in Chapter 3).

In writing against overly medicalized accounts of illness, illness narratives also function to give meaning to the often-difficult (odd, strange, and non-sensical) experiences of illness. As Radley (1995) details, narrative is one form by which patients can shape their suffering; by storying one's experiences with illness, it can "transform symptoms and events into a meaningful whole" (p. 5). Hydén (1997) similarly posits that "by weaving the threads of illness events into the fabric of our lives, physical symptoms are transformed into aspects of our lives, and diagnoses and prognoses attain meaning within the framework of personal life" (p. 53). Meaning and coherency are created through narrative

because they merge illness experiences with a person's larger life story. Williams (1984) refers to this process as narrative reconstruction, stating that illness narratives are used "to reconstitute and repair ruptures between body, self and world by linking-up and interpreting different aspects of biography in order to realign present and past and self with society" (p. 197). Good (1992) and Garro (1994) point out that narrative reconstructions are especially important in cases of chronic and/or undefined conditions—conditions which are typically plagued by high degrees of incoherency, ambiguity and uncertainty.

The inclusion of Candida narratives[7] throughout this dissertation thus serves many key functions. As detailed here, I include these stories as a way for Candida sufferers (as well as sufferers of undefined illness more generally) to learn from what others have experienced. I include them as a way of informing medical practice, and bridging the divide between patient and doctor. I include them alongside the medical accounts of Candida outlined in Chapter 2, as a way of voicing often-silenced "personal" accounts of illness. And while I make no claims at *giving* meaning or coherency to the stories of others, I do think that the inclusion of Candida stories will help others create their own meanings and coherencies vis-à-vis an illness characterized largely by uncertainty. While I did not specifically ask after the effects of sharing their experiences with me, many of the people I interviewed did speak to the importance of being able to tell their stories about Candida, and of being able to talk to someone else who understood what they were going through. It is for these reasons, as well as the ones

[7] I detail the inclusion of these narrative excerpts in the methodology section of this chapter.

discussed here, that I focus (partially) on the lived experiences of an illness that people don't know that much about.

Returning, however, to the doubleness upon which this project is based, I also include Candida narratives as a means of complicating and moving away from (yet at the same time being somewhat reliant on) any simple or straightforward notions of experience. My impetus to understand the discursive terms and limits of people's experiences with Candida contrasts against much of the existing literature on illness narratives. As Anatole Broyard (1992) contends, storytelling is a natural reaction to illness; in his words, "people bleed stories" (p. 20). As Arthur Frank (1995)—one of the most prolific writers in the area of illness narrative—similarly puts forth, "the stories that ill people tell come out of their bodies" (p. 2), and the "ill body speaks eloquently in pains and symptoms" (p. 2). He moreover, unequivocally, insists that "ill bodies *can* be lived, reflected upon, and told outside power/discourse" (Frank, 1996, p. 54, emphasis added). Turning now to feminist poststructural theorizings of experience, I am concerned that what is largely missing from these articulations of illness narratives is a failure to recognize the cultural location of the embodied subjects who tell their stories about illness.

De-centering Humanist Notions of Experience

The notion of experience has long been both a central and contentious category within feminist research. This section, therefore, is not intended to trace the entirety of these complicated and ongoing histories, but rather to sketch key

issues related to poststructural and postfoundational ethnographic pursuits. For more concise overviews of the important and often-tumultuous histories of women's experiences within feminist research, please see Canning (1994), Smith (1993), Smith and Watson (1998), and Spivak (1988). While claims to women's experiences were initially put forth to counter the presumed universality of "the transcendental [white male] subject" (Smith & Watson, 1998, p. 27), these pursuits are easily barbed in the face of poststructural de-centerings of humanist notions of experience. Working against "the humanist credo of the universal subject [that] presumes individual participation in an eternal human nature, and an identification with a common ontology" (Smith, 1993, p. 8), poststructural interrogations of experience seek to show how individuals come into being as social subjects.

Rather than presuming that individuals speak for themselves from some autonomous, fixed and/or essentialized position, feminist poststructural notions of experience entail the recognition that "we can only ever speak ourselves or be spoken into existence within the terms of available discourses" (Davies, 2000, p. 55), and that "to speak", as Weedon (1987) asserts, "is to assume a subject position within discourse, and to become subjected to the power and regulation of that discourse" (p. 119). In the words of Smith and Watson (1998), who (fittingly) paraphrase from Bakhtin (1981), "the word in one's mouth is already somebody else's word" (p. 31). In questioning the discursive terms of experiential claims, poststructural approaches interrogate the "forms of self-representation available to [individuals] at particular historical moments" (Smith & Watson, 1998, p. 22),

contending that subjects cannot speak freely outside already existing discursive regulations. Poststructural re-framings of humanist notions of experience are not about *denying* individual experiences, but rather about locating these experiences within histories of knowledge and power.

Perhaps most influential in what Stanton (1984) terms the feminist "postmodernist campaign against the sovereign self" (quoted in Smith & Watson, 1998, p. 13), is Joan Scott's (1992) article "The Evidence of Experience". Using Samuel Delany's *The Motion of Light in Water*, which recounts Delany's experiences as a black man at a gay male bathhouse, Scott (1992) examines the political effects of writing a history of difference, and the theoretical consequences of presenting one's experiences as somehow separate from the wider discursive structures enabling and constraining that experience. Without denying Delany's work "as a magnificent autobiographical meditation", Scott (1992) argues that it is also an autobiography that "dramatically raises the problem of writing the history of difference, the history, that is, of the designation of 'other'" (p. 406). For Scott, the pursuit of making often-marginalized experiences more visible obfuscates "the workings of the ideological system which produces its categories of representation as fixed immutable identities" (p. 410 – 411). As Scott (1992) aptly contends, it is precisely the "appeal to experience as uncontestable evidence and as an originary point of explanation" that weakens a contextual understanding of the history of difference (p. 399).

Instead of using experience as evidence to naturalize or reify discursively-produced identities, Scott (1992) urges instead for attention "to the historical

processes that, through discourse, position subjects and produce their experiences" (p. 401). Canning (1994) explains that Scott's approach to experience signals "a new kind of historical investigation", one that entails (in Delany's case) "the history of homosexuality instead of homosexuals; of 'blackness' instead of blacks", and, in the case of feminism, a history "of the construction of the feminine instead of women" (p. 375). In Scott's reconfiguration "experience becomes not the origin of explanation, not the authoritative (because seen or felt), evidence that grounds what is known, but rather that which we seek to explain, that about which knowledge is produced" (p. 401). Following Scott (as well as poststructural interrogations of experience more broadly), I explore the discursive workings of power/knowledge that produce Candida (and its experiences) as nebulous, ill-defined, illegitimate. It is not "a matter of looking harder or more closely" at stories of experience, "but of seeing what frames our seeing—spaces of constructed visibility which constitute power/knowledge" (Lather, 2007, p. 119).

Operating from critical poststructural assertions that there are no true, singular or authentic personal voices, I am interested in examining how the stories that people tell about Candida are themselves stories about what can and cannot be told. "Shift[ing] the *status* of experience so that it is no longer guaranteed a truth value but act[ing] as a symptom of a *deeper*, underlying, or latent structure" (Grosz, 1990, p. 64, emphasis in original), I approach people's experiences with Candida not as '*coming out of*' or '*bleeding from*' the body, nor as experiences that '*speak eloquently in pains and symptoms*'. Moving away from ethnographic

(and autoethnographic) practices of essentialized knowing, I investigate the experiences of Candida through Lather's (2007) double(d) science—a methodology concerned with the ethnographic practices possible after poststructural crises of representation. Wrestling with "the clashing investments in how stories are told and of the impossibility of telling everything" (Lather 2007, p. 135), I use this double(d) methodology to work against contained categories, static truths and overarching meta-narratives. Grounded in being "lost, bewildered, [and] suspended in flight" (Serres, 1995, quoted in Lather 1996, p. 539), I proceed cautiously in the exploration of other people's illness experiences.

Methods

Questioning "what might feminist knowledge practices look like that work within and against identity categories, visibility politics, and the romance of voice" (p. 36), Lather (2007) retroactively posits her and Smithies' earlier text as one such example. Dually invested in the much-needed knowledge concerning the experiences of Candida, and in tracing the discursive terms that that shape these often undefined (ambiguous, maddening, and murky) experiences, I conceptualize this project as another. I use textual strategies to speak to the experiences of Candida, while also pursuing a poststructural, Foucault-inspired reading of the interviews.

The Interviews

This project is based on a series of semi-structured interviews asking people to respond to a range of open-ended questions concerning their experiences with Candida. I asked after such areas as their illness symptoms, their encounters with the medical community, their networks of social support, and how they understand their own health (for a complete list of the interview questions, please see Appendix 1, page 219). Given that this research is not simply to recount people's experiences with Candida, I was predominantly concerned with *how* people spoke about their experiences—with the choice of words used, the concepts drawn upon, the repetition of common experiences, and the organization of individual narratives.

Drawing from a similar strategy used by Kaler (2006), I posted requests for my interviews via two not-for-profit organizations: the National Candida Society, and the Canadian Women's Health Network. The National Candida Society is housed in London, England, and was established in 1997 to provide information and support for people with Candida. They also recently founded the International Alliance of Candida Societies, helping to develop two other sibling organizations—one in Spain and one in Norway. Given the influence and membership of London's National Candida Society, it is not surprising that the majority of the people I spoke with are British. I did not contact the Spanish or Norwegian societies as I lack the language skills that would have been necessary for translation. The second organization I was in contact with was the Canadian Women's Health Network. This network was created in 1993, and is housed in

Winnipeg, Manitoba as a voluntary national organization helping to improve the health and lives of girls and women across Canada. They cover a range of health-related topics concerning women. I also attempted to contact the Yeast Connection®, a profit-based organization in the United States based around the bestselling books of Dr. William Crook, but after multiple efforts, I did not receive any response.

In total, I conducted 24 interviews—14 over the phone and 10 via email. Interviewees were selected based on whoever was willing to participate, in the order in which they contacted me. Given that many of my participants resided in various cities across Canada, and the United Kingdom, I wanted to give participants the option of which interview form was more comfortable and convenient for them. Email interviews could be answered at any time (without having to take into consideration differences in time zones) and offered an added degree of anonymity between the participant and the researcher. Phone interviews, alternatively, gave a voice to the researcher and enabled participants to engage in a conversation about their illness experiences. My interviewees ranged in age (from late twenties to late sixties), in citizenship (5 Canadians, 17 English, and 2 Scottish), and in severity of illness (from minor irritation to hospitalization). I did not specifically inquire about my participants' racial, ethnic, religious, class, sexuality and/or ability backgrounds, although during the interviews some participants volunteered this kind of information. Twenty of my participants were women, while only four were men. In order to draw a more representative sample of men's experiences with Candida, I also include in my

analysis two stories posted by men in the National Candida Society's newsletter. These stories are referred to as "Steve" and "Dean's" stories. I refer to the other people with whom I spoke via pseudonym—pseudonyms which they had the opportunity to choose—except for the six participants who preferred to use their real names.

My phone interviews ranged between 30 and 90 minutes, and were transcribed verbatim. However, given the combination of international phone connections, digital recording via speaker phone, and the differences in accent and dialect between Canadian and British English, deciphering exactly what was said was not always possible. If I could not understand the word or sentence being used, I simply marked a blank in the interview transcript and asked the participant to fill it in if possible. Once the interviews were transcribed, participants had the chance to change, add, or delete passages from their transcripts. In general, participants did not change the content of their interview, but rather deleted "ums" and "ahs" common in interview transcription. Also, not transcribed in the interview were details such as tone of voice, speed of delivery, and facial or bodily expressions (Poland, 2002). I did note, where applicable, ellipses in peoples' responses, laughter and silence.

My email interviews ranged from one paragraph to two pages, and did not need to be transcribed as they were sent electronically. While they were intended to be more convenient for people to respond to, they unfortunately did not generate the same kind of detail as the phone interviews[8]. Given the overall lack

[8] Kaler (2003) notes a similar difference between in-person and web-based interviews in her research on women with vulvar pain.

of detail in many of my email interviews (as mentioned, some email interviews were as short as one paragraph), when including narrative passages throughout this dissertation, I draw substantially—though not exclusively—from phone interviews.

Epigraphs and Interludes

I included narrative passages in the opening lines of this dissertation (and continue to include them throughout this dissertation as chapter and section epigraphs) to signal the centrality of experience to this dissertation, to honour the stories of the people with whom I spoke, and to complicate traditional forms of academic prose. Like the narrative excerpts included in Lather and Smithies (1997), these passages are "designed to counter the silence [of illness experiences] as [they] explore what can be learned from the perspectives of those suffering from the disease" (p. xiv). I use these epigraphs to articulate problems with diagnosis, stigmas, delegitmization, symptoms and food restrictions. While epigraphs are predominantly used in academic writing as authoritative claims, I use them to give texture to the experiences of Candida, while also providing me an entry point to the analytic topics at hand. As I explain momentarily, I use these narrative excerpts as passages with which to think.

Helping me "to write towards what I don't understand" (Lather, 2007, p. 40), the epigraphs allow space for the voices of the people with whom I spoke to come through, while also encouraging a re-framing (and thinking differently) about these experiential claims. I purposively align experiential claims in right-

justified text to distinguish them from the left-justified text of the dissertation, only ultimately to insist on their inseparability. By setting these narratives apart from the academic texts which ensues, I approach the notion of experience from commonsense assumptions—as that which is first, a-priori, and parsed from discursive constructions. While personal experiences of illness may seemingly begin from a different position than that of discursive understandings of experience, as I will argue, they are fundamentally structured by the same discursive orderings. The recurring inclusion of narrative excerpts as epigraphs doubly serves as a way to continue returning to, and as a way to continue moving beyond, humanist notions of experience. Claims to experience are paradoxically the tip from which this project precedes, and the point to which this project returns, albeit with different conceptualizations of how these experiences come to be constituted.

In addition to the chapter and section epigraphs, I also include two chapter interludes (one between Chapters 1 and 2, and the other between Chapters 5 and 6). I draw this strategy from Lather (2007), who uses interludes in *Getting Lost* as a means of adding to and complicating the content presented in the adjacent chapters of the interludes (p. xi), and from Lather and Smithies, who use "intertexts" in *Troubling the Angels* to enact "partiality, chunkiness and deferral rather than depiction to signal that representation is irreducible to terms of the real" (Lather, 2000, p. 22). Intertexts are used in *Troubling the Angels* "as both bridges and breathers [from the women's stories] as they take the reader on a journey that troubles any easy sense of what AIDS means" (Lather and Smithies,

1997, p. xvii). I similarly use interludes as an intervening episode, period or space between chapters, and as a means of conveying aspects of peoples' experiences with Candida that did not necessarily "fit" within the analytic contents of each chapter. In Interlude I—Naming the Unnamable—I include stories of the ways in which people became familiar with the idea of "Candida". In Interlude II—Cure/No Cure—I present the ongoing struggles of living with a chronic undefined illness.

In both the interludes and the epigraphs presented throughout this dissertation, many efforts were made to include these passages in the participants' own framings. I extracted these passages directly from interview transcripts, and from email interviews sent to me electronically. I did not alter the participants' emphases, or their choice of words used. In order to present smoother, more concise narrative flows I did change most narratives to present tense, deleted "ums" and "ahs", and, at times, took sentences out of order. This latter strategy was predominantly used in the two Interludes because of the larger content of narrative excerpts. It was also a strategy used by Lather and Smithies (1997).

The textual strategies used in this project are not about stepping outside the thorny issues raised by poststructural ethnography. As Lather (2007) explains, "already situated in the ambivalent tensions of western feminist ethnographic traditions of giving voice to the voiceless" (p. 135), these textual strategies are "both symptom and index of an effort to rethink" the use of other peoples' stories in ethnographic research (p. 22). The textual strategies used "offer both limits and possibilities" (Lather, 2007, p. 37). As such, they "are not so much about solving

the crisis of representation as about troubling the very claims to represent" (p. 37). My purposes, like those of Lather and Smithies (1997), are about "a movement toward the sort of double(d) practices that would allow us to neither assume transparent narrative nor override participant meaning frames" (Lather, 2007, p. 39). In order to investigate the discursive terms and limits of Candida experiences, I use a poststructural, Foucault-inspired notion of discourse.

A Foucault-Inspired Notion of Discourse

In its poststructural definition—the definition with which this project is concerned—the term discourse refers broadly to a system of language, or said differently, to a systematic ordering of language which posits language as a central and constitutive feature of social life (Gubrium & Holstein, 2000). Language is not seen as a simple or neutral medium for communicating information, but rather as a domain in and through which our knowledge about the world is actively shaped—it both forms and informs what we know to be "real", and constitutes, as Wood and Kruger (2000) detail, "what is assumed to be already there" (p. 4). There is, in other words, no prior reality that discourse represents. The poststructural study of discourse examines the structures of language which enable that "reality" to be established in the first place, and draws, most notably, from a notion of discourse put forth by Michel Foucault (1972, 1977, 1978 and 1980).

Foucault's work makes two significant contributions to poststructural approaches to the study of discourse. First, Foucault shows us how discourses are

constitutive—how they create and enable the possibilities for both objects and subjects to exist. Discourses, as Foucault (1972) eminently states, are "practices that systematically form the objects of which they speak" (p. 49). Foucault works from the ontological assumption that there is no prior reality that discourses (attempt to) represent. He contends that our "reality"—or rather what we know and understand to be "real"—is actively produced and reproduced in and through already existing discursive regimes. Discursive regimes, however, are never disparate from relations of power, bringing me to Foucault's second major contribution to the poststructural use of discourse.

Foucault's use of discourse not only positions discourses as constitutive, but also importantly locates the structures of discourse in and through wider relations of power. Unlike Marxian theories of power, which posit power almost exclusively as a repressive and/or restrictive force, Foucault's conceptualization of power (which operates through the active, formative structures of discourses) functions as a productive and disciplining force. Power, for Foucault, is not inscribed on the body, but is rather, actively used in the production of embodiment. It is understood as that which both limits and enables action. And it is put forth not in terms of what it *is* but in terms of what it *does*. As Foucault (1978) explains,

> [i]f power was anything but repressive, if it never did anything but say no, do you really believe that we should be able to obey it? What gives power its hold, what makes it accepted, is quite simply the fact that it does not weigh like a force which says no, but that it runs through, it produces

> things, it induces pleasure, it forms knowledge, it produces discourse; it must be considered a productive network which runs through the entire social body much more than as a negative instance whose function is repressive (p. 36).

Foucault does not articulate a theory of power; he rather re-conceptualizes the relationships of power (Grosz, 1990). Using the topics of madness, medicine, discipline and sexuality, Foucault has convincingly argued that "individuals are the vehicles of power, *not* its points of application" (Foucault, 1980, p. 98, emphasis added). Foucault's power/knowledge/discourse trilogy is central to the ways in which I approach the analysis of Candida narratives.

By focusing on the constitutive role of language, shaped by discourse, I explore how particular stories about Candida come to be told, how particular meanings come to be formed, and how experiences of illness illegitimacy come to be shaped. My aim is not to show how power *acts on* these experiences, but to highlight instead the ways in which these experiences *come to be formed* in and through already prevailing discursive terms and limits. In my analysis, neither the illness of Candida nor its experiences are positioned pre-discursively—they both "bear the important traces to how the relationships of power are produced" (Grosz, 1990, p. 91). I seek to acknowledge both the speaking and the embodied subject as "inevitably positioned within the sociopolitical context" (Lupton, 1992, p. 148). Using Foucault's concept of a discourse—put forth to understand the relationships between language, social institutions, subjectivity and power (Weedon, 1987)—I examine how the discursive fields of 'biomedicine' (Chapter

3), ‘gender’ (Chapter 4) and ‘food science’ (Chapter 5) can be read through peoples’ often-inchoate experiences with Candida.

While Foucault frequently refers to a notion of discourse, he never clearly articulates a method of discourse analysis (Fairclough, 1999). Combining Foucault’s vagueness about the ‘how to’s’ of discourse analysis, alongside the inter- and cross- disciplinarity of discourse analysis, it quickly becomes a tricky method to standardize. As Barker (2005) notes, there is no singular or “commonly accepted version of discourse analysis” (p. 82). Because discourse analysis does not seek to consolidate analytic categories, nor does it seek to produce a particular truth about the object or subject in question, discourse analysis can be a “messy method” (Tonkiss, 2004, p. 371). But the messiness of discourse analysis, especially alongside the messiness of the case of Candida, is productive. Cheek (2004) explains that one of the strengths of discourse analysis is that it is an “approach rather than a fixed method” (p. 1145), allowing researchers to develop an approach that makes sense in light of their particular study. As Philips and Hardy (2002) also assert, “to be too systematic, too mechanical, undermines the very basis of discourse analysis” (p. 74), which is concerned with the wider regulations of knowledge and power.

Although there are no strict rules for poststructural approaches to the study of discourse, Tonkiss (2004) puts forth a few useful strategies, namely: looking for the repetition of key words and themes, paying attention to variations within and among the assortment of texts, reading for emphasis and detail (i.e. to how certain themes are being presented), and attending to the silences. I found these

strategies particularly helpful because they provided me with a way into the experiences of Candida without being overly prescriptive. Using these strategies, common themes that emerged from the interviews included: issues of legitimacy, frustrations with the medical community, challenges in gaining social support, the time and discipline needed to prepare healthy foods, the gendered aspects of the illness, as well as the ongoing aggravations of a wide variety of physical, emotional and cognitive symptoms.

Because I am curious about what can be learned about the social workings of illness through attending to how people talk about their experiences with Candida, I do not read these experiences as indexes of truth. Following poststructural, Foucault-inspired notions of discourse, I read these experiences as indexes of the discursive workings of undefined illness. Extending my analytic frameworks beyond what the people to whom I spoke 'actually said', and beyond "the message [of the story] itself" (Lupton, 1992, p. 145), I also work with Candida narratives as citations with which to think.

Reading Through

Drawing on Elizabeth Ellsworth's (1997) strategy of reading through, I use the words and phrasings offered by the people with whom I spoke as ways to think with and through deliberations on the experiences of Candida. Ellsworth (1997) explains that the process of "'reading through' is not a very common one in the social sciences" (p. 14). Using a more humanities-based approach to research, Ellsworth (1997) explains what she means by reading through:

> I have a number of questions that shape my [research] practice. […]. Some of these are conscious questions that I can pose in language. […]. Some of these questions are less conscious. They exist as traces of thought, emotion and sensation. […] I take these vague and not-so-vague questions and […] ask how the direction of [other people's] writing [can] inflect [my] question with a different sensibility? […] What can I learn about the reading strategies available to me […] by engaging in this process of reading through? (p. 14)

By grouping common illness experiences based on the choice of words and framings used by the people with whom I spoke, I explore what these particular groupings enable me to think about. How do these particular groupings relate to and/or diverge from broader poststructural questions concerning illness, discourse the body and experience?

Ellsworth (1997) explains that the strategy of reading through does not position various texts "as static, given, or known filters or lenses for each other, [but rather] highlights the *process* of my reading and draws attention to the interests I bring and to how those interests shape the meanings I construct" (p. 14, emphasis in original). Given the interests and queries I have outlined in this introductory chapter and the themes that emerged from the interviews, I orient my analysis around three discursive fields: biomedical science, gender, and nutritional health. I read Candida narratives through the discursive terms and limits of these fields, while also reading the discursive terms and limits of these fields through Candida narratives. While biomedicine, gender and food science

are by no means the only discursive fields structuring people's experiences with Candida, they are the ones I found to be the most productive for engaging poststructural queries concerning knowledge, power and subjectivity in an attempt to re-work and think differently about the undefined illness experiences of Candida.

Project Organization

This dissertation is organized into five substantive chapters, two chapter interludes, and one concluding chapter. As I have detailed in this introductory chapter, this dissertation approaches two, at-times contradictory, tasks: to raise awareness of the often ambiguous experiences of Candida, while simultaneously maintaining a critical awareness of the discursive terms in and through which these experiences come to be disorienting, ill-defined and poorly understood. Following Lather (2007), I have argued that my double(d) approach is both necessary and productive to the project at hand.

Given that Candida is difficult to define (and for the most part poorly understood), I spend much of Chapter 2 detailing its medical definitions, causes, diagnoses and treatments. As I explain in Chapter 2, the case of Candida is not homogeneously bound within either biomedical (BM) or complementary/ alternative medical (CAM) practices; it rather straddles—albeit tenuously—both BM and CAM disciplines. Where possible I outline any disparities between the two (often inter-related) medical practices. To be clear, the purpose of this chapter

is mainly descriptive; it is intended to establish a medical framework that I will discursively engage in the subsequent three analytic chapters.

In Chapter 3, my first analytic chapter, I trace the empirical discourses of visibility and locatability that position Candida as biomedicine's ghostly matter. Using Foucault's (1973) genealogy, *The Birth of the Clinic*, I contend that Candida comes to exist as a ghostly matter (both for biomedicine and for the people who experience its nebulous effects) precisely because it operates outside the pathological anatomy of the clinical model. Drawing on the work of sociologist Avery Gordon (1997), I contend that the ghost is a productive figure (and figurative) in and through which to conceptualize the experiences of Candida—experiences which reside in the murky, shadowy spaces between absence and presence, visibility and invisibly—while at the same time maintaining a critical awareness of how these experiences came to be rendered ghostly in the first place.

In Chapter 4, drawing on feminist poststructural theorizings that posit a mutual constitution between "matter and discourse" (Barad, 2007), "words and things" (Sheridan, 2002), I explore the gendered and gendering terms *that lead to* the feminization of Candida, and which in turn, lead to its gendered and gendering illness experiences. Reading the case of Candida alongside Elizabeth Grosz's (1994) analysis of men's seminal fluids and women's menstrual flows, and, specifically, alongside her claim that "female corporeality is inscribed as a mode of seepage" (p. 203), I argue that the feminized case of Candida cannot be

understood outside already-existing (and dominant) discourses concerning leaky female and contained male corporealities.

In Chapter 5, my final analytic chapter, I question the role of food in the case of Candida, and, specifically, the discourses of nutritional science which posit food as both a pathogen and a cure. Drawing on Foucault's (1977; 1990) reworkings of Marx's relations of power, I maintain that discourses of nutritional health are not passively inscribed onto Candidad-bodies[9]. Rather, they are actively used as a means of taming much of the uncertainty that characterizes (and haunts) the case (and bodily experiences) of Candida. Following Foucault's own contentions, I argue that dieting in the case of Candida is used by the people with whom I spoke as a means of producing cleaner and more contained (docile) bodies, as well as a practice in the care of the self.

In my sixth and final chapter I return to some of the methodological and epistemological investments introduced in this opening chapter. I take up Deborah Britzman's (2000) concept of "difficult knowledge" as a way to avoid representing any singular truths concerning the discursive experiences of Candida. Using the concept of difficult knowledge I consider instead the very difficulties (and complicities) in attempting to represent the (often-difficult) stories of others.

As undefined illnesses like Fibromyalgia, Myalgic Encephalomyelitis (ME), Repetitive Strain Injury, Multiple Chemical Sensitivity, Total Allergy Syndrome, Restless Leg Syndrome, Diffuse Musculoskeletal Disorder, Myofacial Pain Syndrome, Endometriosis, Irritable Bowel Syndrome (IBS), Chronic Fatigue

[9] I use the written form of Candidad-bodies (as awkward as it may be) to refer to the *active* inscriptions through which people come to know and understand their bodies as 'having' Candida, not to refer to an essentialized notion of a body 'with' Candida.

Syndrome (CFS), and centrally here, Candida, continue to emerge as unintelligible—and thus disorienting—forms of illness, the urgency lies, I urge, both in voicing the often-privatized accounts of Candida, while at the same time investigating "*how* this thing has come to be silenced, [and] *why* we cannot speak about it" (Scott, 1992, p. 25, emphasis added). If we are able to question the discursive terms and limits of Candida's shadowy existence, then we are also able to question the discursive terms of peoples' murky experiences with it. In Davies (2000) words, to understand the story is also to "understand how the story draws us in and positions us within its terms" (p. 27). With this in mind that I turn now to the ever-nebulous question of *what is Candida*?

Interlude 1: Naming the Unnamable

Rosemary: The symptoms that were really the most troubling [for me] were night indigestion, nasty low-down tummy cramps (particularly in the second half of the night), and for the last year or two, also waking in the night, feeling nausea. I also began to get muscle aches which were very difficult to pin [down]. I didn't spot them until I did a little sketch of the body to show the nutritionist and I found that nearly every body part at some time or another was having aches. Never all at the same time but all parts of me were beginning to ache. [I also suffered] tremendous lack of energy. I'm usually a very energetic person, but I found it was difficult to get many hours of work done each day. In the past I would have packed a lot more in.

I'd read about [Candida] off and on. I'd been interested in nutrition for many years, but shut my mind to the fact that I might have it because in those days [Candida] was cured with such an appallingly strict diet. So I really avoided thinking: "I've got that". But over the last 10 years I have found an excellent nutritional consultant where I live, and when I went to see her she tried various things to get my health better but nothing was quite working. Then, by big surprise, one day when I was presenting her with more details, she said: "you know what? I think this is Candida".

Author's Note: *I include my story about Candida alongside the stories of the 14 people I spoke with over the phone, in part to mark my subjective investments in this research. As mentioned, this project was partially prompted by this "thing" that had begun to plague me, a set of nebulous illness experiences that I speak to momentarily. Predominantly, however, I include my story—a story that was written for a creative non-fiction writing class at a time when autoethnography played a larger role in this project than it does now—to reciprocate the openness shared with me; many people candidly shared*

Will: Here's where things get a little personal. I went online to look up my itchy ass syndrome because I was curious about what I could do about it. And I found all kinds of weird things like: "Make sure the toilet paper you're using isn't scented". "Look at the soaps and shampoos […] that you use". I couldn't figure out any reason why I had [the itchy ass]. They mentioned some topical, anti-itch creams I could use, which were good because it meant that I was not standing around in public itching my ass, but unless I was willing to use those creams 24/7, they didn't solve anything. The little bottles also said: "discontinue use after X number of days. If symptoms persist see your doctor".

There was a feeling of where do I direct my anger to, because I couldn't direct it anywhere. The anger developed because I didn't have any outlet, or positive steps I could take for my itchy ass. And that led to resigning a sort of fatalism about it. It is what it is and it's going to be what it is until it isn't what it is. Done, right? And then when I was talking to a friend, he said: "you know, classic, bingo, you have [Candida]". He was very sure, only because he had gone years with extreme stomach discomfort. Regardless of whether Candida is a real medical thing or not, to me, that is totally irrelevant. I don't care because hearing from my friend that this is what I have, that this is what it looks like, I felt so much better because I have some way to conceptualize this now.

their stories with me and I would like to share mine with them.

I align these stories in parallel columns to symbolically represent the ways in which our stories "utter one another" (Mairs, 1996, p. 473). Our stories utter one another not because we have the same stories, but because, as this dissertation will argue, our stories are shaped in and through the same discursive limits of knowledge and power. Much as they appear on the page, stories about Candida are bound by the frames in which we (can) speak.

Diana: In hindsight I probably had low levels of Candida most of my life. But, certainly, after my first dose of chemotherapy, I could see how this disrupted everything. The chemo killed almost all the good bacteria in my gut. I had no control over my bowels, and there was strange smell, which at the time I thought was chemo chemicals, but it never went away. Throughout the summer I didn't put on any weight. I [also] found that I was developing vertigo, and that my balance was out of kilter. I was told that this was quite normal after chemo and not to worry about it. At the end of the summer I discovered that my symptoms were better when I gave up bread and wheat. I didn't give it up on purpose, but I just didn't happen to eat wheat for a couple of weeks and I thought: "wow, I've got so much energy"! And, for the first time since the chemo, I had proper control of my bowels.

But [then] I started to develop all of these chemical sensitivities to things like polish or perfume or my husband's deodorant. I could get a whiff of diesel after a truck had past and feel my lungs closing up. I thought: "this is really weird. What's happened to my lungs? Why am I getting these symptoms"? If I had a bath, I got wheezy. If I cooked, I got wheezy. I just didn't feel like I was in control of my body.

It must have been the middle of December that I discovered about the Candida. And it was such a revelation because it explained all these weird symptoms I'd been having. It explained about the leaky gut syndrome and chemical sensitivities.

* * *

I first noticed it about six and a half years ago. With all the classic signs of a yeast infection—discharge, itchiness, irritation—I assumed a quick trip to the doctor and a standard prescription would allay my newly detected symptoms. After waiting an hour to see the doctor for five minutes, my hypothesis was confirmed—I did in fact have a yeast infection, or so she claimed. Her diagnosis was speculative, as swabs were never taken.

Kiri: When my Candida is at its worst, I describe it as chronic fatigue. I'm absolutely exhausted. I find it very difficult just to walk up stairs. As someone who likes to be quite fit, I find this very debilitating. I also get a lot of dizziness. My head feels like there is constant mud in it. I can't think clearly. I get very confused and forgetful, and also very irritable. My blood sugars plummet and I feel very grumpy and agitated, and then after I eat, I feel exhausted. I could fall asleep on the spot where I'd eaten a sandwich. I could sleep 12 hours and still feel very exhausted. I think it was just this crushing fatigue that got to me most. I also had pains in my bowels, and my guts and things were always aching. I'd have all sorts of rashes, ringworm, and some of other fungal infections, and lots and lots of thrush. All throughout my life I've had a lot of thrush.

I was kind of worried for a while and no one really knew what it was. And then for some reason someone advised me to read this book [doesn't mention the title], and actually the first page in the book, the forward just describes the generalized symptoms that might be functioning, and I thought: "well, that sounds just like me"! And then I did the diagnostic questionnaire, and I scored very highly on that. I was pretty convinced that Candida was my problem because it made a lot of sense to things I've experienced in the past. At the time, I was happy to avoid the ever-dreaded Pap smear and even more relieved to sidestep the awkward and often heterosexist questions that accompany it—are you sexually active? Have you ever had unprotected sex? Are you currently using birth control?

For the next year I tried prescription medications, over-the-counter treatments, home-remedies old and new and consumed enough yogurt to single-handedly support a local dairy farmer.

Phil: Candida is very difficult to classify. I've actually found that since I've suffered from it, when I get hit by any kind of illness—whether it's a bout of gastric flu, or anything that suppresses your immune system—it lets Candida kind of creep back in, until your body recovers from it. With Candida, the symptoms are so broad. The biggest problems I had were fatigue, diarrhea and annoying things like, sweating, strong BO, dry mouth, bad breath, [and] coating on [my] gums and tongue. I'm not sure hair loss has anything to do with [Candida], but I have my suspicions. [My] absorption of food and general digestion [weren't] great. I think that lead to a kind of like chain of events.

I thought about going to a doctor but I thought: "what essentially are they going to do"? Realistically they might tell me to try an Imodium® or something similar. I was not optimistic on them finding anything. I hadn't had great experiences in the past. I had all of these problems in the past, and I thought: "well, I'll try the natural route". And at the time, my mom was seeing a kinesiologist—I can't remember what for—but she knew about Candida. My problem was not that the remedies didn't work, but rather that as soon as I stopped using them my symptoms came back as if they had never been alleviated in the first place. My even larger predicament was that despite my initial (and somewhat precarious) diagnosis, it seems I did not in fact have a yeast infection.

After a few more visits to the doctor and less luck in avoiding the Pap smear and the awkward questions that went along with it, my puzzle began: although I showed most of the signs of a yeast infection, no yeast could be detected at a microbial level. Somewhat perplexed, the doctor took more swabs, but when these too came back negative it seemed the only thing left to do was to conduct more tests.

Rachel: I used to get a lot of vaginal yeast infections and I was always using all kinds of stuff to try and get rid of them. I think [the infections] caused other symptoms as well, like being tired all the time. I was fighting headaches. I was fighting being tired all the time. I was drowsy, I'd get tired very quickly, and I'd have cravings for sweet foods. I'd also have lots of allergic reactions, constipation, bloating […] a lot of different stuff. I think a lot of drain and energy was from not knowing why. And the doctors weren't telling me anything. They were just giving me more antibiotics, and I was getting more yeast infections. It was like a vicious circle. I'd get better and I'd get worse and I'd get better and I'd get worse.

I know I am an allergic person from my food allergy testing. So, maybe it's just all fungal? You know, because that's really what [Candida] is. I think if [the doctors] can detect that a person has a lot of fungus then that should point to Candida, because isn't that what Candida is? I mean when babies or children get yeast or thrush, isn't that the same thing? I don't know if you can interpret all of that to Candida, but I think it is all part of it. I know I don't have any more vaginal infections. I hardly have any more colds. I am well. I think my immune function has been up ever since I've been off gluten.

In the last three and a half years I have been tested for bacteria vaginosis, diabetes, cervical cancer, parasites, hepatitis B, herpes, Chlamydia, gonorrhoea and HIV. The tests always came back negative. Although I was often thankful for these negative results, there were also times when I wished this thing inside me had a name.

* * *

Janine: This is where it gets embarrassing: [my symptoms include] chronic fatigue, acne, constipation, anal itching, not being able to focus on things, brain fog, depression, premenstrual tension, bloating, not wanting to be near people, not being able to cope with noise. I didn't know what was going on. I didn't like it. I couldn't cope with it. I didn't want it. I hated it. I'd look at myself in the middle of the day and think: "what I am doing here? I'm tired. I'm exhausted. I can't go the length. I can't to do this. I can't do that. I'm unhealthy. I'm a wreck. Why can't I go to the toilet properly? Why can't I go out and eat pizza or have a glass of wine? Why can't I be more energetic? Why can't I actually work like everybody else? Why do I feel this way"?

When I started with the symptoms maybe 10—no it was 8—years ago, I went to pick up a friend, and he thought I might have Candida. I tried the diet, and my symptoms became better, and that's when I thought that I might have it. That's when I began to understand the condition and started to read more about it as something that existed. The evidence for me was whether it came through in my behaviour—if I felt better, if I felt healthy then it [was] real for me.

I sit in the doctor's office with the same uncertainties that have been plaguing me for months. I wonder if, today, he will figure out what is wrong with me, if he will locate something that the last one could not, or if he will he send me home with the same frustrations with which I came in. I watch the receptionist organize files and shuffle papers, carefully avoiding the eye contact of those, like me, waiting to be called.

Lynn: The first time I noticed it was when I was 19. I asked a doctor what [the yeasty substance] was and she looked at it and said it was just a normal sort of discharge. I said: “ok”, and didn’t think it was Candida. I noticed it off and on, maybe 3 times a year? It was very slight. Then it started to really bother me when I came back from Central America last year. I had really bad discharge, [with] a horrible smell. I didn’t know what it was. I took the medication prescribed to me by my doctor, and nothing went away.

I went to a holistic health practitioner, and she said that I should go on a Candida cleanse. So I did. I was on the cleanse for over a month, and everything cleared up. The infection was gone. And that’s when I made a connection between Candida and that an overgrowth of yeast in my body can cause a whole bunch of things to go wrong.

I glance at the posters on the white sterile walls, warning about STDs, about international travel without immunization and about the health risks of influenza. I wonder why, whenever I’m in a doctor’s waiting room, I always see the same posters? I continue to wait impatiently.

The doctor asks about my symptoms, and I wonder how to answer such a limiting question. I stutter. How do I explain that I don’t really know my symptoms; that they are vague and indeterminate; and that they are sometimes worse in the evening than they are in the morning?

Sue: What I understand about Candida is that I have a little bit and [that] it affects my whole body. Sometimes I have certain symptoms and then another time I don't get those and I have totally different symptoms. No two symptoms are the same when I have an attack. I get headaches. It affects my breathing. It affects my mind. If I have an attack I can sometimes feel quite depressed, but it's not like a real depression, it's just feeling very low and very weepy.

It must have been about 1992 when I was put in touch with an alternative practitioner in the UK. Before that I had about two years of being ill and not being able to understand why. I had a very good supportive GP who knew that I was ill, but couldn't understand it. He sent me for all sorts of tests. I had every test going under National Health, and every one of them came back negative. A colleague of mine had found out about this alternative practitioner and I managed to go down and see him and he did lots and lots of tests and at the end of it he said: "you have Candida".

I stutter because I am never sure whether I should swallow these words in fear that I have revealed too much, or whether I should let them escape uncontrollably in one exasperated breath in fear that I can never say enough.

Sensing my obvious hesitation to respond to his earlier question, or more likely getting frustrated that I cannot offer a more accurate account of my symptoms, the doctor takes matters into his own hands. He asks whether I have discharge, what colour it is, what consistency, if I am currently on antibiotics or if I have ever been on prolonged use, if I wear cotton underwear, if I wipe properly, if I use soap.

Aurora: All [of] these funny things started happening in 1992. I suffered weight problems, all kinds of skin problems, ongoing nail infections, having no appetite. Being so tired. And I started having a range of infections permanently. I had chest infections and bronchitis all the time. I had sinus infections every month of the year. Always. I went to the GP and she said: "I don't wish to alarm you, but I think you have Rheumatoid Arthritis". So I just kept taking antibiotics and pessary creams into 1995. When my problems persisted, I had another consultant diagnose me with Myalgic Encephalomyelitis (ME) and Raynaud's Syndrome. That was a shock too. Then, when I moved, I got sent to a lupus clinic and that's when the doctors' there said I had Systemic Lupus Erythematosus (SLE). By this stage I was quite traumatized because I didn't know what on earth was going on with me.

My weight dropped to 5 stone, which is about 100lbs on the Canadian scale. I couldn't really stand up. For years, nothing stayed inside me. Food went in and came out because of the Candida. I was so full of Candida that there was no room for it to go anywhere. I was begging my GP to help me. And she'd say: "I don't know what's wrong with you". I went to see an allergy specialist who eventually told me what I've got, which was the [systemic] candidiasis. I am absolutely convinced that I had candidiasis from the outset of my health problems 12 years ago. There is no doubt in my mind that that it is the root cause, literally and metaphorically for everything that is now wrong with me.

His questions continue like this for what seems like ten solid minutes, allowing me barely enough time to mutter "yes," "no," or "sometimes." He seems intent on writing down my hurried and forced replies, creating something, which, at least on paper, seems tangible and definitive.

Star: I get a lot of gas and bloating and stuff. My tongue is always white—it has always been white for as long as I can remember. I've been diagnosed with Generalized Anxiety Disorder (GAD)—not chronic though—mainly connected to stresses in life. I'm tired all the time. I get headaches. When I'm really stressed out I get hives. My muscles are sore. I have pain. I have trouble sleeping—actually I don't necessarily have trouble sleeping, it sometimes takes me a while to get to sleep, but I sleep, and I wake up and I'm exhausted. I crave sugar. I get diarrhea a number of times a month. I have difficulty concentrating. I have psoriasis. I'm always fighting my weight. I seem to gain weight easily, but have a hard time fighting it off. [And] I get sick every time I get stressed, which doesn't happen to other people.

I went to my allergy doctor and nothing came up, except for dust mites. And I thought: "I'm allergic to more than that because I have reactions to lots of stuff". [When] I went to an environmental allergist who tests for food sensitivities I came with 20 different food sensitivities. I already knew I was lactose intolerant, because I had reacted [to dairy] for years, but it was shocking to know that there were all of these [other] foods that I was sensitive to. I thought: "what's going on with my body"? And then about 6 months ago, my chiropractor has a trained certified nutritionist on staff, so I went to her and she did a live blood analysis, and said I had systemic Candida. [She said] she could see it all through [my] blood, in between all of my cells.

Coercing me into a category that he is perhaps not all that comfortable with, but that is at least recognizable, he writes me a prescription for a yeast infection. I leave with the prescription parchment in hand, and with the same frustrations with which I came in.

* * *

I make an appointment with a naturopath. She asks me when it all began, if there were any traumas in my life around that time, how I deal with stress, what causes me stress.

Meena: When my Candida is at its worst it feels like my insides are imploding. It feels like everything inside me is completely disintegrating.

Up until 1996, I was a normal person. I didn't have any food sensitivities whatsoever. But in 1996/1997, when I was traveling in India for 5 months, I had severe dysentery and I took way too many antibiotics. I took large doses of SuperFloxin®. I was taking two a day for close to two months, which is way over the top! That's how I initially thought I got Candida, but I recently, learned that I also have a certain degree of mercury toxicity in my system (this is though a combination of seeing my naturopath and having a blood test for mercury). What I am realizing is that, yes, I have Candida, but that's the symptom, and the cause is the mercury toxicity in my body. If you'd have interviewed me a year ago I would have said that I took too many antibiotics and that's its ruined the balance in my body. End of story. This is what I'm wrestling with now, and I haven't really come to any conclusions about it.

She inquires about my psycho-emotional support systems, my personality tendencies, my diet, my sleep patterns, my menstrual cycles, my alcohol and caffeine intakes. We talk for two hours. She nods as if she's heard it all before. She seems well versed in the frustrations of those who came before me. She seems to recognize the space between health and illness, presence and absence. Perhaps most importantly, she seems to understand that diseases are not always knowable and/or locatable, that they do not always conform to the (arguably) narrow classifications of biomedicine, and that they cannot always be bound by a simple poster—

Amy: I've always been affected by thrush, ever since I was a teenager, but at the time I didn't know what Candida was. I hadn't really linked it back to any other contexts until I became quite ill a few years ago and I kept getting urinary tract infections. I didn't really know what was going on. I had to pee all the time. But with that also came brain fog, and feeling really spaced out. My body might have been acting normally but I felt like was on another planet. I kept making little mistakes when I was driving and things like that. I was basically feeling fuzzy-headed and just really lethargic and tired all the time, unnaturally tired. I also had some mild IBS symptoms. And then later I also developed muscle aches and pains.

I kept having infections, and I kept getting more and more antibiotics, until this year I was feeling quite ill all the time and my mom suggested I go and see her chiropractor. He suggested that I might have a problem with Candida, and then after that I just went on the internet and looked it up myself. The chiropractor I went to see is also a kinesiologist and said I was reacting really strongly to yeasty products and stuff, and that was enough for me. I didn't get a blood test or anything like that. Before if I had a symptom I would worry about what it was, but now I always just know it's the Candida!

the necessary descriptors would exceed the poster's 11 ½ by 14 inch frame, spilling over and likely staining the white sterile walls.

She suggests that I use tinctures, multivitamins, acidophilus and homeopathics, that I buy organic food, that I do heavy metal and Candida cleanses, that I practice yoga regularly, that I not only avoid wheat, yeast and sugar, but also dried fruit, dairy products and anything fermented.

I rarely cheat. I keep a food log, a dream log and a side-effect log. My non-disease consumes me, and I consume it.

Derek: I used to eat a lot of toast and honey, or toast and marmalade, because I used to only get half an hour for lunch. And I remember by 3 o'clock in the afternoon, if I was driving, I'd have to stop and have a rest because I just couldn't concentrate. I remember being really spaced out. I used to [also] get drunk on half a pint of beer. When I went to [my] GP to complain about it, he said: "a lot of people would like that"! I [also] had a lot of bowel problems, visual disturbances, and memory problems, where I knew I knew something but I couldn't get the words out. A little how am I now.

I read about Candida through a book called: "The Complete Guide to Food, Allergy and Intolerance", written by Dr. Jonathon Brostoff. I went to [my] GP and showed him the book and he said" "hmm, that's interesting". The book did say to have a treatment with Nystatin, [and] my GP did give me a round and it really helped, so eventually [my GP] did say: "I think there's something [to] this Candida".

I embrace the idea that I can control this thing inside of me, that if I eat the right foods and get to the root of my psycho-emotional mood states, that this thing inside me will disappear as unsuspectingly and as mysteriously as it arrived. But when my non-symptoms continue to linger despite my newly adopted regimen, I begin to realize that it is perhaps not my sporadic, yet somehow chronic, irritation that haunts me, but rather the need, not unlike my doctors, to name and to categorize within tightly-bound classifications.

CH. 2

Systemic Yeast Overgrowth

If I were a doctor and somebody came to me and thought they'd got "purple groin fever" or something that I'd never heard of, I'd think: "well, I better go find out what that is and check into that" rather than totally ruling it out.
Diana

What I find frustrating is the treatment I get from the [bio]medical establishment…being told by doctors that I'm really just depressed, and that that's really my problem. When, yes I am depressed, but it's because my body is not working as it should be.
Kara

Denoting the white-like colour of yeast, the etymology of the word Candida stems from the Latin word "candidus" meaning bright, clear, transparent; clean/spotless; lucid; candid; kind; innocent, pure, radiant, unclouded; white; of light color; fair skinned, pale (Whitaker, 2005). Contrary to its etymological Latin roots, however, the case of Candida[10] remains a highly contentious illness category, especially within the boundaries of biomedicine. Plagued by a wide range of indistinct and ambiguous symptoms, as well as a lack of reliable scientific evidence, Candida continues to exist as a medical issue of great ambivalence. Candida has been described, for instance, inconsistently within the wider medical literatures as "complete medical nonsense" (*Candida: diagnostic and therapeutic approaches*, n.d., 1), as well as "the most complex infectious agent yet studied" (Truss, 1981, p. 237). In the pages that follow I outline the

[10] Candida is also referred to here, as well as through wider literatures, as chronic candidiasis, candidiasis hypersensitivity, Candida albicans, Candida-related complex, fungal-type dysbiosis, the yeast syndrome, yeast allergy, yeast overgrowth, yeast problems, and recurrent thrush.

wider biomedical (BM)[11] and complementary/alternative medical (CAM)[12] understandings of Candida—its definitions, diagnoses, causes, symptoms and treatments—as well as bring to the fore the often charged debates surrounding its legitimacy as a disease etiology.

Initially, my intentions of this chapter were to separate "BM" and "CAM" understandings of Candida, yet after reviewing the wide range of related and relevant literatures, I realized that this endeavour is not possible. Not only do the literatures overlap in more ways than they diverge, but each body of literature (if indeed they are separate) is not homogenous. There is more debate, for instance, within biomedicine about the status and legitimacy of Candida, than there is between BM and CAM understandings of Candida. Where necessary, and applicable, I do outline any disparities between CAM and BM definitions, diagnoses, causes, symptoms and treatments of Candida. I also include my participants' experiential accounts as a way to incorporate their illness experiences alongside Candida's medical (and medicalized) accounts.

What is Candida?

Candida has the ability to change into its microbial form and take over your whole body.
Diana

I am told that there's one particular kind of yeast that returns faster, and is a more aggressive colonizer.
Will

[11] I use the term biomedicine to refer to the biologically oriented, and institutionally accredited medicine that dominates Western cultures (Hahn, 1995).

[12] I use the category of CAM to refer to all non-biomedically accredited health practices. This can include naturopathy, traditional Chinese medicine, acupuncture and so on.

I understand Candida as a yeast, a fungus that everyone has and that lives in their gut. It's usually fine, but it can get out of balance and can cause all kinds of difficulties.
Amy

I feel like I am fighting a war against an army and that this fungus is completely taking over.
Kiri

Often simply referred to as "Candida", Candida albicans is a type of yeast that lives in our digestive flora, particularly on the skin, and in the intestinal and genito-urinary tracts (Calderone, 2002; Odds, 1988; Saltarelli, 1989; Truss 1978). It is an organism of sub-microscopic size, approximately 4 - 6 micrometers in diameter (Saltarelli, 1989), and is generally harmless, causing from time-to-time nuisance infections such as vaginitis, oral thrush, diaper rash, esophagitis and colitis (Marrazzo, 2003; Truss, 1981). Taxonomically, Candida is classified as a "fungi imperfecti", or simply translated, "imperfect yeast". Imperfect yeasts are "imperfect" because they are not a clearly defined group; as Saltarelli (1989) explains, "the extremes of one group may be so closely related to another group, and it is difficult to interpret the line of separation" (p. 1). Consequently, very little is known about the biology of Candida, except that multiple species exist. Truss (1978; 1981) maintains that to date there are seventy-nine identifiable species of Candida—albicans being the most common and the most documented of these species. Each of these seventy-nine species, Truss (1981) further details, is suspected to release thirty to thirty-five separate antigens, "meaning that trillions of [Candida] strains are possible" (p. 237). Taxonomically, therefore, "Candida" becomes complicated to define because it is not one distinct entity, but

rather a broad classification of yeast types that comes to stand in for most all yeast-related problems[13].

Ambiguity surrounds not only the taxonomy and biology of Candida, but central to this discussion, there is also great ambivalence about Candida as a disease pathogen. While there is consensus within the BM and CAM communities about the *presence* of Candida albicans in the human body, there is much skepticism about the Candida-yeast hypothesis: the idea that this generally contained fungus can spore through the intestinal wall, change into its pathogenic (i.e. disease-causing) form, and infect any organ, thus playing a much larger role in human illness than most doctors and health practitioners credit and/or realize. Dr. Orion C. Truss (1978; 1980; 1981; 1983; 1984) is often credited with putting forth this hypothesis (although he argues that manifestations of Candida were described by Hippocrates over 2000 years ago). According to Truss, as well as the many others who take up Truss' work, once Candida spores through the intestinal wall it can rampage almost any system of the body, releasing up to seventy-nine distinct toxins, and producing a wide-range of vague and indeterminate symptoms.

A polysymptomatic disorder, Candida affects multiple bodily systems (Cater, 1995). I have compiled a list of the Candida-related symptoms (included both below and in Appendix 2, p. 220) to show the extent to which Candida reportedly "attacks all over" (Crook, 2003, p. 1). A review of the existing BM and

[13] It is because of the multiplicity of Candida organisms that many microbiologists prefer the term "dysbiosis" to the term "Candida" because it aptly points to the state of fungal imbalance occurring when Candida-yeasts grow disproportionally to the amount of good bacteria we have in our gut (which is the state of symbiosis) (Liao, 2003).

CAM literature on Candida reveals that its symptoms can include one or more of the following symptoms:

> Abdominal pain, acne, agitation, allergic reaction to foods, allergies, anal itch, anemia or iron deficiency, anxiety, asthma, athlete's foot, bacterial or viral infections, bad breath, belching, bladder infection, bloating, blurred vision, brain fog, burning during urination, chemical sensitivities, chest pains, chronic fatigue, coating on tongue, confusion, constipation, coughs, cramps, cystitis, decreased breast size, decreased or absent libido, depression, dermatitis, diarrhea, difficulty gaining or losing weight, digestive problems, disorientation, dizziness, dry mouth or throat, dry skin, eczema, edema, emotional problems, environmental intolerance, erratic vision, exhaustion, fatigue, finger and toenail inflammation, fluid retention, food cravings and sensitivities, frequent urination, fuzzy thinking, gas, gastritis, hay fever, head tension, headaches, heartburn, hives, hyperactivity, hyperirritability, hypoglycaemia, impaired decision making, impetigo, impotency, indigestion, infertility, insomnia, intestinal pain, irrational fears, irritability, jock itch, joint and muscle pains, lethargy, loss of sexual desire, low energy, low self-esteem, memory loss, menstrual irregularities, mental confusion, migraines, mood swings, multiple awakenings during the night, nasal congestion, nasal itching or drip, nausea, nervousness, numbness, panic, PMS, prostate problems, psoriasis, puffiness, quick anger, rash, recurrent urinary tract problems, recurring bladder infections, recurring vaginal yeast infections, restlessness, shortness of breath, sinus pressure, skin infections, skin rashes, teeth grinding, trouble concentrating, vaginal discharge, vaginal or genital infections, weight gain, weight loss, and whining (Crook, 2003; Liao, 2002; Martin, 2000; Schumacher & Lund, 2001; Truss, 1981 & Wunderlich, 1997).

The many possible Candida-related symptoms can be categorized into one or more of the following categories: sexual (i.e. loss of libido or impotency), emotional (i.e. mood swings or anxiety), digestive (i.e. bloating or diarrhea), cognitive (i.e. loss of memory or fuzzy thinking), somatic (i.e. sleep disturbances) and/or allergy (i.e. sinus congestion or skin rashes). Also notable for me across this near-comprehensive list is the presence of "everyday" symptoms such as bad

breath, coughing, and whining, which, regardless of a suspected yeast-overgrowth, could theoretically apply to almost anyone.

Truss' Candida hypothesis first appeared in the *Journal of Orthomolecular Psychology* in 1978; in 1980, 1981 and 1984 he published subsequent articles on Candida in the same journal; and in 1983 he published a book called *The Missing Diagnosis*. In the 28 years since Truss' initial publication, his work continues to generate both support and debate within BM and CAM disciplines[14]. Avidly taking up the work of Truss was Dr. William G. Crook. In 1979, Crook actively began treating patients with Candida, as well as advocating for the legitimacy of the Candida-yeast hypothesis. In 1985, Crook published the first edition of *The Yeast Connection*, and up until his death in 2003 he published various titles in the same series including: *The Yeast Connection and Women's Health*, *The Yeast Connection Cookbook*, *Chronic Fatigue Syndrome and the Yeast Connection*, *Tired—So Tired! and The Yeast Connection*, *Yeast Connection Success Stories*, and *The Yeast Connection Handbook.* In a further attempt to provide education as well as medical support for Candida, Crook established the International Health Foundation in 1985. The goal of the foundation was to "obtain credibility for the relationship of Candida albicans to a diverse group of health disorders" (quoted in *Dubious yeast allergies*, n.d., 1). Moreover, in 1998, Truss and Crook together launched an organization called the Candida and Dysbiosis Information Foundation.

[14] While support for Truss' Candida-yeast hypothesis stems from *both* biomedicine and CAM, skepticism surrounding the "disease" stems exclusively from BM practitioners and governing bodies, as I will go on to discuss.

For Truss and Crook, as well as other advocates of the Candida-yeast hypothesis, Candida is a serious health concern that has been described throughout the literature as a hidden (Martin, 2000) or silent (*Candida: the silent epidemic*, n.d.) epidemic; the modern plague (Wunderlich & Kalita, 1984); and the slow killer (Schumacher & Lund, 1995). Candida reportedly affects 60 - 80 percent or more of Americans and Canadians (Moore, 1998)[15], and is a disease that could theoretically underlie a wide range of chronic health problems including arthritis, depression, multiple sclerosis, and schizophrenia (Chaitow, 2003; Crook, 1985a; Martin, 2001; Truss 1983)—an argument I detail in the immunology section of this chapter. Candida is described as an "opportunistic human pathogen" (Liao, 2002, p. 4), and is known to strike when our immune systems are compromised (most commonly, for example, in cases of advanced HIV infection). Moreover, Candida was identified in the 1992 Institute of Medicine Report "as an emerging pathogen" (p. 7), meaning that its incidence in humans has increased in the past two decades and will likely continue to increase in the near future (Liao, 2002).

Despite the argued severity of Candida, as well as the overwhelming support by parts of the BM community, Truss' hypothesis has equally received a great deal of BM scrutiny. As detailed by one health website, "in the 23 [now 30] years since Truss' description of this condition there is still a great deal of controversy surrounding exactly what Candida is" (*Candida: diagnostic and therapeutic approaches*, n.d., 4). The American Academy of Allergy, Asthma and

[15] This statistic is also echoed by Martin (2000), who claims that Candida affects as many as 90 percent of men, women and children (p. 4).

Immunology (AAAAI) strongly criticizes the concept of Candida as a disease category, as well as the diagnostic and treatment approaches used by its proponents. The AAAAI's position statement on Candida concludes that "the concept of candidiasis hypersensitivity is speculative and unproven" (Anderson et al., 1986, p. 272). Similarly, in a few of the more recent attempts by respected medical bodies to classify Candida, the British Society for Allergy Environmental and Nutritional Medicine (BSAENM) concludes that there is "insufficient data to confirm that Candida albicans is always the only cause [for allergies]" (quoted in *Candida: diagnostic and therapeutic approaches*, n. d., 2). For the Infectious Diseases and Immunization Committee of the Canadian Pediatric Society, "the hypothesis of chronic candidiasis must be considered speculative and unproven"—drawing blatantly from the AAAAI's position detailed above (quoted in Moore, 1998, p. 2).

Cynics of the Candida-yeast hypothesis argue, often heatedly, against its viability. According to one health website, "Candida is complete medical nonsense with absolutely no scientific fact at all" (*Candida: diagnostic and therapeutic approaches*, n.d., 1), and an illness that is largely promoted by "unqualified doctors" (*Candida: diagnostic and therapeutic approaches*, n.d., 1). Knoke (1996) states explicitly that the clinical existence of Candida has been critically denied. Further detailed on another health website, the support for the Candida-yeast hypothesis appears in "offbeat publications that cater to physicians who prescribe large amounts of vitamins to emotionally disturbed patients" (*Dubious yeast allergies*, n.d., 1); practitioners "who diagnose nonexistent yeast

problems should have their licenses revoked" (*Dubious yeast allergies*, n.d., 4). The often-times malevolent debates surrounding Candida influence not only its etiology or viability as a disease category, but extend also to its presumed causes, diagnoses and treatment modalities. As I summarize these aspects of Candida (mostly from the works of Truss and Crook because of their extensive efforts in forwarding the Candida hypothesis) I include where relevant the debates, controversies and differences of opinion that also accompany the discussion of Candida.

Reasons for Yeast Overgrowth

I think Candida has multiple causes. I think it has a lot of risk factors. I think it's worse lately [for me] because I am under a lot of stress.
Amy

I had a lot of antibiotics in my childhood.
Kara

The exact causes of Candida are difficult to establish. Truss argues that although Candida is usually confined to the skin and mucous membranes it can also infect any organ, causing a wide variety of symptoms, and affecting the body's overall ability to control the (over)growth of Candida yeasts. One of the central questions for Truss is: why can Candida live relatively peacefully among some individuals while being largely invasive among others? Because Candida is an opportunistic organism (in that it grows at the site from which it is cultured), according to Truss as well as other practitioners, many factors can promote its overgrowth. Chief factors "feeding" the Candida organism, notably documented from *both* BM and CAM literatures, include: the recurrent use of broad spectrum

antibiotics, birth control pills, and immunosuppressant medications, diets high in carbohydrates, and the lack of an immunological response (Crook, 2003; Martin, 2000; Truss, 1983; Wunderlich, 1997; Wunderlich & Kalita, 1984)**.** It should be noted, however, that while many of the suspected causes of Candida are agreed upon between BM and CAM literatures, for those skeptical of the Candida diagnosis, the idea that antibiotics, birth control pills, immunosuppressant drugs, and/or diets high in carbohydrates can "cause" Candida is equally dubious (Moore, 1998). Broader cultural and/or environmental factors such as stress, and the presence of environmental moulds, are also listed (largely within the contexts of CAM) as potential culprits in the Candida-yeast complex.

Broad Spectrum Antibiotics

Administered to wipe out "unfriendly" bacteria with the ultimate goal of eliminating infection, broad spectrum antibiotics also, in the process, eliminate "friendly" bacteria (such as lactobacillus) that work to keep Candida in check, and, as such, are widely listed as a key factor in the suspected cause of yeast overgrowth. Truss (1981) points out that in the thirteen years following the availability and wide usage of antibiotics, there was a corresponding proliferation of articles in medical journals detailing the rapid increase of intestinal and vaginal yeast infections. Even skeptics of the Candida-related complex maintain that antibiotics can stimulate the overgrowth of yeast (*Dubious yeast allergies*, n.d.).

The National Candida Society[16] similarly documents that before the introduction of broad-spectrum antibiotics, Candida accounted for only twenty-five percent of vaginal infections; now they argue that this figure is closer to eighty percent (*Introduction to candida*, n.d.). Recurrent thrush, according to Marrazzo (2003), has become such a problem for so many women that in the last few years it has been necessary to make pharmaceutical remedies available over the counter. While the relationship between the use of broad spectrum antibiotics and the overgrowth of yeast is well accepted within standard BM practice (as well as in practices of CAM), the idea that prolonged and/or recurrent antibiotic use could cause prolonged and/or recurrent yeast is still contentious. But for the many supporters of the chronic Candida hypothesis, antibiotic use is a major contributing factor for the cause of chronic yeast overgrowth.

Immunosuppressants and the Birth Control Pill

Other drugs suspected in influencing the opportunistic growth of Candida are cortisone-containing immunosuppressants and birth control pills. Because birth control pills contain both estrogens and progesterone they stimulate the growth of Candida much like other corticoid steroid based medications (common ones including cortisone and prednisone often used in the management of asthma and in the treatment of acne). According to Crook (1985a) and Odds (1988) any steroid-based medication used for prolonged periods of time can cause changes in

[16] Founded in 1997, the National Candida Society provides information and support to people with Candida. It also raises awareness of the causes, treatments and related symptoms of this condition.

the mucous membranes which make it easier for the ever-present Candida to multiply. Like antibiotics, the birth control pill has been widely used over the last three-plus decades; it has been used, and continues to be used, as a method of contraception and as a way of treating women with menstrual cramps and/or irregularities. It should be noted that pure estrogen pills, which are frequently prescribed for women during and after menopause, do not encourage the growth of yeasts.

Diet

Another chief culprit in the overgrowth of Candida is prolonged high carbohydrate intake (Crook, 1985a; Eaton & Howard, 1998; Martin, 2000; Schumacher & Lund, 2001; Truss, 1983; and Wunderlich 1997). According to Crook (1985a), yeasts thrive on carbohydrates, including: refined sugars, corn syrup and molasses; unrefined sugars such as honey, maple syrup and fructose found in fruits; as well as all gluten-containing foods (wheat, rye, barley and oats). Of the research I have found on Candida, it seems to be almost exclusively documented within North American and British contexts—this is perhaps not surprising when considering that western diets are often extremely high in the intake of carbohydrates (and refined sugars). And while there are certainly debates within the literature about how strict the Candida-diet should be, as well as about the particularities of the diet (some argue, for instance, that all yeast-containing foods and beverages including dairy and cheeses, vinegar, processed and smoked meats, mushrooms, dried or candied fruit, and alcohol should also be

restricted), most sources, to some degree, list diet as a key factor in promoting the overgrowth of Candida albicans.

Cultural and/or Environmental Factors

Perhaps because Candida is of unknown etiology, many (mostly CAM) sources also list a wide range of cultural/environmental causes that may contribute to the overgrowth of yeast. It has long been suspected that stress can contribute to ill health, and for Wallace (2004), the National Candida Society (*Introduction to candida*, n.d.), Schumacher and Lund (2001), and Wunderlich (1997), stress can also be a contributing factor in the case of Candida. Excessive stress, as Schumacher and Lund (2001) explain, causes the release of a hormone called "cortisol", and because cortisol not only depresses the immune system, but also raises blood sugar levels, it can help feed Candida cells. Moreover, as Martin (2000) similarly explains, "Candida is often found in people with certain personality types – those who are doers, givers, overachievers, and workaholics; who have low self esteem; who are type A personalities and who spread themselves too thin" (p. 2).

Food and water quality are also listed as potential contributors to yeast overgrowth. Non-organic meat and dairy products are often pumped full of hormones like progesterone (to encourage maximum growth) as well antibiotics (to discourage animal infection and disease), and because of this are suspected to contribute to widespread occurrence of Candida overgrowth (Chaitow, 2003; Schumacher & Lund, 2001). Chaitow (2003) also points out that even if animal

and dairy products are not consumed, the high levels of antibiotics and steroids used in farming can "run-off" into local rivers and eventually end up in water supplies (p. 34). Tap water is further vilified because it often contains high levels of toxic chemicals like chlorine, which, as Liao (2002) explains, can kill off the good bacteria that normally work to keep Candida in check.

Candida and the (lack of) Immunological Response

To understand the immune response, or more accurately, the lack of immune response in the case of Candida, one must understand the structure of the mucous membranes where yeasts first attack. As noted earlier, yeasts live normally on mucous membranes which line the intestinal tract, and are meant to provide a mechanical barrier between the attacking antigens and the rest of the body. When an immune system is functioning at capacity Candida yeasts are not able to penetrate the mucous membranes. Mucous membranes are mucous secreting glands, and protect the delicate membranes by coating them with antibodies. When yeasts, toxins or other enemies try to break through the mucous membranes, antibodies protect entry by forming an antigen/antibody complex, also or more commonly referred to as an immune complex. However, when an immune system is compromised, usually as a result of long-term antibiotic use (which wipe out friendly bacteria), immunosuppressant drugs, and/or severe immunodeficiency as in the case of HIV/AIDS, Candida yeasts not only multiply but can also penetrate the mucous membranes and invade the rest of the body (Truss, 1983).

The inability of the immune defenses to respond effectively to the overgrowth (and spread) of yeast is known as immunological tolerance or unresponsiveness, meaning quite literally that the antigen (in this case Candida) is tolerated in the tissue rather than stimulating an immune response and being rejected from the body. As a result, Candida albicans can slowly increase its total area of tissue invasion, releasing toxins inside the body, and causing multiple symptoms and side affects ranging from vaginitis and cystitis to hormonal imbalances and depression (Crook, 1985a; Truss, 1980). It is generally agreed within biomedicine that Candida seems to best attack when an immune system is compromised, which is why it is so common among those suffering from HIV/AIDS (Crook, 2000; Eaton, 2004; Prasad, 1991; Truss, 1983; & Tumbay, Seelinger & Ang, 1991). Much more contentious, however, is Truss's claim that Candida could theoretically underlie a whole host of other autoimmune disorders.

Truss (1981) somewhat boldly states that "Candida may in fact be one disease manifested in many ways" (p. 234), and could theoretically underlie a wide range of autoimmune diseases. Supporting and elaborating on this speculation is the work of Crook (1985a; 2000; 2003). First, because Candida is known to thrive in immune-compromised individuals, it makes sense that it may also affect those suffering from asthma, psoriasis, multiple sclerosis, systemic lupus, rheumatoid arthritis, erythematosus, Crohn's disease, and myasthenia gravis, which are by definition autoimmune dysfunctions (Crook, 2000). Second, and noted across a variety of cases, were the improvements of seemingly non-Candida related autoimmune disease when treated with antifungal and anti-yeast

medications. An abstract published in the *Journal of Allergy and Clinical Immunology*, for instance, describes the response of some asthmatic patients to the systemic antifungal drug, nizoral (van der Brempt, Mairesse & Ledent, 1994). Medical doctor Sidney Baker similarly affirms the favourable response of several of his patients with psoriasis to oral nystatin (Baker, 1982). Moreover, in their own medical practices, Truss (1983) and Crook (1985a; 2003) found that many of their patients respond favourably, and sometimes dramatically, to dietary changes and antifungal medications. Crook (2003) explains that Candida is not necessarily *the cause* of autoimmune diseases like HIV/AIDS, multiple sclerosis or asthma, but that "there's growing evidence that there is a yeast connection" (p. 222). Whether these potentially significant speculations are founded, or not, Candida seems to play a vital role in immune system functioning.

Not only does Candida seem to manifest a wide range of related symptoms (as outlined in Appendix 2, p. 220), but, from what I have outlined here, it also appears that Candida can be caused (or encouraged) by a wide range of prescription, hormonal, dietary, environmental, cultural and/or immunological factors. As Truss (1981) himself summarizes,

> [t]hus emerges the picture of a universally present organism of great complexity and variability, its own physiology and growth characteristics influenced strongly by many factors in our lives—those as simple as diet or the amount of mould in the air we breathe, or as complex as the hormones of the menstrual cycle and pregnancy, or as poorly understood as those that influence the competency of the

> immune system. It has been said that [Candida] is the most complex infectious agent yet studied (p. 237).

For Truss, as well as those medical practitioners who credit Truss' hypothesis, there is little question that Candida is complex. There also seems to be little debate concerning its presumed prevalence among women.

"A Female Problem"

With the exception of Miles, Olsen & Rogers (1977) and Martin (2000) who argue that Candida affects men, women and children alike (because the main habitat of Candida is the digestive tract and not, contrary to popular belief, the vagina), the vast majority of the literature reports that yeast-related problems are more common among women, and those with severely compromised immune systems, such as those suffering from HIV/AIDS or cancer. Specifically at risk, according to the literature, are pre-menopausal women. Truss (1981), for instance, states quite clearly that "the single largest category of chronic candidiasis seems to be older teenage and adult women" (p. 236). There are multiple explanations for the susceptibility of women to Candida. These include: the differences in anatomy between women and men, women's recurrent use of the birth control pill, as well as the hormonal fluctuations associated with menstrual cycles and with pregnancies, and lastly, the recurrent and/or persistent use of antibiotics.

Women's anatomy has been regarded as one of the chief culprits for why women seem to get Candida more often than men. First, a woman's vagina fosters a warm, dark environment for yeasts to flourish. Second, a woman's urethra (the

tube leading from the urinary bladder to the outside of the vaginal canal) is short, making it easier for bacteria to enter the bladder and set up an infection. And third, because the anal opening to the vulva and the vagina are in close proximity, women have an increased chance of developing an infection (Crook, 2003)

Another suspected culprit promoting the growth of yeast among women is the birth control pill, which has gained popularity and widespread use since its invention in 1969 and its widespread distribution shortly thereafter. Truss (1983) explains that many women using the pill also experience chronic vaginitis, and, as a result of these observations, he suggests that alternative methods of contraception be used in order to lower the susceptibility of women to Candida. Ellen Grant, a British obstetrician and gynecologist, also expresses concern about the possible connections between the pill and the chronic growth of Candida. In her book, *The Bitter Pill*, she argues that rates of Candida are at least doubled among women who use the pill (p. 17).

The colonization of yeast is also encouraged by hormonal changes associated with both menstrual cycles and pregnancy. Estrogens that are produced throughout a woman's monthly cycle do not seem to aggravate the growth of Candida. Progesterone on the other hand, produced prior to ovulation in very small quantities, and then in larger quantities after ovulation until the onset of the next period, "greatly aggravates yeast growth in women" (Truss, 1983, p. 30). Progesterone is also produced during pregnancy when conception occurs. Detailing the links between hormonal cycles and Candida, Truss (1983, p. 30) argues that

> [s]tatistical studies have shown that approximately 35 [percent] of women develop yeast vaginitis during pregnancy. Also, women with chronic yeast vaginitis usually are aware that their symptoms are worse from ovulation to the next period, coinciding with the interval of increased progesterone production in the monthly cycle.

While the exact relationship between hormones and Candida is not yet known, Truss (1981; 1984) and Crook (1985a; 2003) argue for a potentially strong correlation between them.

As noted in the previous section on the causes of Candida, the recurrent and/or persistent use of antibiotics is one of the leading (yet unproven) reasons for yeast overgrowth. Notably, women use antibiotics more often than men, thus perpetuating the links between women and Candida. There are three reasons outlined by Crook (1983; 2003) as to why women use (or are prescribed) antibiotics more often than men. First, he explains that because women visit physicians more often than men, when plagued by fever, cough or cold they are also more likely to receive antibiotics. Second, antibiotics are prescribed to treat urinary tract and bladder infections, which are also more common among women. Urinary tract and bladder infections are commonly caused by frequent or prolonged sexual intercourse, as well as by waiting too long to urinate (Crook, 2003). The third and final reason, at least according to Crook (1985a), why women are more likely than men to use antibiotics is because "women are more concerned with their complexions" (p. 31), and, as such, are more apt to be treated with long-term antibiotics to prevent and/or control acne.

While it is possible for men to get Candida, it is not, according to the literature, common. As outlined, women are particularly susceptible to the overgrowth of Candida because of anatomical particularities, the production of progesterone in hormone and pregnancy cycles, the use of the pill which also contains high doses of progesterone, and the frequent and/or persistent use of antibiotics. In contrast, yeast growth on male genitalia is rare; if yeast does manifest, it is often restricted to the intestinal tract and/or the prostate gland. Further restricting the development of Candida in men is the lack of hormonal fluctuations caused by menstrual cycles, the use of the pill, and/or pregnancies. When dealing with men who have Candida, Truss (1983) states that "there is never the superimposed progesterone factor" (p. 55). Truss argues that one of the difficulties in detecting Candida in men, despite the sometimes common assumption that it rarely affects men, is the lack of hormonal imbalances. Because men do not produce progesterone in the same ways and/or fluctuations as do women, "[Candida] does not produce in men the extremes of emotion seen in women" (Truss, 1983, p. 55). The remaining influences of antibiotic and/or corticoid-steroid use, diets high in sugar and carbohydrates, as well as suppressed immune functioning are thought to be equally at work in men with Candida.

Diagnosing Candida

> Finding out what was wrong with me took an awful lot out of me.
> Aurora

> Nobody wants to feel as ill as I do without a diagnosis.
> Sue

Aside from the obvious need by many sufferers to have their illness diagnosed, there is significant debate within the literature about whether Candida overgrowth can actually be detected. Doctors skeptical of the Candida-yeast theory frequently point out that there are no unequivocal objective tests to verify its existence as a disease pathogen. As Marshall (1999) explains, "you cannot be tested for a Candida allergy" (p. 406); equally, according Saltarelli (1989), "no single test is sufficient for full identification of Candida species" (p. 20). Even if a positive culture can be detected, it often accomplishes little since the presence of Candida can be found in virtually everyone. Further complicating the diagnosis of Candida is the wide range of nebulous, subjective and often fluctuating symptoms that can accompany chronic candidiasis.

Complaints of depression, agitation, loss of memory, weakness, dizziness, insomnia, loss of libido, as well as various disturbances of smell, taste, vision, and/or hearing (among many, many more summarized above) are frequent in the case of Candida, and, as Truss (1978) explains, are referable to almost any system of the body. Combining this with the lack of scientific testing needed to diagnose the overgrowth of Candida, it is perhaps not surprising that Candida gets dismissed as a viable disease category, and gets relegated to the realm of the psychosomatic (Eaton, 2004). Truss (1981) comments that, "armed with the evidence that there is nothing physically wrong, the diagnosis of psychosomatic illness is almost irresistible" (p. 232). Regardless, however, of the wide range of reported psychological and emotional side-effects, as well as the lack of reliable scientific testing, for Truss and Crook (as well as for other supporters of the

Candida-yeast hypothesis), Candida is not a psychosomatic disorder, but points instead to a physiological overgrowth of yeast. Despite the skepticism from many biomedical professionals about the presence and ensuing diagnosis of yeast overgrowth, there appear to be ways to test for Candida overgrowth.

The difficulty in testing for Candida lies not merely in confirming its presence, but in determining its *overgrowth*. The following six methods are used, and not without limitations, to try and ascertain the degree and severity of Candida-yeast overgrowth. Because the condition of yeast overgrowth is not often recognized within standard BM practice, many of these tests are administered by private diagnostic laboratories such as Genova Diagnostics® (formally known as Great Smokies Diagnostic Laboratory®), and promoted either though organizations such as the National Candida Society, or though private (largely CAM) practitioners.

Blood Test

Sometimes referred to as a live blood analysis, this test measures (or attempts to measure) the presence of two Candida antibodies—the IgA and the IgG—within the bloodstream (*Introduction to candida*, n.d.). If Candida has become pathogenic (i.e. disease-causing) it should elicit an immune response (*Candida: diagnostic and therapeutic approaches*, n.d.). It is, therefore, assumed that the presence of the IgA and the IgG in the bloodstream also indicates the presence of Candida outside the gastrointestinal tract where it is normally confined. As Chaitow (2003), however, points out, there are two limitations of

this testing mechanism. First, this test has shown to produce false-negative results, meaning that no antibodies were detected even though Candida was present[17]. Second, the presence of Candida antibodies only indicates that there has been a previous yeast problem, and, as such, may not provide an accurate picture of *current* yeast activities.

Saliva (ELISA) Test

The enzyme-linked immunosorbant assay (ELISA) test, often referred to simply as the saliva test, also measures the presence and activity of the same two Candida antibodies—the IgA and IgG (*Candida: diagnostic and therapeutic approaches,* n.d.). Chaitow (2003) explains that because seventy-five to eighty percent of people secrete minute amounts of blood through fluids like saliva, the saliva test can achieve the same results as the blood test, but often does not require the extraction of blood by a nurse or registered health care professional. The ELISA test is thus considered more accessible for those who suspect a Candida overgrowth.

Urine Test

Unlike the blood and saliva tests that measure levels of Candida antibodies, the urine test measures the metabolic activity of Candida. Stemming from the word metabolism (which itself stems from the word metamorphosis), metabolic activity refers to the chemical changes in living cells by which energy

[17] Chaitow's (2003) critique, notably, does not indicate how the "presence" of Candida was measured.

is produced, as well as by which new material is assimilated into the body (*Metabolic*, n.d.). The metabolic activity of Candida outside the gastro-intestinal tract often indicates Candida overgrowth (*Introduction to candida*, n.d.). Calderone (2002) argues differently; he notes that Candida species would only be present in a urine sample if they had caused a local infection (most often as the result of a urinary tract infection), and therefore concludes that this type of test is not useful for detecting the widespread or systemic spread of Candida.

Stool Test

Since Candida is present in the gut, it is possible to culture it from a stool sample. And while the mere presence of Candida is not remarkable, the stool sample can measure two other potentially significant factors: specific strains of Candida cells as well as their quantities (*Candida: diagnostic and therapeutic approaches,* n.d.). Identifying the quantity of Candida cells can help diagnose the severity of the condition, while identifying the specific yeast strain (remembering that Candida albicans is but one of the seventy-nine known strains) can make treatment more effective and/or efficient. The other advantage of stool analysis is that it can also potentially detect the presence of parasites and pathogenic bacteria which may also be causing or aggravating Candida-related symptoms (Liao, 2002).

Gut Fermentation Test

As Hunniset and Howard (1990) explain, some strains of Candida can ferment carbohydrates by reduction of acetaldehyde to form ethanol, which in sufficient concentrations, can induce in some individuals a feeling of drunkenness (sometimes referred to as the 'auto-brewery syndrome'). The gut fermentation test then measures the presence of glucose-fermenting organisms in the stomach as well as in the small intestine. A resting blood alcohol level is first measured, then after the ingestion of a sugar dose, a second sample is analyzed. If alcohol appears in the blood, then it is assumed that fermentation is going on (Calderone, 2002). But, as Calderone (2002) further notes, the test does not give any indication as to what is doing the fermentation, and there is increasing evidence that many bacteria can provide such a fermentation reaction.

Applied Kinesiology

Also known as a muscle-response test, applied kinesiology was developed in 1964 by George J. Goodheart, and is used today by a variety of CAM practitioners to detect a range of impairments, including organ dysfunctions, food allergies, nutrient deficiencies and energy blockages within the body (Cutler, 2001). Because it measures food allergies and intolerances, it is also used to diagnose Candida. Applied kinesiology works under the assumption that the body will indicate an adverse reaction to certain foods and that this reaction can be measured through muscle responses (Frost, 2002). An overgrowth of Candida can be gauged by placing various foods that normally feed the Candida organism (i.e.

sugar or yeast-containing foods) under a person's tongue. If a person is sensitive to yeast (thereby indicating a yeast overgrowth) they will not be able to mount the appropriate muscle response necessary to resist the downward pressure being placed on their arm by a CAM practitioner. If a person is not sensitive to yeast (thereby indicating normal levels of Candida) they will be able to resist the practitioner's arm pressure. While many practitioners have found this method useful for its ability to assess the body's reaction to certain foods, it has also been critiqued by biomedical science for its lack of methodological consistency. Cutler (2001) notes that differences from one test to another may be due to suggestibility (i.e. if a person already assumes they have a yeast intolerance they may subconsciously fail to mount a muscle response), variations in the amount of force applied by the practitioner, and/or muscle fatigue exhibited by the patient.

Crook's Questionnaire

As a result of the many difficulties associated with testing and measuring the overgrowth of Candida, Truss and Crook (and others) often rely on a patient's case history, as well as their response to antifungal medications, to diagnose a Candida infection. In 1985 Crook developed a seventy to ninety item questionnaire to help structure and facilitate the examination of a patient's case history. Crook's (1985) questionnaire inquires about antibiotic, birth control, and immunosuppressant use; symptoms and side-effects; as well as diet and food patterns, particularly those with high intakes of sugars and starches. Scores over 180 "almost certainly" indicate Candida related problems; scores over 120

indicate that Candida "probably" plays a role; scores between 60 and 120 indicate a "possible" Candida problem; and scores under 60 are "less apt" to indicate Candida-related problems. Versions of this questionnaire (see for instance Appendix 3, p. 221) have been widely used by physicians and health care practitioners to help indicate the presence of chronic candidiasis (see Adams, 1985; Liao, 2002; Schumacher & Lund, 2001; and Wunderlich, 1997). Not only does Crook's questionnaire continue to be widely deployed (twenty three years after its development), but also, according to a 1991 study conducted at Seattle's Bastyr University, it is also relatively accurate. Blair, Hangee-Bauer and Calabrese (1991) have shown that there exists a positive correlation between the growth of Candida on stool samples and the scores reported on Crook's questionnaire.

Despite the popularity (and speculative success) of Crook's questionnaire, many remain dubious of Crook's diagnostic methods. One website points out that there is no score in Crook's questionnaire that would *not* indicate Candida overgrowth (*Dubious yeast allergies*, n.d.). As outlined above, Crook's scores indicate that Candida "almost certainly", "probably", "possibly" or "less aptly" causes health-related problems. According to the results of the questionnaire, Candida could therefore theoretically affect *everyone*. For those who do not support Truss' Candida-yeast hypothesis, diagnosis is some what irrelevant since the suspected condition is considered non-existent. For those who do support Truss' hypothesis, the diagnostic methods outlined here (despite their limitations)

can help detect the presence of yeast overgrowth, and, consequently, can help a patient's recovery.

Treating Candida

> What is so frustrating is that the [bio]medical community is spending tons of money on me. I'm going to a bowel surgeon, physiotherapy, having x-rays and blood tests and everything is costing a lot of money, but none of it is directed in the right direction.
> Diana

> One operates in a fog trying to find a way out of this illness.
> Aurora

Once a yeast problem is detected, or suspected, there is little variation between BM and CAM treatments of Candida. Treating Candida generally comprises three facets: (1) a low sugar, low carbohydrate diet, (2) avoiding and/or reducing medications that stimulate the growth of yeast, and (3) taking medications that help inhibit the growth of yeast. Yeast vaccines may also be recommended, but they are more generally used in extreme cases of yeast overgrowth. The treatments of Candida are designed to restrict yeast overgrowth, with the exception of the yeast vaccine which is intended to stimulate the white blood cells (and more specifically the antibodies they produce) in an attempt to restore the former effectiveness of the immune system in fighting (Candida) yeast.

Diet

Diet is a key feature in the treatment of Candida. General agreement exists that starches and sugars are the prime foods that feed yeast (Chaitow, 2003;

Crook, 1984; Eaton, 1998; Schumacher & Lund, 2001; Truss, 1978; Wunderlich, 1997; and Wunderlich & Kalita, 1984). It is therefore recommended that patients with Candida, or a suspected yeast problem, avoid all sugars including honey, maple syrup, corn syrup, fruit, and fruit juices, as well as most starches including breads, pastries and flours, which also contain yeast. Patients are encouraged instead to eat whole, unrefined grains such as quinoa, amaranth and spelt, in addition to plenty of vegetables and meat proteins, which are less well utilized by fungi. Artificial sweeteners can be used as a substitute for sugar, but are generally not recommended because of their many possible adverse affects[18].

Debates arise about how strict the Candida—sometimes referred to as the Candida-control—diet should be. Some advocates encourage patients to reduce and/or avoid not only sugars and starches, but also all yeast and mold containing foods and beverages including (as noted previously): cheeses, vinegars, processed and smoked meats, mushrooms, dried or candied fruit, and, alcohol. Varying intensities of the Candida control diet are recommended for anywhere from ten days to three months, depending on the severity of yeast-related problems. The goal of the Candida diet is to greatly limit the intake of foods and beverages that feed yeasts. The decreased availability of yeast producing foods slows the rate of multiplication of yeast cells and should reduce the amount of yeast products entering the bloodstream (Eaton, 1998). The deeper and more pervasive the yeast is in the body, the longer it will take to clear from the body. Once yeasts have

[18] Although approved by the FDA, Aspartame (NutraSweet) has been reported to cause many adverse affects including headaches, cramps, depression and other symptoms (Crook, 2000). Stevia, however, is a natural (non-chemical) sweetener that can be used as a substitute to sugar.

"died off", previously-prohibited foods (i.e. sugars and starches) can slowly and pragmatically be reintroduced back into the patient's diet. Because diet is often one of the key facets of treating Candida, large parts of Candida self help texts are devoted towards recipes and cooking strategies to avoid troublesome yeast-feeding foods.

Antibiotics, the Birth Control Pill and Immunosuppressant Medications

Often in conjunction with a Candida-control diet, physicians and naturopathic practitioners also recommend limiting and/or avoiding the use of medications that promote the growth of yeast—chief among these medications (as outlined earlier) are antibiotics, the birth control pill and immunosuppressants. Although antibiotics can be a valuable life-saving medication, they are almost always also traceable to Candida-related problems. It is, thus, strongly suggested that people with yeast-related problems either avoid the use of antibiotics, or, if this is not possible, to follow-up their use with an anti-yeast medication such as diflucan, nystatin or nizoral[19].

Birth control pills, for similar reasons as antibiotics, should also be avoided. As outlined above, high doses of progesterone are found in the birth control pill and can greatly aggravate the growth of yeast in women. In an attempt to reduce and control the overgrowth of yeast, alternative methods of contraception are recommended.

The third type of medication suspected in hindering the body's normal defences to the overgrowth of Candida is immunosuppressants.

[19] I outline these prescription medications in the following section.

Immunosuppressant drugs are specifically designed to suppress certain manifestations of the immune system, namely the inflammation caused by a body's reaction to an antigen. When experiencing a sore throat, for example, from a common cold, we are not experiencing the germ itself but instead our bodies' inflammatory reaction *to* the germ (i.e. which becomes noticed by us as a sore throat). In an attempt to suppress the inflammation common to various types of arthritis, bone and joint problems, asthma, acne, and psoriases, immunosuppressant drugs are often used. But by inhibiting one manifestation (the inflammation response) of the immune system, immunosuppressant drugs also suppress other important immune functions, and consequently, enable Candida to grow relatively unchallenged. It is, as such, advised to reduce or discontinue the use of immunosuppressant medications if bothered by Candida, or Candida-related, problems.

Antifungal (prescription) Medications

The use and identification of antifungal medications began in the 1940s and continues to be a prominent component of treating Candida (Calderone, 2002). Unfortunately, however, Candida can develop immunity to many of the available antifungal medications (Calderone, 2002). Further, as Liao (2002) notes, there have been limited resources expended by the pharmaceutical industry because, until recently, fungal infections were not considered a major health problem (and, indeed, for some, they remain an insignificant health concern). As a result, fungal therapy has been slow, and there are a limited number of antifungal

medications available. Of the available (prescription) antifungal medications, the most commonly prescribed are nystatin, nizoral and diflucan.

Nystatin (miconazole) is an antifungal antibiotic which has proved effective against a wide variety of yeasts and yeast-like fungi (Calderone, 2002; Liao, 2002). It has been on the market relatively side-effect free for the past 45 years. It is virtually non-toxic, containing no chemicals or dyes and is well tolerated by all age groups (except in large doses where it has been known to produce diarrhea, nausea and vomiting) (Chaitow, 2003; Crook, 1985b). Because nystatin is relatively side-effect free, it can be used for several weeks in an attempt to reduce the exposure of white blood cells to invasive Candida yeasts. While nystatin therapy has been proven very useful to Truss and Crook, Dismukes, Wade, Lee, Dockery and Hain (1990) do not necessarily agree with its long-term effectiveness. In a double-blind trial, Dismukes et al. (1990) show that while nystatin therapy did relieve vaginal symptoms significantly, it "did no better than a placebo in relieving systematic or psychological symptoms of candidiasis hypersensitivity syndrome" (p. 1720). As a result of their findings, they argue that long-term nystatin therapy appears to be unwarranted in fully treating Candida, and its associated symptoms.

A second commonly prescribed anti-yeast/antifungal medication is nizoral. Introduced into the United States in 1981, nizoral is a potent antifungal medication. Due to its potency, nizoral is more effective in treating severe cases of chronic candidiasis, but also produces more severe side-effects (Crook, 1985b). This antifungal drug has been associated with endocrine dysfunction, elevated

liver enzymes and liver toxicity (i.e. hepatitis). Strong opponents of the use of antifungal medications for the treatment of chronic candidiasis, note that nizoral has an incidence of hepatitis of about 1 in 10, 000 and has also been responsible for several deaths (*Dubious yeast allergies*, n.d.).

Compared to both nystatin and nizoral, diflucan (produced by Pfizer®) and flucanazole (generic) is one of the newer antifungal medications, licensed for use in the United States in the spring of 1990, and now readily used in Canada (Crook, 2000)[20]. Diflucan was originally used for treating patients with HIV/AIDS, cancer and other severe immunosupression, but later became known as being very effective against the treatment of vaginal candidiasis. Diflucan is supposed to prevent the yeast cell from growing and thus inhibiting the transformation of the cell into its pathogenic form (Crook, 2000). A close cousin of nizoral[21], and also a synthetic compound, diflucan can also produce headaches, digestive upsets, abnormalities in liver function, and liver (hepatic) toxicity (Liao, 2002). Despite these side-effects, however, diflucan is the antifungal medication most often prescribed by physicians. As Crook (2002) states, it can accomplish in one capsule what other treatments accomplish in seven, and is therefore considered both more economical, and more convenient to the user.

[20] As of March 9, 2010 diflucan (flucanazole) was made available over the counter in Canada (Personal Communication, Health Canada).

[21] Nizoral and diflucan are part of the "azole" family, differentiated by whether they contain two or three nitrogen atoms (Crook, 1985).

Anti-yeast (herbal) Medications

While medical doctors often recommend the use of prescription medications, CAM practitioners most often recommend the use of natural anti-yeast and antifungal medications**.** As Stiles, Sparks & Ronzio (1995) remind us, long before advent of refrigeration it was recognized that antimicrobial properties of culinary herbs and spices could retard food spoilage, in addition to imparting flavour. For many practitioners of CAM, the antifungal and antimicrobial agents that occur in foods, spices and herbs play an important role in balancing gut flora, and, of chief concern here, helping to fight the overproduction of Candida.

Similar to the long list of symptoms that are suspected to accompany the Candida-related complex (as outlined above) included here are equally long lists of natural herbal medications that are assumed to help fight the growth of Candida yeast. The following herbal medications (which are also listed in alphabetical order in Appendix 4, p. 222) were detailed for their effectiveness against Candida yeasts:

> alfalfa, aloe vera, astragalus, berberine, betaine and pepsin hydrochloride, biotin, black seed, black walnut, boneset, boric acid, caprylic acid, castor bean oil, cayenne, chaparral, chlorophyll, citrus seed extracts, cloves, coenzyme Q10, colloidal silver, colostrums/bovine colostrums, comfrey leaf and root, cramp bark, dandelion leaf, dulse, Echinacea, fennel seed, fish and fish oils, flaxseed and hempseed oil, fructo-oligosaccharides, garlic, gentian formula, germanium, getian root, ginger, Golden Seal, grape root, grapefruit seed extract, green hull, hyssop, kelp, lactobacillus acidophilus and bifidus, larch arabinogalactan, licorice, marshmallow root, medicinal mushrooms, morinda, nee, neem leaf, nicotinic acid, ocean and fresh water algae, olive leaf extract, olive oil, onions, oregano extract, oregano oil, oregon grape, para-aminobenzoic acid, Pau D'arco, peppermint oil, peppermint seed, phyllium husk powder, plant tannis, Propolis, pumpkin seed, quasi, seaweeds, selenium, slippery elm bark, tanalbit, tea tree oil, thyme, undecylenic acid, Uva

> Ursi, vitamin E, wheat grass, yogurt, Zinc (Birdsall, 1997; Liao, 2002; Martin, 2000; Schumacher & Lund, 2001; Wallace, 2004).

Also included in the gamut of herbal anti-yeast medications were the names of commercial herbal products such as CandiGONE®, CandiZYME®, or Oxy-Pro®. Products such as these often feature high dosages of some combination of the long list of herbs outlined here. Moreover, these products are often included as part of information pamphlets, brochures and websites on Candida (see for instance *Candida overgrowth is a serious health concern*, n.d., and Schumacher & Lund, 2001).

I do not detail each of the herbs or natural antifungal medications listed here, because quite simply there was often little or no information provided on them. I do, however, explain the antifungal properties of garlic and probiotics (the active ingredient found in yogurt) as they are two of the most commonly used herbal anti-yeast medications. Garlic, according to one website, is one of the most potent antimicrobial agents (*Candida: A blessing disguise*, n.d.). It has been shown to be effective against all but two of 26 strains of Candida albicans. In the 1985 March issue of *Scientific American*, it was reported that garlic was effective against 200 varieties of pathogenic fungi. Similarly for Wallace (2004) garlic contains allicin, an ingredient that inhibits growth of Candida.

Probiotics, usually referred to as acidophilus, is the active ingredient found in yogurt, and is also claimed to contain friendly bacteria that work to keep Candida in check (Hamilton-Miller, Shah & Smith, 1996). Lactobacillus, acidophilus and bifidobacteria occur naturally in the gut, but often get wiped out by the overgrowth and overproduction of Candida (Wallace, 2004). In order to

return the gut to its normal flora balance, it is widely cited throughout the literature that yogurt be taken orally, inserted vaginally, or taken in a concentrated acidophilus supplement form (Chaitow, 2003; Crook, 2003; Martin, 2000; and Wallace, 2004). While yogurt and probiotics supplements are often used by those who suspect chronic candidiasis (as outlined by Nyirjesy, Weitz, Grody & Lorber, 1997), in an investigation of the microbiological content of thirteen brands of probiotics bought over the counter in Britain, Hamilton-Miller et al. (1996) found that many of these brands "contained no viable lactobacilli or contained organisms other than acidophilus" (p. 55). Hamilton-Miller et al. (1996) conclude, therefore, that some probiotics products are misleading, not only in terms of their microbiological contents, but also in their expected or suspected benefits to the (in this case, Candida) user.

Yeast Vaccine

The first three facets of Candida treatment—diet, reducing/avoiding yeast-stimulating medications, and introducing yeast-fighting medications—are designed to restrict and/or inhibit the growth of yeast. The fourth treatment, the yeast vaccine (also known as yeast desensitization), is intended to stimulate the body's immunity against Candida (Chaitow, 2003; Wunderlich, 1997). Usually as a result of the long-term or persistent use of antibiotics, immunosuppressants and/or the birth control pill, the body loses its normal ability to defend against the overgrowth of Candida. By injecting carefully controlled doses of Candida into the bloodstream, it is proposed that the body will replace its abnormal "allergic"

response to Candida with a more normal “immune” response. According to Truss (1983), the yeast vaccine has been proven to stimulate white blood cells (which in turn produce antibodies) and which ultimately help keep the growth of Candida in check. The yeast vaccine is almost always used in combination with one or more of the above-outlined treatments, and is most often used in extreme cases of chronic candidiasis.

A low sugar, low carbohydrate diet, avoiding and/or reducing medications that stimulate the growth of yeast, taking medications (either prescriptions or herbal) that help fight the growth of yeast, and finally, the use of a yeast vaccine are the four most common BM treatments for Candida. Other treatments and precautionary measures were also outlined throughout both BM and CAM literatures. Crook (2000) argues, for instance, that air and house borne molds can also trigger the overgrowth of yeast. He suggests that reducing one’s contact with these molds, even if it involves moving to a different house, is recommended. He also suggests, like Schumacher and Lund (2001) that nutritional supplements, drinking plenty of water and exercising can also prove to be beneficial for the eradication of Candida because they help stimulate the immune system. One source further adds that chewing thoroughly, taking digestive enzymes, increasing fiber consumption, and using colonics and enemas can not only help re-establish beneficial flora, but can also to help eliminate poisons and toxins from body (*Candida is a serious health concern*, n.d.).

Summary

My goal in this chapter has not been so much to answer the question of "what is Candida" as it has been to lay out much of the available information on Candida—its debates, definitions, diagnoses, causes, symptoms and treatments—in order to establish a discursive framework I later unpack. Candida emerges within BM and CAM literature (and not without exception or contradiction) as a yeast-related syndrome of vague symptomatology that predominantly affects women and those with compromised immune systems. It seems to flourish with the help of broad-spectrum antibiotics, immunosuppressant drugs, and diets high in sugars and carbohydrates. It cannot be easily (or unproblematically) diagnosed. And, it is often treated with antifungal medications as well as a low sugar, low carbohydrate diet. For those who credit Truss' Candida-yeast hypothesis, it is a complex disease category that cannot be understood by standard biomedical approaches to disease, approaches, which as Adams (1983) describes, are often typified by the equation: "x leads to y symptoms, which can be cured by z treatment" (p. 9). And while disparities exist between the CAM and BM diagnostics and treatments of Candida, the larger debates concerning Candida's overall viability as a (legitimate) disease etiology stem, most notably, from within the terms of biomedicine itself.

Given Candida's nebulous status, and keeping in mind the goals of this dissertation I set out in Chapter 1, I seek not to prove the legitimacy of the medical case of Candida, but to understand instead the effects of the discursive terms upon which it fails to be produced as a legitimate and reputable disease. As

Showalter's (1997) states in the case of Chronic Fatigue Syndrome (CFS), "what lies behind CFS is neither a virus nor a psychiatry, but our idea of what constitutes a real illness, what doesn't, and what we do to make something real" (p. 117). The same, I argue, can be said about Candida, enabling me to question the terms upon which Candida comes to be deemed "un-real" and "ill-defined". I turn next to further elaboration of this idea through an exploration of the biomedical discourses of empirical visibility and locatability that help produce Candida's vague, mysterious and, ultimately, ghostly existence.

CH. 3

Illness as Metaphor:
Candida as Biomedicine's Ghostly Matter

I feel that I am a host to a foreign entity that is feeding off me, always laying in wait for my weaknesses to show.
Sophie

I understand Candida as a big sort of looming presence trying to get [my] attention.
Rachel

My eldest daughter is always saying: "ohhh, the Candida is gonna get you"!
Diana

While the people I spoke with never explicitly use the words "ghostly" or "haunting" to describe their experiences with Candida, many of them do speak, albeit implicitly—though, consistently and uncannily[22]—to Candida as ghostly. Candida was referred to as "parasitic", "miasmic", "a looming presence", "living death", "not of this world", and, as an "overall sense" that "things" were not "quite right". The people I spoke with moreover repeated words such as "creep", "odd", "bizarre", "strange", and "peculiar" to describe their symptoms of illness, and the haunting ways in which Candida lurks, without diagnosis, within the body's supposedly knowable depths. It is with these descriptions that I have come

[22] I am aware that Freud's (2003) use of the uncanny refers very particularly to that which is familiar, homely (in German, *heimlich*), while simultaneously also being unfamiliar, strange, unhomely (*unheimlich*) (p. 125). The uncanny is not just that which "excites fear" (p. 123), but a "class of the frightening which leads back to what is known, of old and long familiar" (p. 124). Using the logics of his own psychoanalytic method, Freud reduces the experiences of the uncanny to two—though not always sharply distinguishable—subconscious processes: (1) the revival of childhood fantasies and traumas, and (2) the confirmation of seemingly surmounted "primitive" beliefs in animism and mysticism (p. 156). I use the uncanny, not in its psychoanalytic sense, not to understand the root of the experience of the uncanny, but in its colloquial sense (albeit derived from Freud) as an odd familiarity and strange recurrence (Royle, 2003).

to conceptualize Candida as a ghostly matter, and, more specifically, as biomedicine's ghostly matter.

By framing Candida as ghostly I speak (and listen) a little more carefully to the experiences of illness which are neither wholly absent, nor wholly present. I use the metaphor of the ghost as a descriptive tool to help articulate the often inarticulate illness experiences of Candida. Consistent with my double(d) efforts detailed in Chapter 1, I also use the ghost as a theoretical tool to explore the terms in and through which Candida comes to be rendered ghostly by the dominant discursive limits of biomedical science. It is precisely because of the specter's "paradoxical phenomenality" (Derrida, 1994, p. 7) as "neither being nor non-being" (Derrida, 1994, p. xix), that I find it such an apt and productive metaphor for the case of Candida[23]. Drawing on the important work of Avery Gordon's *Ghostly Matters* (1997/2008), I use the ghost to question what "modern [medical] history has rendered ghostly" (p. 18), and to explore that which exists (at least within standard biomedical practices) largely as an "exclusion and an invisibility" (p. 15). Concerned with the dialectics of presence and absence, inclusion and exclusion, visibility and invisibility, Gordon uses *Ghostly Matters* as a

[23] Derrida (1994) takes up the specter as a theoretical treatise on the often-established (and therefore largely unquestioned) categories of absence and presence, visibility and invisibility, life and death. Derrida's hauntology (a homonym of the English ontology) takes up the specter in specific relation to Marx and Engels' (1849) claim that "a specter is haunting Europe, the specter of Communism" (quoted in Derrida, 1994, p. 4). *Specters of Marx* was written as a "long awaited" (Lewis, 1999) and "provoking" (Jameson, 1999) commentary on the often incongruous relationship between Derridean deconstruction and Marxism. I do not engage Derrida's readings of Marx, or the relationships between these two bodies of theory (for overviews of these debates please see Sprinkler, 1999). I do, however, use the term specter as a synonym for the word ghost, and am interested in, like Derrida (1994), the terms of the specter's construction.

"mediation" (Gordon, 1997, p. 19), and "epistemology" (Van Wagenen, 2004, p. 287) on the topic of haunting[24].

Ghostly Metaphors

Significant for Gordon as well as for my purposes in this chapter is not only the simple, often overlooked point that ghostly matters are key features of social life, but moreover that ghostly matters require a different relationship to the (sociological) production of knowledge. As Gordon (1997) explains:

> *Ghostly Matters* is about haunting, a paradigmatic way in which life is more complicated than those of us who study it have usually granted. Haunting is a constituent element of modern social life. It is neither premodern superstition nor individual psychosis; it is a generalizable social phenomenon of great import. To study social life one must confront the ghostly aspects of it (p. 7).

Gordon's (2008) concern is not with "reducing matters to the epiphenomenal" (p. xvii), but with exploring new ways of better writing "the history of the present by attempting to imagine beyond the limits of what is already understandable" (Radway, 2008, p. xii).

Stymied by realist ethnographic representations (most notably in reference to the histories of racial violence and trauma), Gordon (1997) uses the mediation and epistemology of haunting to question what "the ghost say[s] as it speaks,

[24] Despite being written three years after Derrida's *Specter's of Marx* (1994), and engaging similar philosophical inquiries into the (h)ontological status of the ghost, there are very few references to Derrida (1994) in Gordon (1997). His work is referenced in one footnote and in one epigraph. My assumption is that most of Gordon's (1997) manuscript was written before *Specters of Marx* was published.

barely, in the interstices of the visible and the invisible" (p. 24). In exploring what the ghost says, Gordon follows three ghosts: (1) the absence of Sabrina Spielren (read through a photograph taken in the early days of psychoanalysis), (2) the stories of the disappeared in Argentina (read through Luisa Valenzuela's *He Who Searches*), and (3) the stories of African slavery in the United States (read through Toni Morrison's *Beloved*). Gordon's focus is on the 'evidence' of things barely seen for what it can tell about the relationship between knowledge, power and experience. She contends that the concept of haunting more fully registers phenomena like torture and slavery than do other modes of social experience.

Thinking with, alongside, and in response to the ghosts raised in Luisa Valenzuela and Tony Morrison's novels, as well as through the absence of Sabrina Sprielren, Gordon (2008) argues that the haunted and haunting figures summoned through these particular tellings "richly conjure, describe, narrate and explains the liens, the costs, the forfeits and the losses of modern systems of abusive power" (p. xvii). By "throwing off the conventions of ethnographic authenticity and following where the ghosts lead", Gordon acknowledges the ghostly matters that are so often eluded (and elided) in more common humanist accounts of violence and terror (Van Wagenen, 2004, p. 295). The ghost is not "some ineffable excess" (Gordon, 2008, p. xvi), nor is it "simply a dead or missing person" (Gordon, 1997. p. 8). For Gordon (2008), "the whole essence if you can use that word of a ghost is that it has a real presence and demands its due, your attention" (p. xvi). The ghost demands our attention not because it requires our validation; indeed it already exists without it. The ghost demands our

attention because to recognize the ghost is also to recognize "the violence of the force[s]" behind the ghost—its "sheets and chains" (Gordon, 1997, p. 22).

Despite being principally concerned with racial and colonial histories of violence and trauma, Gordon's treatise on haunting is also broadly focused. To investigate the ghost is to investigate "that dense site where history and subjectivity make social life" (Gordon, 1997, p. 8). In summarizing Gordon's contributions to the study of sociology, Van Wagenen (2004) maintains that "Gordon's epistemology demands that sociology rethink its object of study, its method of telling stories, [and] the kinds of data it allows to count as such" (p. 289). In short, Gordon (1997) argues for the relevance of ghostly matters to the sociological imagination, making the case for that which is "elusive, fantastic, contingent and often barely there" (p. 26).

Given Gordon's (1997) pursuits, her concept of haunting is particularly productive for me as I too explore "the traffic in domains of experience that are anything but transparent and referential" (p. 25). Following the ghostly frames put forth by Gordon, I use the mediation of haunting to question the discursive terms of Candida's nebulous existence. I argue that Candida fails to exist—not in some inherent or essential way—but precisely because it fails to conform to empirical modes of visibility and locatability. Yet, as productive as these ghostly framings may be, my conceptualization of Candida as biomedicine's ghostly matter sits in direct contrast to Susan Sontag's (1989/2001) now classic *Illness as Metaphor*.

To recall, Sontag argues staunchly *against* the use of metaphor for describing illness, and in particular for describing illness where its "causation is

not understood" (2001, p. 61, emphasis in original). Analyzing the metaphors of tuberculosis, cancer and AIDS, Sontag aptly questions the ways in which metaphors moralize and blame those afflicted with these illnesses. As she contends,

> [n]othing is more punitive than to give disease a meaning—that meaning being invariably a moralistic one […] First, the subjects of deepest dread (corruption, decay, pollution, anomie, weakness) are identified with the disease. The disease itself becomes a metaphor. Then, in the name of the disease (that is, using it as a metaphor), that horror is imposed on other things. The disease becomes adjectival. Something is said to be disease-like, meaning that it is disgusting or ugly. In French, a moldering stone façade is still lépreuse (Sontag, 2001, p. 58).

Sontag's aim in exposing the often negative connotations associated with illness is ultimately to strip metaphoric thinking from illness, and reduce illness solely to its physical causes; she sates: "the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphorical thinking" (Sontag, 2001, p. 3).

While I think it is necessary to understand the *ways* in which metaphors construct our often negative and moralistic thoughts (and feelings and experiences) concerning illness, I also think that to position illness as somehow "purified" of, or ontologically separate from, the formative structures of language—be these metaphorical, or otherwise—is problematic. I am moreover not the first to make related critiques of Sontag's work. Levin (1999) likewise

confronts Sontag's intent to position disease "as the simply physical", or as that which is "unencumbered by the complexity of subjective meanings" (p. 107). In Stacey's (1997) cultural analysis of cancer, she too takes issues with Sontag's attempt to separate illness from metaphor. Rather than being devoid of metaphor, Stacey (1997) contends that the pathological picture of cancer is heavily painted through metaphorical representations; she explains, for example, that figurative language is routinely used to describe a tumour's size, shape, colour, pattern, grain, surface and texture, thereby affirming the ways in which "science and medicine are themselves full of metaphorical representations" (p. 59).

Despite Sontag's aspirations of stripping metaphor from illness, detailed in these critiques are the ways in which "illness itself is socially embedded" (Levin, 1999, p. 106). Sontag's arguments against the use of illness metaphor positions illness as that which exists value-free prior to metaphor; metaphor, by extension, is positioned as that which comes to act upon, and, ultimately, pollutes the assumed "purely" physical causes of illness. In attempting to highlight the moral and political aspects of illness, Sontag paradoxically reproduces a notion of illness that exists essentially of the body, and therefore, separately from any social and/or political realms—indeed the very framing of illness against which she seeks to work.

While recognizing the cautions raised by Sontag concerning the use of illness as metaphor, I position Candida explicitly within metaphorical terms. I do not support Sontag's claim that illnesses can—or should—be detached from metaphorical thinking, and side instead with Gordon for the *productive* use of

ghostly metaphors. To pursue an investigation into Candida as biomedicine's ghostly matter, and to understand the terms of Candida's ghostly presence (and ghostly present), I first trace the empirical notions of visibility and locatability as read through Michel Foucault's *Birth of the Clinic*. Second, I argue that it is precisely because Candida eludes ocular and singular detection within the assumed empirical boundaries of the biological body that it comes to exist (and be experienced) as a haunting trace of the barely visible, as a possessive force consuming the body it invades, and as a specter of death haunting the empirical frames that rendered it ghostly in the first place.

Making Science Ocular[25]

I was going to my GP every week saying: "please, please, please". I was begging her to help me. And she'd say: "I don't know what's wrong with you". She'd take blood tests, and it wasn't Celiac Disease. Another GP suggested it was Giardia Lamblia…No, it wasn't that either. I think my GP was under the impression that it was psychosomatic in the end.
Aurora

I had anemia and thyroid tests. I had my hormone levels tested and all the other major things that you would look for, and they were all fine. My doctor was sympathetic, but he couldn't find anything.
Janine

I went to my allergy doctor and nothing came up.
Star

I had a very good supportive GP who knew that I was ill, but couldn't understand it. He sent me for all sorts of tests. I had every test going under National Health, and every one of them came back negative. And he said: "I don't know what's wrong with you, but I do know that you're ill, and I don't know how to help you".
Sue

[25] I take this subheading from Petit (1797) who states: "one must, as far as possible, make science ocular" (quoted in Foucault, 1973, p. 88).

> My doctor checked everything and said there's nothing wrong. He said I was completely normal. So I asked him: "Well, what it is then? I went from doing all of this, to going from eleven stone to dropping four stone. I'm struggling to walk up stairs and I'm 23/24 years old. How do you explain this"? He said: "I can't. I don't know". I think he thinks it's my mind that's causing me all these problems. There was nothing I could do; his tests were coming back negative every single time, and yet, this was happening to me.
>
> Phil

Obvious in these passages is the disjoint between the experiences of Candida, and the incapacities of biomedicine to locate and/or confirm these illness experiences. As Aurora states, "I was going to my GP every week […] I was begging her to help me". Similarly, as Phil describes, "there was nothing I could do. [My doctor's] tests were coming back negative every single time, and yet, this was happening to me". Detailed by a few of the people with whom I spoke, there are some doctors who do acknowledge that which eludes their diagnostic gaze. As Sue's doctor compassionately states, "I don't know what's wrong with you, but I do know that you're ill". Likewise, Janine's doctor "was sympathetic, but couldn't find anything". More common, unfortunately, is the tendency by many biomedical practitioners to assume that because Candida cannot be positively measured in the body that it must be a psychosomatic manifestation [26] [27]. As Phil states, "I think [my doctor] thinks it's my mind that's causing me all these

[26] Emerging in the 1930s predominantly, though not exclusively, through Freudian psychoanalytic concepts, Levin (1999) explains that psychosomatic medicine relies heavily on Cartesian logics of mind-body dualisms, dictating that if an illness cannot be located within the supposed boundaries of the biological, then it must be a manifestation of the mind (p. 112 - 113).

[27] The inclination of biomedical science towards the psychosomatic diagnosis when objective pathological findings cannot be detected is not only common to the case of Candida, but has also been documented across a variety of other undefined disorders (see for instance Malterud, 1999, Nettleton, 2006, Slim & Madden, 2008, Ware, 1992 & Wilson, 2004).

problems". In parallel terms, Aurora's doctor "was under the impression that [her condition] was psychosomatic in the end". I do not reject the category of the psychosomatic per se, but explore instead the empirical frames of visibility and locatability that combine to produce Candida's etiological status as "unreal" and "illegitimate". For this analysis I begin where Foucault (1973) begins: with "the classificatory model" of illness of the eighteenth century (p. 5). The classificatory model is important both for Foucault, and for my purposes in this chapter, because it marks ontological and epistemological separations with the impending empirical model of Enlightenment science.

Foucault (1973) explains that because classificatory medicine existed before the advent of surgery, where bodies were literally sliced open in an attempt to map the body's "anatomical atlas" (p. 3), the symptoms of disease in the eighteenth century were the only manifestations that "allow[ed] the invariable form of disease […] to show through" (p. 90). In the classificatory model, "the symptom was all that was visible; it [was] the closest to the essential; [and] it [was] the first transcription to the inaccessible nature of the disease" (p. 90). Symptoms were deemed the sign of a deeper—yet inaccessible—pathology. In Foucault's words, "cough, pain [and] fever [were] not pleurisy itself", but they did "provide a basis for recognition—a recognition that gradually gropes its way into the dimensions of the hidden" (p. 90). The collection and visible forms of disease symptoms provided a unique access to the inaccessible depths of illness. Illness in the classificatory model became known not in and of itself, but entirely in and through the discernible (and indiscernible) symptoms it left behind. This

approach to the study of illness became quickly obsolete as the empirical logics of biomedicine shifted the ways in which doctors constituted the sign, symptom and pathology of disease.

Emerging in the early nineteenth century and entrenched in the empirical paradigms of science, "the anatomo-clinical method" (Foucault, 1973, p. 3) (henceforth the clinical method or clinical model) marked the epistemological underpinnings of contemporary western biomedicine. In contrast to the classificatory model, the clinical model postulated illness as visible, locatable pathologies within the increasingly well-charted (and chartered) spaces of the physical body (p. 5). As medicine was able to pierce the previously unknown depths of the physical body, it gained a new understanding of illness—one that approached the study of illness and the human body "with the purity of an unprejudiced gaze" (Foucault, 1973, p. 195). Operating within the new-found Enlightenment ideals, illness in the clinical method was deemed stable and homogenous; it was examined as if in a pristine state, and viewed as something disconnected from culture. Unlike the classificatory model of the previous century, illness came to be deeply tied to the spaces—and in Foucault's terms—to the "closed privileged regions" (p. 15) of the human body. In locating illness within the body, the clinical model marked a fundamental shift, not only in the conceptualization of "illness", but critically also in the construction of the "visible".

Changing notions of illness, as Foucault persuasively argues, was "nothing more than a syntactical reorganization of disease in which the limits of the visible

and the invisible follow[ed] a new pattern" (p. 195). The new clinical model "dictated itself to making visible and knowable the previously invisible interiors of the human body" (p. 136). Through the technologies of the medical gaze (most notably through the advent of surgery), "the whole dark underside of disease came to light" (195). Symptoms were no longer the accessible signs of deeper yet unknown pathologies because illnesses became visible in their own right. In Foucault's words, "the abyss beneath illness, which was the illness itself, [had] emerged into the light of language" (p. 195). Critical to Foucault's analysis are the ways in which changing perceptions of illness were fundamentally organized by "how the forms of visibility" had also changed (p. 195). It was through these changing notions of visibility that Foucault puts forth what he terms the "pathological anatomy" of the clinical model (p. 122).

According to the pathological anatomy of the clinical model, illness existed only if it could be detected within the increasingly knowable spaces of the human body. In Foucault's words, "the presence of disease in an organ dictated the truth and existence of the disease" (p. 20). Unlike the classificatory model of the previous century, visibility and locatability became benchmarks, not only for the detection, but also for the truth, of illness pathology. As Foucault explains, "[t]his new positive medicine [was] marked at the empirical level" (p. 197). By locating illness within closed privileged regions of the human body, the clinical method made possible "a welding of disease onto the organism" (Foucault, 1973, p. xviii), and set in motion "the fusing of the seeing and believing, of the visible and legible, of the perceivable and the expressible" (Foucault, 1973, p. 56).

Guided by the positivist assumption that a single, knowable, and measurable reality exists, the medicine of "organs, sites and causes" was born (Foucault, 1973, p. 122). It is through this medicine of organs, sites and causes that Candida comes to exist as a ghostly matter. Because of the ocular and locatable truths put forth by the pathological anatomy of the clinical model, Candida comes to exist (and be experienced) as a haunting trace of the barely visible, and as a possessive force consuming the body it normally or naturally inhabits.

Traces of the Barely Visible

> I had palpitations, I had disturbed sleep, and I'd wake up in sort of a panic. I'd fall asleep and wake up ten minutes later feeling sort of panicky. The palpitations were always at night.
>
> Diana

> I had these perfectly formed circles [on my skin], and I went to my doctor and she said it might be some kind of allergy. And the penny dropped and I thought: "Ah ha, I bet it was the chocolate [that I ate]". The circles itched, and burned, and were raised, so if I rubbed my hand against them I could feel them. And then within two to three hours, they were gone. They were really weird, but I only got them on my face. This is what I mean when I said that Candida is trying to out-fox me. It's constantly giving me different symptoms that I'm not quick enough to say: "Ah, I bet that's Candida". I go on for a couple of weeks thinking "What was that"? And then the penny drops. It's most peculiar. Some things that I had at the beginning are gone, and new ones keep popping up all the time. The latest ones are these weird swellings.
>
> Sue

> My head would feel like there's constant mud in it. I couldn't think clearly. I'd just get very confused and forgetful, and I was also very irritable, my blood sugar would go down and I would feel very grumpy and agitated, but then after eating I would feel exhausted. I could sleep twelve hours and still feel exhausted. I think it was this crushing fatigue that got to me the most.
>
> Kara

While ghosts do not tell us why we are being haunted, they do often make their spectral presences known. Detailed by the people with whom I spoke, Candida's ghostly presence comes to be experienced through "palpitations", "disturbed sleep", "panic", "perfectly formed circles", "weird swellings", "the inability to think clearly", "confusion", "forgetfulness", "irritability", "agitation", "exhaustion", and "crushing fatigue". Not only are many of these symptoms themselves difficult to pin down, but in returning to Gordon's epistemology of haunting, in the absence of a definitive biomedical pathology, these symptoms also mark the presence of an illness which is supposed to be "absent", "illegitimate" and/or "all-in-one's-head". These symptoms come to exist as haunting traces of the barely visible.

"If haunting describes how that which appears to be not there is often a seething presence, acting on and often meddling with taken-for-granted realities", then, as Gordon (1997) describes, "the ghost is just the sign, or the empirical evidence if you like that tells you a haunting is taking place" (p. 8). The presence of Candida comes to make itself known as strange and bizarre symptoms which are there one minute and gone the next. Guided by Foucault's analysis of the pathological anatomy of the clinical model, I contend that there is nothing inherently ghostly about the case of Candida, but rather that it comes to take on a ghostly existence because it eludes dominant empirical notions of objective visibility. As we know from Chapter 2, Candida fails to be detected by the blood, saliva, urine, stool, and gut fermentation tests that attempt to see—but fail to see—its systemic overgrowth. When doctors go looking for Candida they find not

illness, but rather that which is supposed to reside in the well-known spaces of the human body. Candida *is* visible to biomedicine, just not in its pathogenic form. Part of its failure to be seen in its pathogenic form by biomedicine can be explained by its transcendence of self/non-self immunological distinctions.

> According to Burnet and Medawar's (1949) theory of immunology,
>
> [t]he body is instructed early in its development as to which kinds of antigens belong to the category of "self" and it learns to tolerate these. Later encounters with those antigens […] will not lead to an immune response, while all other antigens […] will trigger immune response and clearance from the system (Weasel, 2001, p. 29).

While Burnet and Medawar's self versus non-self model is not the only theory of immunology[28], it is the most widely acknowledged within biomedicine, winning the Nobel Prize in Medicine in 1960 (Weasel, 2001). Central to Burnet and Medawar's theory is the assumed (inherent) ability of the body to distinguish "self" from "non-self"[29].

According to this model of immunology, Candida-yeasts fail to get recognized as other-than-self because they are seen as naturally occurring aspects

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[28] Matzinger (1994) puts forth what she terms the danger model of immunity. Based on a growing dissatisfaction among immunologists of the self vs. non-self model, the danger model is not based on the premise that the body needs to identify and defend itself against foreign invaders. It is guided instead by an understanding of the body's need to recognize and respond to signals of danger, regardless of their origin.

[29] Emerging in the years directly surrounding the end of World War II, Weasel (2001) points out that Burnet and Medawar's (1949) model of immunology cannot be removed from military references of military surveillance—surveillance that detects "foreign" antigens which are considered threats to the host system. Emily Martin (1994) also highlights the outwardly xenophobic (and thus problematic) assumptions of this model of immunology.

of human digestive flora. Further compounding the immune system's inability to detect the pathogenic presence of Candida-yeasts are what are known (at least within microbiology circles) as "biofilms". Biofilms are sheets of microorganisms that literally envelope fungal organisms. They attach, colonize and grow around—yet separately from—the fungi they encapsulate (Flannery, 2004). In the case of Candida, biofilms help mask the visible presence of pathogenic yeasts. Operating as a screen of invisibility, they shroud the ocular (and thus pathogenic) detection of Candida overgrowth. In the absence of a (visible, detectable) pathology, Candida therefore remains a standard, mundane, and largely invisible aspect of biological functioning.

Concealed by the guise of the normal, Candida symptoms come to materialize as the effects of an illness without pathology. Candida's ghostly matter lurks, looms and haunts not only the diagnostic standards of biomedical science, but also the lives and bodies of those who experience its nebulous effects. Because Candida's symptoms are all that are visible, marking the spectral presence of an illness without pathology, the illness of Candida exists within biomedicine much like the illnesses of the eighteenth century classificatory model—discernible only through the haunting traces it leaves behind. Candida further comes to take on a ghostly existence because it fails to be contained within any one "privileged region" of the human body, thus possessing and consuming the bodies in which it normally and naturally resides.

Possessions

Candida lives where it is not supposed to.
Aurora

Once [Candida] leaves the lining of your gut, it can go anywhere.
Sue

There was no part of my system that had not been affected.
Aurora

I just didn't feel like I was in control of my body.
Diana

There are times when the Candida takes over and I think I should just give into it.
Sue

Candida doesn't give anything back. It just takes more than it gives.
Kara

The language used by the people I interviewed to describe their experiences with Candida raises ghostly images of a porous, specter-like figure that can travel throughout the body, attacking the body from multiple, simultaneous, and unbeknownst locations. For Aurora, "there was no part of [her] body that had not been affected". Similarly, for Sue, "once [Candida] leaves the lining of your gut, it can go anywhere". Existing as a ubiquitous (largely invisible) presence within the body, Candida also yields no locatable pathology. To recall from Chapter 2, Candida is a disorder that "attacks all over" (Crook, 2003, p. 1). Once Candida-yeasts spore through the mucous membranes of the intestinal wall that normally work to keep them in check, they can change into their pathogenic form and affect multiple bodily systems (Cater, 1995).

Foucault (1973) argues that the technologies of the clinical model—the physical examination, post-mortems, the stethoscope, the microscope, disciplines

of anatomy, psychiatry, radiology and surgery—not only served to render the body more visible, but also pertinently served to disclose the reality of the pathological anatomical fact. As discussed above, the truth of illness in the clinical model became overwhelmingly measured by its presence in an organ. To borrow from Englehardt (1986):

> [p]atient problems came to be understood as *bona fide* problems only if they had a pathoanatomical or pathophysiological truth value. Absent a lesion or a physiological disturbance to account readily for the complaint, the complaint was likely to be regarded as *male fide* [i.e. illegitimate and unreal] (quoted in Wendell, 1996, p. 123).

According to the biomedical postulation that the truth of illness resided in its visible location, the lack of Candida's pathology can be understood partially by its failure to be contained by any one biological organism. We can see Candida's failure to reside in any one location by its corresponding failure to be contained by the blood, saliva, urine, stool, and gut fermentation tests that attempt to measure its overgrowth.

While medical technologies play a significant role in determining, or in the case of Candida, eluding the pathological presence of disease in an organism, Foucault (1973) notes that these are not the only technologies at work. The impetus to delimit illness within singular, privileged regions of the human body "is indicated—but not, of course, exhausted—by the minute but decisive change, whereby the question: 'What's the matter with you', […] was replaced by that other question: 'Where does it hurt'" (Foucault, 1973, p. xviii)? By changing the

terms of the question being asked, the clinical method is also able to effectively change the knowledge/power formations upon which illnesses come to be deemed real. Moving away from a concern with the overall effects of illness (i.e. as in the classificatory model), the clinical model moves towards ever-stricter definitions of disease.

Given the change in the terms of the question being asked, when faced with the question: "Where does it hurt?", how are Candida sufferers to articulate that which does not reside in any one particular location? The short answer is that within biomedical approaches to the sign, symptom and pathology of illness they cannot—their answers fail to fit within the ideological terms of the question being asked. Frustrated by the limiting terms to which they are being asked not only to respond, but also to conform, it is not surprising that many people with Candida turn to CAM diagnostics as a means of confirming their ghostly experiences.

If we take, for example, Crook's diagnostic questionnaire we can see that it yields very little concern for the location or site of Candida overgrowth (see Appendix 3, p. 221). Akin in some ways to the diagnostic regimes of the classificatory model, Crook's questionnaire is predominantly concerned with the overall effects of systemic yeast overgrowth. By asking such questions as "are you bothered by fatigue, depression, poor memory or nerves" (Crook, 2003, p. 4), Crook's questionnaire attempts to provide "a basis for recognition—a recognition that eventually gropes its way into the dimensions of the hidden" (Foucault, 1973, p. 90). Moving away from strict empirical models of pathological anatomy, Crook's questionnaire even inquires into (and therefore acknowledges) whether

patients “feel bad all over” (Crooks, 2003, p. 4). Operating outside the pathological anatomy of the clinical model, we can understand not only why Crook’s questionnaire is so controversial to biomedicine, but also why CAM diagnostics are more readily able to account for those matters deemed (too) ghostly by biomedicine—not only because of the kinds of questions they ask, but also because of the kinds of responses they enable.

In failing to reside in any one privileged biological region, Candida yeasts are able to increase their total area of tissue invasion, taking over and possessing the body in which they normally and naturally reside. Outlined in the epigraph of this section, Diane states explicitly that she “didn’t feel like [she] was in control of [her] body”. Similarly for Sue, “there are times when the Candida takes over and [she thinks she] should just give into it”. Kara likewise characterizes Candida as a parasitic presence that “takes more than it gives”. Arguably most poignantly-stated is Sophie, who asserts in the opening epigraph of this chapter that she feels that she is “host to a foreign entity that is feeding off of [her], always laying in wait for [her] weaknesses to show”. Despite Candida existing in virtually everyone, in its failure to reside in any one location, Candida exists as a force operating separate from, yet consuming, the body it invades. Akin to many science-fiction storylines, Candida-yeasts colonize the human body in search of food and self-preservation.

In a *New York Times Magazine* article entitled, “The Fungus Among Us”, Marston (1996) explains that once fungi inhabit the human body they can be virtually impossible to eliminate; because “fungi are organized like mammalian

cells" (p. 1), they are "similar enough to us on the cellular level" (p. 1) that any attempts to eliminate fungi from the human body can also risk harming the human host. While I discuss the forms of dietary exorcisms needed to rid the body of Candida overgrowth in Chapter 5, important here is that the medical and experiential conceptualizations of Candida as a possessive force cannot be removed from the dominant discourses of the pathological anatomy of the clinical model. Candida exists as a parasitic consuming force because it fails singular (and ocular) location within any one privileged region of the physical body. In its lack of visibility and locatability, Candida also comes to exist and be experienced as a specter of death, haunting the very certainties rendering it ghostly to begin with.

Specters of Death: Loss of Certainty

> I must be dying in some way to feel this rubbish all the time and no one can tell me what it is.
> Kara

> No power on earth would have got me to eat Christmas pudding or pie at Christmas or anything because I *knew*, I just knew how ill it would make me—I thought it would kill me quite frankly. My whole digestion was completely shot, and I know, I know I would have died. The cancer would have come back. And people would have said: "Oh, she died of cancer, very sad for the poor woman". But I kept saying to my [partner]: "if I die, it's not because of the cancer, it's because of the Candida. The cancer may come back, and they'll think its cancer, but it's the Candida that would have killed me".
> Diana

> When it first happened I personally think it's like a living death. That's what I would say. That sounds a bit severe but it really did feel like that. You're alive, but you just feel dead.
> Janine

> I had to tell my mother that if I didn't concentrate on my diet, it was going to kill me. After that, she was a lot nicer about it.
> Diana

> One of these times, I know I am not going to bounce back.
> Meena

> I went from being a typical person in [my] twenties in good health to literally thinking I was dying.
> Phil

One of the more surprising recurrences in my interview transcripts was the explicit mention of death by a handful of the people with whom I spoke. Kara thought she "must be dying in some way". For Janine, Candida was like "a living death". Phil "literally [thought he] was dying". And, as Diane unambiguously states, "if I die it's not because of the cancer, it's because of the Candida". While Candida can cause death in extreme circumstances—in cases of AIDS where the body's immune defenses are already severely compromised—it generally exists as a non life-threatening, chronic condition (Liao, 2002), thus begging the question: why the repeated and often-explicit references to death by the people I spoke with?

References to death are not only common across Candida narratives, but are also notable across other cases of chronic undefined illness. In Ware's (1992) study of Chronic Fatigue Syndrome (CFS), she too points out the curiousness with which many of her participants would rather be diagnosed with advanced forms of cancer than live with the uncertainty and ambiguity of CFS. As stated by one of her participants:

> It would be easier in many ways if someone was to say to me ok, we've found out what's wrong with you. You've got a tumour the size of a

> grapefruit and you've got 2 years to live. Ok. Now I know. That's what it is (Ware, 1992, p. 354).

While this passage conveys the frustration of not being able to express what the body is experiencing, it is also speaks to the empirically-inspired desire for bodily certainty—even if that certainty entails "a tumour the size of a grapefruit" and "2 years to live".

Drawing from Gordon (1997) we can understand that "haunting is a process that links an institution and an individual, a social structure and a subject, and a history and a biography" (Gordon, 1997, p. 19). Given this, the specters of death encountered in undefined illness are not attributable to individual narratives, but can rather be located within broader biomedical structures of knowledge and power. So while I initially thought that references to death across Candida narratives were surprising, given the weight of the pathological anatomy of the clinical model (which presumes a singular, locatable and detectable truth to pathology), references to death in the face of bodily ambiguity are, in fact, not surprising at all.

Critical to Gordon's mediation of haunting is the assertion that ghosts are never innocent. As she explains, ghosts are "haunting reminders of lingering trouble" (2008, p. xix), reminiscent of "we have lost, or, perhaps never really had" (1997, p. 51). If we follow the specters of death in cases of Candida (and in cases of chronic undefined illness more broadly), we find that what is missing is not simply a diagnosis. What is missing in the case of Candida is the certainty that we have come to expect from biomedical ways of knowing the body. What is being

haunted in the case of Candida, therefore, is not individual bodies, but rather the empirical desire to objectively *know* the body and all of its discontents. The specters of death raised in cases of undefined illness can be understood as reminiscent of what biomedicine has worked so hard to keep at bay.

Created through exclusions and prohibitions, the ghostly case of Candida not only emerges from empirical modes of knowing the body, but in its ethereal form haunts the very certainties upon which it became deemed ghostly in the first place. Despite the weighty claims put forth by biomedical science, "the body is no more stable than the diseases that inhabit it" (Taylor, 1993, p. 221). As I have argued in the case of Candida, illnesses are not always objectively visible or singularly locatable, but this does not mean that they are not without ghostly effects—indeed they continue to exist as haunting/ghostly reminders and remainders of the failures of the Enlightenment's empirical medical model.

Lessons from the Ghost

> I think Candida has changed my life all-in-all for the good in a weird way because it's made me aware of something I didn't know about. I would have never known how to eat healthily if it hadn't been for Candida. It has changed my life catastrophically.
>
> Kara

> [Candida] left me a different person. I'm not the same person physically, or in any way, emotionally or spiritually. I've been uprooted more or less from the life I was used to.
>
> Aurora

Another surprising recurrence across my interview transcripts are the ways in which many of the people with whom I spoke described Candida as having had a positive effect on their relationship to their bodies, the food that they eat, their

ideas concerning personal health, as well as their lifelong aspirations. While Frank (1996) points out that these kinds of narrative tropes are common in illness narratives more generally, I find them particularly curious alongside the specters of death raised in the previous section. As one of my participants paradoxically states: “I must be dying in some way to feel this rubbish all the time”, and yet, “Candida has changed my life all-in-all for the good” (Kara). While I take up the potentially transformative effects of the Candida diet in Chapter 5, I conclude this chapter with the potentially transformative effects of the ghost.

As Gordon (1997) maintains, “being haunted draws us affectively, sometimes against our will and always a bit magically, into the structure of feeling of a reality we come to experience, not as cold knowledge, but as transformative recognition” (p. 8). Ghostly matters in the case of Candida, therefore, as Aurora explains, not only “uproot” us from the “lives we were used to”, but they also alter our relationship to that which is “elusive, fantastic, contingent and often barely there” (Gordon, 1997, p. 26). Learning to live with ghosts is not a matter of simply accepting or rejecting the ghost. It is also not a matter of reconciling empirical divides between visibility, invisibility, absence, and presence. Learning to live with ghosts is about learning to think differently about its ethereal constructions.

“When the whole situation cries out for clearly distinguishing between truth and lies, between what is known and what is unknown, between the real and the unthinkable and yet that is what is precisely impossible” (Gordon, 1997, p.

64), the ghost provides us with a different way of seeing. As Gordon (1997) elucidates,

> [f]ollowing the ghost is about making a contract that changes you and refashions the social relations in which you are located. It is about putting life back in where only a vague memory or a bare trace was visible to those who bothered to look. It is sometimes about writing ghost stories, stories that not only repair representational mistakes, but also strive to understand the conditions under which a memory was produced in the first place, toward a countermemory, for the future (p. 22).

While Gordon's efforts for countermemories are towards the histories of violence and terror, I have contended that ghostly matters can also be productively applied to the case of Candida.

By framing Candida as productively ghostly I have sought to articulate the often inarticulate experiences of an illness which is there and yet not, while simultaneously questioning the biomedical terms of its ghostly existence. My aim has not been to prove that Candida is real and/or does exist. With the help of Foucault's genealogical analysis, as well as Gordon's mediation of haunting, my aim has been to interrogate the case of Candida as a complex discursive system of permission, prohibition, absence, presence, visibility and invisibility. Despite Candida being largely peripheral to biomedicine, Candida also acts as a central index of biomedicine's empirical workings of power and knowledge. Candida's illegitimacy cannot be understood without reference to these regulating discursive

terms. And as I discuss in the subsequent chapter, Candida's illegitimacy can also not be examined separately from wider discourses concerning gender.

CH. 4

Candida, Leaky Bodies and the Feminization of Yeast

My GP insisted that yeast issues were the domain of women and people with HIV immune compromised systems exclusively, and since I was neither, I couldn't possibly have a yeast infection.
Dean

The notion of yeast is very tied to women and not to men and that's why I ruled myself out, even before considering whether I could have it or not.
Will

Candida is more common among women.
Martha

Candida tends to affect women more than men.
Cheryl

I always believed that Candida was something that afflicted women.
Steve

As indicated here, Candida is commonly regarded as that which "afflicts women" (Steve), as that which is "more common among women" (Martha), as that which is "tied to women" (Will), and as that which "tends to affect women more than men" (Cheryl). As we know from Chapter 2, the overall feminization of Candida (at least for those who support the Candida-yeast hypothesis) is further evidenced by a range of medical sources. Wunderlich and Kalita (1984) maintain that "Candida seems to strike women more often than [it does] men" (p. 4). Mazarro (2003) contends that "Candida occurs in at least 40% of adult women" (p. 993). And, as Truss (1981) indicates, "the single largest category of chronic candidiasis is older teenage and adult women" (p. 236). Although Miles, Olsen and Rogers (1977), as well as Martin (2000), claim that Candida affects men,

women and children alike because it inhabits the digestive tract, and not contrary to popular belief the vagina (a point of analysis I will return to later in this chapter), the vast majority of medical sources point to Candida's presumed prevalence among women[30].

Despite any seeming certainty from medical communities concerning the feminization of Candida (and of yeast), I argue towards a discursive reading of such ideological claims. I do not take at face value the medical assumption that Candida affects women more than men, or that its physical manifestations (and symptoms) are somehow ontologically different in men than they are in women. Reading Candida's symptoms alongside more extensively considered corporeal flows—namely men's seminal fluids and women's menstrual flows—I argue that the feminized case of Candida can be understood as an instantiation of Elizabeth Grosz's (1994) claim that "female corporeality is inscribed as a mode of seepage" (p. 203). While Candida affects both men and women, *how* it comes to be experienced by the people with whom I spoke cannot be separated from already existing leaky and contained gendered (and gender*ing*) discourses.

Drawing on feminist poststructural theorizings that posit a mutual constitution between "matter" and "discourse" (Barad, 2007), "nature" and "culture" (Grosz, 1994), "words and things" (Sheridan, 2002), I conceptualize gender in the case of Candida as an active and ongoing materialization, and not as a predisposing risk factor contributing to, or deterring from, the proliferation of

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[30] This trend is also evident in other cases of chronic undefined disorders. As Malterud (1999) explains "there is a remarkable and consistent majority of women compared to men who suffer from [a variety of] medically unexplained disorders" (p. 279). Barker (2005), also, for instance, speaks to the "overwhelming feminization" of the Fibromyalgia Syndrome (p. 46).

systemic yeasts. My aim is neither to essentialize, nor to negate, the differences between men's and women's experiences of Candida. Rather, "seeking to transcend current theoretical debates that demand a choice either between a material or a discursive explanation of medical phenomena" (Reuter, 2002, p. 751), I explore the gendered and gendering terms *that lead to* the feminization of Candida, and which in turn, lead to its gendered and gendering illness experiences. I situate this analysis within what Sheridan (2002) has termed a "new materialism" (p. 21).

New Materialism(s)

Since the feminist and poststructural "turn to culture" of the 1970s, bodies are understood as inseparable from culture as opposed to enlightenment definitions that situate bodies in a pure and essentialist materiality (Sheridan, 2002, p. 23). The broad and increasingly diverse fields of feminist and poststructural body theorizings insist on bodies as historical and culturally specific entities shaped, disciplined and maintained within and through the intricate workings of power (detailed in Chapter 1), and as entities whose materiality cannot be removed from the constitutive effects of culture. To understand that the matter of bodies is culturally inflected does not negate, in Butler's (1993) words, that "bodies live and die; eat and sleep; feel pain, pleasure; endure illness and violence" (p. xi); it does, however, critically reposition how bodies *come* to matter.

Drawing on Judith Butler's (1993) concept of materialization, Elizabeth Grosz's (1987; 1994) corporeal feminism, and Karen Barad's (2003; 2007) intra-action, I theorize the matters of Candida as simultaneously material *and* discursive. In exploring the medical manifestations of yeast, as well as people's experiences with its physical, emotional and cognitive symptoms, I contend that the matters of Candida cannot be understood outside the wider regulatory workings of gender. I use Butler, Grosz and Barad to argue for the ways in which Candida is simultaneously material and discursive, ultimately in an attempt to move beyond dominant assumptions that Candida is somehow *inherently* feminized. I am not claiming that Butler, Grosz and Barad are identical in their reformulations of the often-fraught dichotomies between "matter" and "discourse". Speaking to some of their differences, I use these three theories in parallel terms for how they can enable the discussion—namely an ability to transcend the dichotomies of "nature" and "culture", "matter" and "discourse".

Materialization

Emerging partly as a response to the critiques launched against her earlier work, *Gender Trouble*, which claim a lack of engagement with the body's materiality (see for instance Rahman & Witz, 2003), Butler's (1993) concept of materialization works from a particular reconfiguration of the concept of constructionism. She contends that a constructionist approach to the body (and I would add, by extension, to illness) misses the point because it rests on the assumption that nature and culture are dichotomous systems (p. 3). Operating

within this fraught binary relationship, the task of constructionism has largely been to show how culture acts upon, disrupts, inscribes, and/or sets up an outside to nature.

Implicit in the constructionist approach is the presupposition that nature somehow passively precedes the active and ensuing inscriptions of culture (Butler, 1993, p. 4). To imply that culture disrupts nature rests on the ontological assumption that nature holds some form of previous constancy that is not chaotic and unpredictable. This form of constructionist thinking (i.e. one which posits culture as malleable and nature as irrefutably passive) reinscribes that which it seeks to work against: namely the reductionist ideal of an inert and passive biological body. Butler (1993) urges us to consider that if we do not critically challenge notions of the supposedly inert and passive biological body, we too remain complicit in its formation and maintenance as an objectively distinct entity; in her words: "there is no reference to a pure body which is not at the same time a further formation of that body" (p. 12). In order to work beyond reductionist ideals of the human body, feminist and poststructural theorizings must do more than reverse the binaries of nature and culture[31]—they must entail "a rethinking of the meaning of construction itself" (Butler, 1993, p. xi). It is through this rethinking that Butler puts forth her concept of materialization.

Butler (1993) uses the concept of materialization as a way to give credence to the body's fleshy and embodied materiality while at the same time

[31] Foucault (1980) makes a similar argument about the logic of reverse discourse. In *The History of Sexuality,* Foucault argues that homosexuality became legitimated through many of the same discourses that delegitimated it in the first place, and as a result, these terms became part of the very movement that the gay and lesbian liberation movement attempted to oppose.

taking care not to reinscribe the body's materiality as a passive site of cultural inscription. Arguing for the ways in which (sexed) bodies are shaped, enabled and constrained in and through the regulatory regimes of power and knowledge in the Foucauldian sense, Butler (1993) contends that "the matter of bodies will be indissociable from the regulatory norms that govern their materialization" (p. 2). By understanding the ways in which bodies "are the effect of power" and "power's most productive effect" (p. 2), Butler's concept of materialization effectively enables a reworking of materiality so that it can be understood as the ritualized repetition of norms which produce and stabilize what we come to know as "*the effect of boundary, fixity and surface we call matter*" (Butler, 1993, p. 9, emphasis in original).

Corporeal Feminism

Like Butler, Grosz also moves beyond dualistic accounts of the body. Grosz's concept of "corporeal feminism" was first introduced in 1987 in an article in *Australian Feminist Studies,* and then further elaborated in 1994 in *Volatile Bodies*. In short, it entails a merging of the body with subjectivity, or, as Grosz (1994) details, "a refiguring of the body so that it can now be understood as the very 'stuff' of subjectivity" (p. ix). Grosz's admits that her endeavours are risky when considering feminism's long and warranted skepticisms about the often-deterministic links between female subjectivity and the specificities of the female body. However, as she upholds, her arguments towards a corporeal feminism are not about reinscribing biologically determined conceptions of the female body (or

of female subjectivity); they are rather specifically about writing against them. As she contends, "I will deny that there is the 'real', material body on one hand and its various cultural and historical representations on the other. It is my claim […] that these cultural inscriptions quite literally constitute bodies and help produce them as such" (p. x). Important for Grosz is that bodies are not inert or bound systems, but that bodies "function interactively and productively" (p. xi), paralleling Butler's (1993) arguments.

One of the ways in which Butler and Grosz diverge, however, and where I find Grosz's corporeal feminism particularly useful for my purposes in this chapter, is with Grosz's focus on the matters and seepages of corporeal flows. Drawing on the psychoanalytic theories of Julia Kristeva (1982), as well as the anthropological works of Mary Douglas (1966), Grosz (1994) contends that any bodily substance that crosses corporeal boundaries—pus, blood, saliva, breast milk, fecal matter, semen, and menstrual blood—highlights the impossibility of biological bodies as closed systems. To draw elaborately from Grosz (1994),

> [b]odily flows attest to the permeability of the body, its necessary dependence on an outside, its liability to collapse into this outside, to the perilous divisions between the body's inside and outside […]. They attest to a certain irreducible "dirt" or disgust, a horror of the unknown or the unspecifiable that permeates, lurks, lingers and at times leaks out of the body, a testimony to the fraudulence or impossibility of the "clean" and "proper" (p. 193 – 194).

Bodily flows, according to Grosz, confirm the inevitability of bodies to leak, to seep and to ooze beyond the boundaries that purportedly attempt to contain them. But while all bodies have similar capacities to secrete corporeal flows, Grosz argues that it is women's bodies that are invariably put forth as leakier than men's.

Analyzing men's seminal fluids and women's menstrual flows, Grosz underlines the gendered discourses in and through which these secretions come to be produced, and the ways in which they come to exist in and through "different indices of control, disgust and revulsion" (p. 195). I use the specificities of Grosz's arguments throughout the chapter to help me think through the gendered case of Candida. What I find curious and somewhat perplexing, despite a long list of corporeal flows mentioned by Grosz (1994)—pus, blood, saliva, breast milk, fecal matter, semen, and menstrual blood—she makes no reference to the presence (or seepage) of yeast. Julia Kristeva (1982), who is also unambiguously concerned with "the sticky, viscous or amorphous things which are associated primarily with the female and more particularly with the maternal body" (p. 81), moreover (oddly) makes no reference to yeast.

From Chapter 2 we know that the presence of yeast can inhibit sexual function, and can secrete from genital organs, often especially during pregnancy (Liao, 2002). Moreover, akin to menstrual blood and seminal fluids, yeasts are neither solid, nor liquid—they are what Kristeva (1982) might refer to as, "the in-between, the ambiguous, [and] the composite" (p. 4). Despite the lack of discussion of yeast by both Grosz and Kristeva, I argue that the case of Candida

can be understood as an instantiation of Grosz's (1994) claim that "female corporeality is inscribed as a mode of seepage" (p. 203). The case of Candida further reinscribes dominant hegemonic assumptions concerning contained male and leaky female bodies, and, as such, should be included in feminist concerns of corporeal flows.

Intra-Action

Like Butler and Grosz, feminist poststructuralist and physicist Karen Barad (2007) also urges for the necessary reworking of the often-dichotomized categories of nature and culture. In parallel terms to both Butler and Grosz, Barad (2007) details that,

> [m]atter, like meaning, is not an individually articulated static entity. Matter is not little bits of nature, or a blank slate, surface, or site passively awaiting signification; nor is it an uncontested ground for scientific, feminist, or Marxist theories. Matter is not a support, location, referent or source for sustainability for discourse. Matter is not immutable or passive. It does not require the mark of an external force like culture or history to complete it. Matter is always already an ongoing historicity. (Barad, 2007, p. 821)

She too insists on bodies as historical and culturally specific entities shaped, disciplined and maintained in and through the intricate workings of power, and as entities whose materiality cannot be removed from the constitutive effects of culture. Where Barad differs quite substantially from Butler and Grosz (she

doesn't specifically mention Grosz but she does Butler) is her ability to account for what she deems "the agency of matter" (p. 215), and for the important ways in which the "world kicks back" (p. 215).

Critiquing Butler's (1993) failure to analyze how matter matters (she argues that Butler only accounts for how discourse matters), Barad proposes an intra-active approach to the matter of bodies. Using the theories of quantum physicist Niels Bohr, Barad argues for the active and ongoing *intra-action* between matter and meaning. In her words, intra-action is "the mutual constitution of objects and their agencies of observation" (p. 196). It is based on the notion that physical things have material qualities, but that their material qualities can only be understood in relation to the objects (and subjects) through which these entities become understood and put into action. To illustrate this point she uses the example of tools. Tools are material entities, but they do not, and cannot, "take on specific meanings without reference to the bodies that use them" (p. 197). A hammer is not a hammer until someone hammers with it.

Using Barad's theory of intra-action, I argue that the matter of yeast (and more broadly the illness of Candida) does not take on gendered meanings without reference to the gendered bodies in and through which these meanings come to materialize. While yeast is a material entity, its gendered materializations on and in male and female bodies cannot be removed from wider leaky and contained gendered (and gendering) discourses. With the help of Barad (2007), matter and meaning, gender and discourse, can be understood as "intra-active becoming […] not a thing but a doing, a congealing of agency" (p. 210). Barad's theory of intra-

action accounts for the matter of matter, without removing matter from the constitutive effects of culture.

In attempts to dislodge (particularly sexed) bodies from the narrow confines of biological reductionism, feminist poststructural theories have faced charges of cultural relativism, somatophobia, and a failure to engage what some have deemed the fleshy and visceral materiality of the biological body (see Birke, 2003; Rahman & Witz, 2003; and Spelman, 1988). According to some of these critiques, the poststructural body has become a "de-materialised body, a 'body without organs', [and] a body without 'biology'" (quoted in Sheridan, 2002, p. 28). Birke (2000) contends that while feminist poststructuralists in the past few decades have been quick to highlight how power, discourse and knowledge get inscribed *on* the body, they have subsequently failed to theorize the body's *interiority*. In her words, feminist poststructural theories of the body have lacked engagement with "the 'bits' we have inside our bodies" (p. 46), and the "blood and guts" (p. 48) that comprise the biological body.

While I am not convinced of Birke's (2000) charges that feminist poststructural body theorizings have failed to account for the body's interiority (indeed, within the past few decades of feminist poststructural body theorizings there has been specific concern with women's reproductive organs, pregnancy, cancers, HIV/AIDS, the immune system, and hormones—all of which exist in the crudest sense "inside" the body), I do take seriously the gendered matters of yeast. Working with Barad's notion of intra-action, Butler's concept of materialization, and Grosz's corporeal feminism, I approach the medical case of yeast overgrowth

as a non-dualistic whole, as at once a material reality—an illness, a symptom, a feeling of physical discomfort—*as well as* the reiteration of discursive terms. Referring back to the doubleness upon which this dissertation is premised, the theories I have detailed here not only account for a recognition of the lived realities of Candida (i.e. the embodied materialities so commonly discussed by my participants), but they also enable me to maintain a critical understanding of how these embodied materialities come to be produced in, and shaped through, the terms of available discourse. In the discussion that follows, I consider how the leakiness of Candida is constituted as feminine through reading the meaning made of its symptoms alongside more extensively considered bodily seepages.

Contained Male Corporealities

> The only symptom that I can really clearly identify [with Candida] is my itchy ass.
> Will

> The biggest problems I had with Candida were fatigue and diarrhea as well as annoying things like, sweating, strong BO, dry mouth, bad breath, coating on gums and tongue. I'm not sure hair loss has anything to do with Candida, but I have my suspicions.
> Phil

> At age 35, I suffered a nervous breakdown where I was hospitalized for a week and was unable to work for six months. At this time I was completely "spaced out" with feelings of unreality, brain fog, severe memory dysfunction and tinnitus [ringing in the ear].
> Steve

> I contracted a case of jock itch so severe that it was oozing sores.
> Dean

At first glance, Candida in the men included in this study may seem like an instantiation of leaky male bodies. Candida is experienced, as indicated in these passages, as "an itchy ass", "diarrhea", "sweating", "strong BO", "dry mouth", "bad breath", "coating on gums and tongue", "hair loss", "brain fog", "memory dysfunction", "tinnitus", "jock itch", and "oozing sores". Not only are many of these symptoms overtly leaky (i.e. diarrhea, sweating), but many of these symptoms also arouse a sense of repulsion and/or contamination (i.e. an itchy ass, coating on gums and tongue and oozing sores). Despite the palpable leakiness and pollution of Candida on and in male bodies, it is my contention that Candida does not come to be intra-actively materialized as such. Akin to other male flows, the matter of yeast in these cases (regardless of leakiness and/or pollution) reproduces hegemonic masculine ideals of clean and contained male embodiments.

Grosz (1994) contends that while men have many of the same capacities to leak, seep, and ooze as women, it is "female corporealities that are [consistently] inscribed as a mode of seepage" (p. 203). When leaky male bodies do enter discursive representation, Grosz explains that they are either in reference to HIV/AIDS male bodies[32], or they are in reference to male ejaculation, which is rarely viewed in terms of its potential for messiness and/or pollution. Describing the solidification of men's seminal flows, Grosz (1994) argues that,

> [s]eminal fluid is understood primarily as what it makes, what it achieves, a causal agent and thus a thing, a solid: its fluidity, its potential seepage, the element in it that is uncontrollable, its spread, its formlessness, is

[32] As Waldby (1996) has argued HIV/AIDS male bodies become quickly reinscribed back into leaky feminized modes of corporeality through "a kind of homosexualization or feminization of the T cell and hence the whole immune system" (19).

> perpetually displaced in discourse onto its properties, its capacity to fertilize, to father, to produce an object. (p. 199)

The liquidities of sperm are effectively restored into something concrete, solid, and productive, regardless of the fact that men "waste" thousands of sperm *per* ejaculation, and regardless of the potential pollution of sperm as a carrier or STIs or STDs. Grosz's observations concerning the eventual solidity and productivity of men's seminal flows are indeed apt when considering the very definition of the word seminal, referring both (and simultaneously) to male sperm, and to that which contributes to the seeds of later development (*Seminal*, n.d.).

While Candida in the men included here does not render male bodies productive in the same way that male ejaculation can be seen to do, it does, nevertheless, render these bodies solid, contained, and perhaps most importantly, effectively distanced from the leaky corporealities normally attributed to women. Of the sixteen symptoms mentioned in the narrative passages included above, all but two of these symptoms are physical—physical in the sense that they tie to biological and not cognitive or emotional experiences. With the exception of Steve *no* emotional or cognitive symptoms were mentioned. The physicality of these symptoms in the case of Candida is significant because it renders Candida—an illness with no objective pathological traces—within physical, and thus more rationalized, terms. In an illness marked largely by a contentious etiological presence, as well as a wide range of possible symptoms, the physicality of men's symptoms come to occupy a space of rationality in contrast to the *i*rrationality and *un*containability we will see in the case of Candida in women.

The physicality of men's symptoms in the case Candida is further observable across wider medical literatures. In outlining the Candida-related symptoms for men, Crook (2003) outlines the following: digestive problems, intolerance to chemicals, skin problems, cravings for sweets and alcohol, prostatitis (inflammation of the prostate gland), respiratory problems, and impaired sex drive. Of these seven symptoms, *all* of them are physical, and conversely, none of them tie to mood, behaviour and/or cognitive dysfunctions. While the symptoms listed by Crook (digestive problems, intolerance to chemicals, skin problems etc.) as well as the ones mentioned by the men with whom I spoke (an itchy ass, fatigue, strong BO etc.) may not be understood as rational in any strict sense of the term, they are rational in the sense that they tie to the physical body. While historically it has been women's bodies that have been more commonly allied with biology, corporeality and nature than men's (Grosz, 1987), in the case of Candida, men's alignment with biology (through the near-exclusive physicality of men's symptoms) distances male bodies from the leaky corporealities we will see in the case of Candida in women.

Moreover, the men with whom I spoke not only experience fewer (and often no) emotional symptoms, but they also experience fewer symptoms overall. As Will asserts, "the *only* symptom that I can clearly identify [with Candida] is my itchy ass". He then goes on to question: "Am I more tired now than I was before? Am I more susceptible to stress? To depression? Probably. Why? Who knows"? Indicating that there may be more (notably non-physical) symptoms at work Will seems reluctant to attribute these symptoms to Candida. Similarly, one

men's health website states that in the case of Candida in men *sometimes there are no symptoms* (*Yeast infection in men*, n.d.). If we recall the seemingly endless list of possible Candida symptoms discussed in Chapter 2 and outlined in Appendix 2 (please see p. 220)—symptoms that range from headaches to insomnia, and/or from diarrhea to whining—the latter claim that men experience no symptoms is truly quite remarkable.

Having said this, I am not negating that men *may* experience more physical, and less overall, symptoms than women. What I am contending is that these illness experiences be understood in relation to already prevailing discourses concerning contained male corporealities. In a similar capacity as Grosz (1994), I question whether:

> [t]he reduction of men's body fluids to the by-products of pleasure and the raw materials of reproduction, along with men's refusal to acknowledge the effects of flows that move through various parts of the body, and from the inside out, have to do with men's attempt to distance themselves from the very kind of corporeality—uncontrollable, excessive, expansive, disruptive, irrational—they have attributed to women? (p. 200)

The issue in question is not that male bodies fail to leak. The issue in question is that when men's bodies do leak—when they escape the norms that attempt to contain them—their flows are distanced from associations with the uncontainability normally attributed to women; it is men's "liquidities that [they] seem to want to cast out of their own self-representations" (Grosz, 1994, p. 203).

In the case of Candida, and in the specific cases of the men with whom I spoke, I have argued that there is a separation of male bodies from the leaky, uncontained and feminized forms of corporeality normally attributed to women through a kind of rationalization of men's Candida symptoms. As I discuss briefly now, there is also an explicit dissociation of men with yeast.

Despite the fact that Candida is a yeast-related disorder, and despite the fact that men do get Candida, the word yeast is never linked to male bodies, or pertinently, to male genitalia. Detailed by the medical literates in Chapter 2, yeast overgrowth on male genitalia is rare; if yeast does manifest, it is often restricted to the head of the penis, and referred to as balanitis (*Yeast infection in men*, n.d.). While yeast can and does manifest in men at the head of the penis, the presence of balanitis does not appear to disrupt the stability of the clean, contained and bounded male body. Manifestations of yeast in men are removed from the depths of the male body. Yeast in the case of balanitis does not emerge from inside the male body, but rather appears as inflammation at the head of the penis, notably one of the male body's most distal points. The medicalized term balanitis, as opposed to the lay term "yeast", further distances any obvious (or concrete) associations of men with yeast. With its overtly scientific overtones, the term balanitis obscures the presence of yeast on male genitalia, and in doing so, serves to render clean, the normally dirty associations given to manifestations of yeast.

We can further see the distancing of men's bodies from associations with yeast through men's illness narratives. Steve effectively separates his experiences of Candida—experiences which are notably marked by a range of emotional and

cognitive symptoms (i.e. brain fog, depression, and nervous breakdown) from associations with leaky femininity by the opening statement of his narrative: “here is a man’s story”. If associations with (leaky) femininity were not already implied in the case of Candida, Steve would not have to proclaim his story as “a man’s story”. By counterposing his story against those of women, Steve not only distances his symptoms, but also by extension his body (because that is where the symptoms are experienced), from associations with leaky (presumed feminine) modes of embodiment. Also distancing his body (and specifically, his itchy ass) from associations with femininity is Will, who states:

> [d]o I think about myself as someone who has Candida? If you specifically asked me, I would say yes, but I don’t think about it in that way most of the time. I think about it as this is the problem and the problem is the symptom. And it doesn’t have another name other than itchy ass syndrome. As long as that’s under control more or less then it’s sort of a non-issue. I don’t have to worry about where [Candida] stands within the medical field or anything. I would be happy to skirt the whole medical profession on this right now, because it’s something that I don’t think is going to be very helpful for me and there is a lot of stigma around it.

Will’s aversion to associations with the feminization of Candida (and to the delegitmization often experienced by women by biomedical practice) can be understood both by his unwillingness to name his illness (and see it beyond his

singular symptom) and his outright avoidance of the medical profession for fear that he too will be labeled in stigmatized (read: leaky feminized) terms.

The dissociation of Steve and Will with the leakiness normally attributed to women is paralleled across other cases of corporeal flows. In a recent study examining men's attitudes towards bodily flows, Longhurst (2001) notes, quite poignantly, how one of her male participants referred to his penis using the pronoun "she" after his penis lost control while urinating standing up. As John states: "I was pissing away, you know, I'd had a couple of drinks and then, and yeah, *she* started squirting off to the side" (quoted in Longhurst, 2001, p. 82, emphasis in original). Longhurst herself appropriately summarizes that "the urinating penis that fails to control its own flow is feminised" (p. 82). This example is pertinent both for the seemingly automatic association John makes between leakiness and femininity (even when it was his own body that was polluting), and for the ways in which John's male body is distanced from leakiness, lack of containment and lack of control. As Longhurst notes, discourses of "solidity and rationality become linked to masculinity" despite the presence of leakiness (p. 31). The omissions of male corporealities that do leak, combined with the consistent and familiar representations of leaky female bodies, enable (heterosexual, white, monogamous) men "to retain their position as rational and untainted by the messiness of corporeal flows" (Longhurst, 2001, p. 67).

In the examples detailed thus far, the case of Candida in men further reinscribes already familiar discourses concerning clean and contained rationalized male bodies. Despite men having systemic yeast overgrowth, men's

bodies in the case of Candida are not rendered leaky or uncontained. The permeability of male bodies is disguised by the rationalization of men's symptoms, and by the distancing of yeast from associations with male bodies, and male genitalia. While Grosz (1994) never specifically mentions the case of yeast, Candida in the men with whom I spoke can be understood as once again reducing male fluids "to the solid" (p. 199). Of further interest is the way in which contained male corporealities come to mark the constitutive norm from which women's bodies come to be pathologized as messy, abhorrent, and, to borrow Grosz's (1994) term, *volatile*. It is to this volatility that I now turn.

Leaky Female Corporealities

> I had to pee all the time. I had to be near a toilet at all times.
> Amy

> The lack of control over my bowels was the most obvious symptom for me. I could be in my kitchen getting dinner ready and get the urge to go to the loo and I would run to my bathroom next door and not get there in time, whereas two minutes earlier I had no inclination that I was going to need to go.
> Diana

> It feels like my insides are imploding. It feels like everything inside me is just caving in, that everything inside me is completely disintegrating.
> Meena

> For years, nothing stayed inside me. Food went in and came out, because I was so full of the Candida.
> Aurora

> Candida leaks.
> Ann

In contrast to male seminal flows, Grosz contends that women's menstrual flows reveal markedly different material-discursive connotations. Menstrual blood

is rarely valued for its reproductive, potentially life-forming, capabilities; it is, instead, always already tied to a woman's hormonal cycle, and, as such, reinforces female bodies as "excessive, expansive, disruptive and irrational" (Grosz, 1994, p. 200). Seminal fluids materialize through male bodies as clean, contained, productive and rational, while menstrual flows materialize through female bodies as excessive *and* lacking. To borrow from Grosz (1994),

> [t]he female body has been constructed not only as a lack or absence but with more complexity, as a leaking, uncontrollable, seeping liquid; as formless flow; as viscosity, entrapping, secreting; as lacking not so much or simply the phallus, but self-containment (p. 203).

Given the assumptions concerning the viscosity of menstruation, women both fail and exceed hegemonic masculine ideals that bodily fluids be harboured inside the body.

Female bodies in reference to the women who participated in my study can also be understood as excessive and lacking—they are excessive in terms of their symptoms, and lacking in terms of their containment and control. As detailed in the above epigraph, many of the women with whom I spoke describe Candida in overtly leaky terms. Denoting the formlessness to which Grosz speaks, when asked to describe her experiences with Candida Meena responded that "everything inside [her] is just caving in" and that "everything inside [her] is completely disintegrating". In similarly porous terms, Aurora also conveys how "for years nothing stayed inside [her]. Food went in and came out, because [she] was so full of the Candida". And, in further terms of uncontainability is Amy,

who state quite plainly that she "had to pee all the time", and Diana, who, despite having a bathroom in the next room, would sometimes "not get there in time". In contrast to the manifestations of Candida in men discussed above, Candida in women (in these instantiations) is not concrete. Seeping and oozing (often unpredictably) from the leaky feminized body, Candida is aptly summed up by one of the women I interviewed as that which "leaks" (Ann).

Candida's overall leakiness and lack of containment in the women with whom I spoke can be further understood as excessive when considering the number of symptoms many of them associate with its overgrowth. Once again in contrast to the discussions of Candida in men, Candida in the women included in my study is not singular, nor is it rational. When asked to describe any symptoms she had experienced, one of the women who sent me her story electronically, included the following:

> Where do I start? Thrush – both oral and vaginal, premenstrual tension, painful, heavy and irregular periods, breast tenderness, lack of sexual urges, eczema, bruising, athletes foot, psoriasis, dandruff, sore throat, inhalant allergies, food allergies, fatigue, lack of concentration, irritable bowel, diarrhea, constipation, bloating, abdominal pain, flatulence, bad breath, brittle nails, dry eyes, sore tongue, headaches, eczema inside ears, discharge from ears, catarrh, palpitations, insomnia, waking tired, mood swings, crying, self- pity, irritability, poor memory, feeling drained, occasional anemia, trouble focusing, aching joints and muscles, hot and cold flashes, mouth ulcers, hypoglycemia, temper flare ups, thinning of

> hair on scalp and eye brows, sinusitis, apathy, fuzzy brain, [and] no energy for exercise. (Trish)

Listing 52 symptoms total, Trish goes on to say that "there are probably more but I can't remember them all". While many of Trish's symptoms are physical (i.e. thrush, diarrhea, psoriasis, and hair thinning), they are neither rational nor contained. Based on the sheer extent of Trish's symptoms, her physical symptoms read as excessive and disproportionate for a singular etiological cause. They are moreover rendered uncontained because they are paired alongside a wide range of emotional and cognitive symptoms (apathy, temper flare-ups, mood swings, crying, self-pity, and irritability).

Wider medical literatures also point to the excessiveness and uncontainability of Candida in women. In contrast to the purely physical symptoms in men discussed by Crook (2003), he articulates the following Candida-related symptoms for women: premenstrual syndrome (PMS), menstrual irregularities, vaginal problems, skin problems, abdominal pain, loss of sexual feeling, infertility, fatigue, headache, depression, irritability, uncoordination, being "spaced out", and poor memory. In contrast to the Candida symptoms experienced by men, six of these symptoms (i.e. PMS, fatigue, depression, irritability, being "spaced out", and poor memory) are either emotional and/or cognitive, and of the remaining eight, five of these symptoms tie to sex organs and sexual dysfunction (i.e. menstrual irregularities, loss of sexual feeling, which in men in was referred to as impaired sexual function, vaginal problems, and infertility). PMS is the suspected cause of Candida (i.e. because of the production

of progesterone) and one of its symptoms—it is paradoxically the root and symptomatic manifestation of Candida. Unlike Candida in men, where "there is never the superimposed progesterone factor" (Truss, 1983, p. 55), the seemingly ever-present progesterone factor at work in women further sediments the irrationality, unpredictability and uncontainability of female bodies.

Despite the presence of many physical symptoms of Candida in women, it does not come to be materialized (or experienced) in hegemonically masculine terms. It is neither concrete nor contained. Moreover, as I now discuss, it is through Candida's pervasiveness in women—its overall lack of containment, control and moderation—that Candida comes to reinscribe female bodies as dirty, dangerous and threatening. When bodies leak or seep, pus or bleed, allowing or forcing the inside out, their effects are often one of "disturbance" (Turner, 2003, p. 1), and/or of "horror" (Cone and Martin, 2003, p. 330). In Shildrick's (2002) words, "any substance that crosses corporeal boundaries is a significant focus of cultural anxiety and regulation because it is seen as a vehicle of contamination and infection" (p. 81-82). While the lack of bodily containment often immediately connotes the contagious dangers of fluidities, as both Grosz (1994), and Shildrick (2002), importantly remind us, "the notion of threat is rarely gender-neutral" (Shildrick, 2002, p. 75).

While yeast is rarely, if ever, ascribed to male bodies or to male genitalia, it is commonly ascribed both to female bodies, and to female genitalia. To recall from Chapter 2, "the health problems of women are often *yeast*-connected" (Crook, 1986, p. 173), "females develop *yeast* connected health problems more

often than males or children" (Crook, 2003, p. 190), and "women are more susceptible to *yeast*-related illnesses" (Adams, 1985, p. 10). Notice in these passages the conflation between the word yeast and the systemic overgrowth of Candida. Not only is the word yeast explicitly linked to women, but it is also often explicitly linked to women's anatomy. As argued throughout the wider biomedical and CAM literatures, women are particularly susceptible to yeast overgrowth because the vagina is an ideal breeding ground for yeasts to proliferate (Crook, 2003; Wallace, 2004). Unlike the medicalized (and sanitized) term of balanitis used to describe yeast at the head of the penis, pathogenic yeasts are often unabashedly linked to women, and to vaginas. Yeast is feminized not only because it lacks containment and control, but because it emerges alongside already dominant and prevailing discourses that posit women's vaginas as sites of infection and contamination.

Locating the discourses of menstruation primarily in relation to the consumption demands of capitalism, Shail (2007) notes that menstruation has not always been regarded as "impure or excess matter" (p. 78). He notes that conceptualizations of menstruation as leaky and dirty developed alongside two closely-related discourses: the creation of a two-sexed system in Western medical thought and Western notions of hygiene. Prior to the emergence of a two-sexed system in medical thought, menstruation was conceived as an "*active preparation* […] of specific substances, by organs or tissues specifically endowed for that purpose" (Stolberg, 2005, quoted in Shail, 2007, p. 77 – 78, emphasis added). In similar terms to Grosz's analysis of semen, menstruation, according to early

conceptualizations was deemed productive and rational: it had purpose, and was understood to form something concrete. However, as the two-sex system began to take shape in the second half of the eighteenth century, so did the "sexed spheres of corporeal activity" (Shail, 2007, p. 78). According to Shail, menstruation played a vital role not only in demarcating women's bodies from men's (despite the fact that not all women bleed), but also in putting forth the assumption that women's bodies are inherently leakier than men's. Framed as a problem of hygiene, menstruation became conceptualized as that which needed "dealing with" (Shail, 2007, p. 81), or, in other words, as that which needed to be cleansed and contained.

In an attempt to propel the production and consumption of disposable sanitary towels, Kotex (1926) helped synergize the newly-formed associations between seepage and hygiene by marketing menstruation as "women's oldest hygienic problem" (quoted in Shail, 2007, p. 79). Eighty some-odd-years after this advertising campaign, Kotex continues to gender discharge as exclusively female. In 1996, they launched the emergence of the everyday panty-liner for everyday discharge, marketed "for freshness throughout the month" (Kotex, 1996, quoted in Shail, 2007, p. 91). The implication of the everyday liner is not to contain the flow of menstruation, for this does not (for most women) happen *throughout* the month. The implication of the everyday liner is rather to contain the flow of other vaginal discharges (of which yeast is likely a part). As Shail (2007) remarks, this particular advertising campaign further naturalizes "the exclusivity of female flows and the associated idea of a female-only waste-

producing bodily activity" (p. 91). Important for Shail, for Grosz, as well as for my purposes in this chapter, is that leaky (and thus presumed dirty) female bodies do not simply exist prior to signifying systems, but rather, that they come to exist *as* leaky (and presumably dirty) *by* signifying systems.

In her study of asymptomatic shedding of genital herpes[33], Pliskin (1995) revisits the threat of the vagina dentata—a metaphoric mouth with "teeth ready to bite off or castrate the penis" (p. 490). Much like my arguments towards the intra-active materializations of Candida, Pliskin argues that "the problem of asymptomatic shedding of genital herpes among women is not simply a physiological phenomenon" (p. 484). The gendered assumptions of asymptomatic shedding, for Pliskin (1995), need to be understood as "a selective rendering of nature" (Hubbard, 1990, quoted in Pliskin, 1995, p. 480). Working against the dominant misconception that women are the primary shedders of genital herpes, Pliskin teases out the gendered assumptions at work in these medical claims.

While there have been no published studies to date on heterosexual men (thereby rendering it difficult, if not impossible, to garner any statistics linking asymptomatic shedding to men), there have been partner-to-partner transmission studies. These partner-to-partner studies reveal that asymptomatic shedding is *equal* among men and women (indicating that men can pass it to women just as easily as women can pass it to men). Significant for Pliskin (1995), however, are the differences outlined as to *why* men and women unknowingly transmit genital

[33] Asymptomatic shedding refers to "an infected person shedding the virus without having any of the signs or symptoms associated with herpes. Because of the lack of symptoms, or the failure to recognize that the signs and symptoms one does have are those of herpes, the infected person is not cognizant that he or she is infectious and could thus transmit herpes to others" (Pliskin, 1995, p. 481).

herpes. Detailed by the medical doctors and health care professionals interviewed in Pliskin's (1995) research, men transmit herpes because of their promiscuous and inattentive sexual behaviours, while women transmit herpes because of their anatomy. "Tucked away in the vaginal vault", asymptomatic herpes in women remains hidden and undetected (Pliskin, 1995, p. 486). In contrast to men, where asymptomatic transmission is based on something men *do*, asymptomatic shedding in women is assumed to be part and parcel of who women *are*, emerging deep from within a woman's body.

The threat of the disease-ridden vagina dentata is not only common in Pliskin's (1995) study of asymptomatic herpes. Gilman (1988) has similarly shown that the vagina is also blamed in the case of venereal disease for many of the same reasons outlined by Pliskin (1995). Furthermore, in the case of HIV/AIDS, despite women being more commonly infected by men, Waldby (1996) notes that it is women who are most often targeted in safe-sex campaigns. Grosz (1994) is indeed correct when she states that while "there are beliefs that each sex is a danger to the other through contact with sexual fluids", only one sex tends to be "endangered by contact with the other, usually males from females" (p. 193). The same is observable in the case of Candida. Despite Candida affecting both men and women, it is women who are usually blamed for its transmission.

One of the men with whom I spoke states that he "suspects that [his] initial yeast exposure was most likely sexual in origin" (Dean). Without knowing Dean's sexual orientation, or the specific sexual practices involved, the inference (given

what we already know concerning the threat of leaky female bodies) is that Dean contracted his Candida from a female partner, via sexual intercourse. If this speculation is indeed correct, then it is noteworthy to point out that Dean does not attribute *his* yeast overgrowth to one of the other many possible factors—diets rich in sugars and/or carbohydrates, repeated use of antibiotic and/or corticoid-steroids use, or as the result of suppressed immune functioning. Reinscribing dominant discourses concerning leaky, dirty and dangerous female flows, Dean relegates *his* yeast overgrowth to a woman, and most notably, to her vagina. In framing the reasons for his illness, Dean's systemic yeast overgrowth is not internal to himself—it does not emerge from within his own body—but is rather (once again) associated with the presumed infectious dangers of women's leaky corporealities.

In the case of Candida, much like the cases of asymptomatic genital herpes, HIV/AIDS, and venereal disease, we can see how "the [constructed] horror of femininity is linked to the voraciousness and indeterminacy of the vagina dentata" (Longhurst, 2001, p. 31), as well as to the voraciousness and indeterminacy of leaky female bodies more broadly. Like Shildrick (2002), I have considered "what if the question of contagion, of contamination, were found to reside not only in the supposed materialities of bodies, but in the structure of discourse itself" (p. 78)? The leaky feminized case of Candida can be understood not solely in relationship to its physical manifestations, but also in reference to the leaky and contained gendered embodiments in and through which these symptoms come to be intra-actively materialized. It is through the leaky feminized contagion

that female bodies are reinscribed not only as a mode of seepage (i.e. to recall Grosz's claim), but in its seeping viscosity, and in its failure to be contained in women, Candida also emerges as a feminized threat.

Summary

While feminists of the body have long been concerned with the expulsion and retention of bodily flows (namely of sexualized flows), they have curiously neglected to examine the case of yeast. Despite Candida yeasts existing in all human digestive floras, their systemic, uncontrolled and uncontained overgrowths are overwhelmingly feminized. Through an analysis of the yeast-related manifestations of Candida, it has been my contention that yeast is akin to other corporeal flows in that it reproduces the threat of leaky, dirty and dangerous female bodies, while simultaneously upholding male bodies as clean, contained, rationalized, and, as a result, less threatening. Materializing alongside already dominant discourses of semen, when Candida does materialize on and in male bodies, it is often effectively removed from associations with leaky, porous, uncontained and unbridled forms of feminized corporealities. Materializing alongside already dominant discourses of menstruation, as well as the related threats of the vagina dentata, discourses of yeast in women are neither clean, nor contained. The feminized case of yeast can be understood, therefore, not only as a *symptom* of Candida, but critically also as *symptomatic* of wider gendered and gendering relations.

By conceptualizing the materializations of Candida outside the material effects of the illness alone, my aim has not been to essentialize the leakiness and containedness of respectively female and male bodies. Rather than assuming that gender is something that interacts with already existing bodies that have Candida, I have argued for the ways in which leaky and contained gendered discourses can be understood as intra-active and ongoing materializations of Candidad-bodies. My aim has been precisely instead to untangle the intra-active materializations of these seeming essentialities. Using the new materialisms of Butler (1993), Grosz (1994) and Barad (2007) to move beyond problematic dualisms of nature, culture, matter and discourse, I have argued for the ways in male and female corporealities in the case of Candida come to be intra-actively materialized (and experienced) as leaky and contained.

I am not negating that men and women can and do experience Candida differently; I am, however, questioning *how* these leaky and contained gendered embodiments come to be produced within and through already existing gendered and gendering relations. As feminist poststructural body theorizings have insistently and consistently contended, "bodies themselves, in their materialities are never self-present, given things" (Grosz, 1994, p. 209). In Reuter's (2002) words: "a body is never just a body, but a body with normative meaning – the outcome of power relations" (p. 763). The illness experiences and medical understandings of the feminized case of Candida (and of yeast) are therefore inextricable from the constitutive effects of gender; they materialize at once, and simultaneously. While recognizing the material effects of Candida (and of

gender), I also recognize that there is also "no absolute outside, no ontological 'thereness' that exceeds or counters the boundaries of discourse" (Butler, 1993, p. 9). The feminized case of Candida does not, and cannot, pre-exist medical pathology; it is not found to reside inherently in the materialities of the female body, but can be found to reside in the very pathologies in and through which its feminized status comes to materialize.

Instead of arguing that male bodies do leak, I have sided instead with Shildrick (1997) in her assertion that "a feminist-inspired ethic must do more than simply extend the scope of morality" (p. 2). As other chronic undefined disorders, such as Fibromyalgia, also emerge in overly (and overtly) feminized conceptualizations, I think the more productive questioning lies in examining the gendered structures of power and knowledge at work in these medical claims. As Shildrick (2002) rightly argues, "the issue is not one of revaluing differently [here leaky] embodied others, but of rethinking the nature of embodiment itself" (p. 2). The issue is also to conceptualize illness beyond simply biological contexts. To borrow from Reuter (2007): "the body is not merely where a disease happens but also the material-discursive instantiation of disease and cultural categories" (Reuter, 2007, p. 170). Guided by these critical frames, the feminized yeast-related case of Candida enables a rethinking of the "nature" of leaky and contained gendered embodiments, and in doing so, (hopefully) also enables a rethinking of Candida beyond essentialized and inherently feminized terms.

Moving away from gendered and gendering materializations of power, I turn in the following chapter to a discussion of regulatory power. Taking up

Foucault's reconceptualization of power as an active productive force of the body, I argue that diet and food in the case of Candida can be understood *both* as a means of disciplinary tactic (i.e. as a disciplinary strategy to reduce the overgrowth of Candida-yeasts), as well as a means in and through which to pursue personal acts of freedom, and to foster a more enlightened sense of self.

Ch. 5

Taming Uncertainty:
Food, Discipline and the Care of the Self

My life is not my own. It is controlled by food. Everywhere I go food is an issue.
Trish

You've opened Pandora's Box.
Janine

Food occupies many curious paradoxes within contemporary western culture. It is both the everyday and the ceremonial; the public and the private; a need as well as an indulgence. Food is not only the fodder that keeps us alive, but also something that can make us sick. Despite the many inconsistencies of food and eating in an age of both sheer excess, and sheer lack, one fact about food remains unfaltering: "food practices […] are far more complex than a simple nutritional or biological perspective would allow" (Lupton, 1996, p. 7). Food is more than the simple sum total of its caloric properties; it is often a key ingredient in the gender, race and class inequalities that comprise its global production and consumption practices, as well as a feature item on the menu of other contemporary social issues: dieting, body image, animal rights, and international trade. If we dig a little further in the food pantry, as Probyn (2000) urges us to do, we also see that food and eating are deeply connected to the seemingly unrelated topics of "love, sex, relationships, family, economics, comfort, obsession, pleasure, control, desire, shame, disgust, fear, hatred, work, [and] leisure" (p. 1). But of the many, and at-times unsuspecting, roles that food plays in contemporary

western culture, none, arguably, is more dominant than the associations of food with health and illness.

Warnings and admonitions, Coveney (2000) notes, "constantly alert us to the fact that we could be digging our own graves with our knives and forks" (p. vii – viii). Foods high in cholesterol, fats, salts, additives, and preservatives have been linked to "cardiovascular disease, some cancers, osteoporosis, diabetes, dental decay, elevated blood pressure, gall bladder disease, and bowel conditions" (Lupton, 1996, p. 74). On top of life-threatening conditions, "unhealthy" diet choices have also been linked to behavioural and mood disorders such as depression, attention deficit and hyperactivity syndromes (Balfe, 2007), and most recently to cases of chronic undefined disorders including Fibromyalgia, Celiac Disease, Chronic Fatigue Syndrome, Crohn's Disease, Irritable Bowel Syndrome, and, centrally here, Candida.

As we detailed in Chapter 2, for those who credit the Candida-yeast hypothesis, the overgrowth of Candida is strongly linked to the overconsumption of "yeast-producing foods"[34]—namely wheat, yeast and sugar, but also other food rogues including dairy, alcohol, vinegars, dried fruit, caffeine, cured meat, non-organic produce, unfiltered water and even fruits too high in concentrated sugars. The many excesses of western diet—too many sweets, too many refined sugars, too many carbohydrates, and too many processed foods—are vilified yet again in relation to the occurrence of Candida. While food habits are not the only

[34] There is still significant skepticism within biomedical communities as to the possibility that foods can cause yeast overgrowth. However, for those biomedical and alternative health practitioners who credit the Candida-yeast hypothesis, food is a major culprit in the chronic overgrowth of Candida.

suspected cause of Candida—antibiotics, steroids, immunosuppressant medications, and birth control pills are also blamed, alongside a whole host of possible personal and environmental factors (i.e. stress, trauma, mold, and allergies)—food habits are one of the predominant means in and through which Candida overgrowth is controlled. Despite never specifically asking about food, it is not surprising, therefore, that references to food figured quite strongly across the narratives of the people with whom I interviewed[35]. Rife with meticulous details concerning what people eat on a day-to-day basis, the kinds of food they avoid, and the often diligent processes in and through which their food is prepared, the question of food in the case of Candida is persistent. As one of the women with whom I spoke jokingly conveys, to question the role of food in the case of Candida is akin to opening "Pandora's Box" (Janine). Despite being in jest, Janine's metaphor is spot on as it connotes at the colloquial level that which is more complicated than one might initially assume, and at the formal Greek mythological level that which also contains hope[36].

Notoriously entwined with the narratives concerning food are equally recurring tropes of frustration, fear, hope, and loss—frustrations concerning the rigidity of the diet, fears about going hungry or not being able to eat the "right" kind of foods, hope that the diet is helping, and the loss of not being able to eat once-pleasurable foods. Conveying some of this poignancy, as well as harkening

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[35] Issues concerning food were most commonly raised in response to the question: "What does Candida mean for your daily life"? For a full list of interview questions please see Appendix 1 (p. 218).

[36] According to Fritz (1993), Pandora opened the jar out of curiosity that was said to release all the evils of mankind into the world. However, after she re-sealed the jar, what remained inside was hope.

back to the theme of possession I discussed in Chapter 3, is Trish, who states: "My life is not my own. It is controlled by food. Everywhere I go food is an issue". It was responses such as these, alongside those rigorous in detail that led me to question in much the same way as Chernin (1985) (despite the 25-year gap between her query and mine): "why the obsession with food and why now" (p. ix)? What is it about food in the case of Candida that renders it so focal to many of the people with whom I spoke? What are the discourses rendering food both a source of great anxiety *and* a source of unyielding hope for Candida sufferers? And, in what ways, and to what ends, is food being *used* by Candidad-bodies?

To question the focal role of food in the case of Candida I trace the discourses of nutritional science that position food both as a pathogen and as a cure. A brief exploration into these discursive frames yields overtly moral inflections concerning health and self-discipline. Next, drawing on Foucault's theories of docility, I argue that the discourses of nutritional science are not passively inscribed onto Candidad-bodies, but rather actively used by Candidad-bodies as a means in and through which to rid/minimize the overgrowth of Candida yeasts. As Foucault (1977) contends, theories of docility—and the disciplinary regimes in and through which docility comes to be enacted—are useful in exploring the ways in which power can be a productive force of embodied corporealities. I further take up Foucault's (1985) later work, and namely his claim that disciplinary practices should be understood as an ethical practice in the care of the self. Following Heyes' (2007) assertion that "the work of Foucauldian feminists on dieting […] would be more complete if it mirrored

the phases of Foucault's own oeuvre, showing how not only technologies of power but also technologies of the self are engaged in complex interplay" (p. 79), I too insist that the regulation of diet in the case of Candida is more than the seeming practices of docility. Diet in the case of Candida can also be understood as a practice that creates and cultivates a personal sense of freedom, autonomy, and self-care. With Probyn's (2000) alliteration of the "the cultural, the culinary and the corporeal" (p. 4), I dig in to the often paradoxical—yet undeniably central—roles that food plays in the lives of the people with whom I spoke.

Food as Pathogen/Food as Cure

> I see Candida as my punishment for eating too many sweets as a child, and a punishment for having been caught up in that cycle of starving and overeating in my early twenties.
> Janet

> The only way to kill Candida is to starve it first.
> Trish

> I am on a 95% raw vegan diet.
> Steve

> That's what a cleanse is…bringing stuff out of your system.
> Star

> I felt absolutely awful and it was wonderful because I thought: "it's really kicking in now; it's really killing off the fungus".
> Diana

The idea that food can cure illness is not new; food has long been used as a means of battling disease. Under the Hippocratic medical model, the then-understood properties of food—hot, cold, wet and dry—were used to regulate illnesses caused by the deficiencies and excesses in phlegm, black bile, yellow

bile and blood (Lupton, 1996, p. 69). While traces of medieval medical philosophy remain—many people, for instance, still treat the common cold with hot soup—it is nutritional science discourses that now largely dictate the ways in which food is understood both as a pathogen, and as a cure.

Lupton (1996) documents that "by the mid-nineteenth century scientists were separating food into their constituent parts of protein, carbohydrates, fats, minerals and water, and assigning specific physiological function to each nutrient" (p. 70). Scientists were concerned not only with the nutritional and chemical elements of foods, but, pertinently, also with the effects of these nutritional and chemical elements on the human body. Food was no longer understood in terms of its descriptive—hot, cold, wet, dry—characteristics, but rather entirely by its physiological properties, and critically, with the ways in which these physiological properties could interact with the human body. "Precisely quantifiable through the statistical truths of mathematics" (Turner, 1982, p. 258), diet for the first time in history was rational. Emerging alongside Enlightenment-inspired understandings of the human body, these rationalized conceptualizations of food are evident in the creation of the discipline of nutrition—a discipline based on the assumption that foods have measurable effects on the human body. The very definition of the word "nutrition" means to nourish, to promote growth, to furnish and/or to sustain (*Nutrition*, n.d.). Given the rationalization of diet that emerged alongside its effect on the human body, it was not only diet that was assumed to be quantifiable.

The human body likewise became seen in increasingly mechanical terms: as the perfunctory receptor of food's fuel, and as a "complex system of pipes, pumps and canals [that] can only be satisfactorily maintained by the correct input of food and liquid, appropriate exercise and careful evacuation" (Turner, 1982, p. 260). The rationalization of diet gave way to the corollary rationalization of the human body, and in doing so, merged the "optimal" functioning of the human body with the "optimal" intake of scientifically calculated consumptions of food. It was in and through the discourses of nutritional science that human bodies became "the objects of nutrition"—quantifiable, measurable, mechanic, and malleable in and through the metabolic properties of nutrition (Coveney, 2000, p. 28). Because biomedical science situates the problem of disease in the deep anatomical structures of the human body (as detailed in Chapter 3), the human body alongside the discourses of nutritional science became "a causal space" (Crawford, 1980, p. 371). Under the newly-found nutritional and mechanical configurations between bodies and food, Crawford (1980) points out how "individual behaviors, attitudes and emotions became the preoccupation with personal health, and the primary focus for the […] achievement of well-being" (p. 368). One hundred years (give or take) after the discourses of nutrition took shape they remain alive and well in the dietary case of Candida.

Despite being largely promoted by complementary and alternative health practitioners, the underlying assumptions of the Candida diet are heavily encumbered with nutritional scientific discourses—discourses, which as Crawford (1980) states, foster "a depoliticization and undermining of the social factors

contributing to disease" (p. 368). The onus of the Candida diet is focused entirely at the level of the individual. It is not, for instance, focused on the national food standards that might reduce the amount of refined sugars, or antibiotics, present in many of the foods we consume. Implicit in the attempt to rid the body's overgrowth of Candida (and encourage the growth of friendly yeast-fighting bacteria instead) is the nutritional scientific trope that the avoidance of the "wrong" kind of foods and the consumption of the "right" kinds of foods will lead to the desired effects on the human body. To exorcise Candida from the human body, it is premised on the scientific ideal that the consumption of "pure" and "healthy" foods will cleanse and detoxify the yeast-ridden body. Echoing such individualistic pursuits is Trish, who states that "the only way to kill Candida is to starve it first". Star similarly explains that "that's what a cleanse is…bringing stuff out of your system". Even when the consumption of healthy food does not immediately provide relief for the Candidad-body, the underlying assumption is that the diet is functioning as it should. As Diana notes, "I felt absolutely awful and it was wonderful because I thought: it's really kicking in now; it's really killing off the fungus'".

According to the rationalizations put forth by the discourses of nutritional science, the "healthiest", most "appropriate" way to eat, as Turner (1982) points out, entails a symbolic "return to nature", consuming foods that are raw, clean, unpreserved and unprocessed (p. 263). In the case of the Candida diet, it is without doubt the most "natural" foods that are being sought and consumed—foods free of yeast, refined sugars, refined starches, anything fermented, anything

with alcohol, anything processed, packaged, pre-cooked or laced with preservatives. In Steve's case, he is on a "95% raw vegan diet". Food cannot, arguably, get much "purer" than this. While I am not negating that foods can have physiological effects on the human body, I am also wary of taking these scientific formulas—formulas that over-simplistically posit "healthy" food with a "healthy" body—at face value. Because "moral meanings are regularly embedded within foods", when we consume foods, "their [moral] meanings are also transferred" (Lupton, 1996, p. 141). The consumption of "healthy" food in the case of Candida is not solely about avoiding yeast-producing foods, but also critically about biting into the dominant discourses which impute "healthy" foods with an "ability to restore purity and wholesomeness" (Lupton, 1996, p. 89).

Although wrapped in the apparently neutral discourses of science, the language of nutrition—even in its most banal expressions—draws heavily on "moral sub-texts around bodily discipline and the importance of self-control" (Lupton, 1996, p. 74). Food is not only often tactlessly divided between "good" and "bad", but is often also undiplomatically predicated between "punishment" and "reward". When debating, for instance, whether or not we *should* (a word in itself with moral intonation) indulge in the simple sweetness of a candy bar, or the salty crispiness of a plate of French fries, we may say to ourselves: "I *deserve* that candy bar because I have eaten *well* today", or conversely, "I *don't deserve* those fries because I have eaten *poorly* today". We may also link our overall health (or lack of overall heath) to years of "healthy" and/or "unhealthy" food choices. These narrative tropes are also at work in the case of Candida. As indicated by

one of the women with whom I spoke, “I see Candida as my punishment for eating too many sweets as a child, and a punishment for having been caught up in that cycle of starving and overeating in my early twenties” (Janet). Coveney (2000) sums it best when he states that “the combinations of science and moral conduct are never so apparent as they are in nutrition” (p. 28). Part science, part commercial, part salvation, the rhetoric of nutrition is outwardly moral: if we discipline ourselves today, we will be rewarded with good health tomorrow. This is quite simply not always, or even often, the case.

While the idea of “good” food used to be about “tasty, rich dishes, it now connotes something much different” (Coveney, 2000, p. 2). “Good” food has become an indicator of self-control and of a concern for one’s health, while “bad” food has become indicative of a lack of concern for one’s health, as well as a sign of moral weakness and/or decay. As healthy food’s temptress opposite, “unhealthy” food has become one of the most sinister of weapons: easy to bite into, yet hard to digest. Heyes (2007) contends that within popular dietary discourse, the conflations between weight and health have become so commonplace that being “‘overweight has become [synonymous] for being ‘unhealthy’” (p. 68). Despite the many contradictions—and falsities—of the conflations between weight and health, overweight bodies consistently represent “gluttony, lack of self-discipline, hedonism, [and] self-indulgence”, while slim bodies on the other end of the moral spectrum reveal “a high level of control and ability to transcend the desire of the flesh” (Lupton, 1996, p. 16). It is indeed within this moralistic logic that anorexic bodies are often deemed to possess the

highest degrees of self-control because of their persistent ability to refuse the desires of their own hunger (Bordo, 1993).

An examination into the discourses of food as pathogen/cure reveals that these discourses are guided not by the supposed virtues of science and morality, but critically, by the supposed virtues of science *as* morality; "science has come to form the basis of our moral judgments" (Coveney, 2000, p. viii). Turner (1982) likewise maintains that "contemporary anxieties about eating and dieting, slimming and anorexia, eating and allergy are part of the extension of rational calculation over the body and the employment of science in the apparatus of social control" (p. 267). Despite the conflations between science and morality in the production and circulation of the discourses of nutritional science, I argue that these discourses are not passively inscribed onto Candidad-bodies. Drawing on Foucault's (1977) notions of disciplinary power, I argue that the discourses of nutritional science are rather actively used by Candidad-bodies to produce a notion of self that can be contained and controlled, and in Foucault's terms, rendered "docile". "It is precisely this moral imperative which is encoded into nutrition", Coveney (2000) reminds us, that makes the regulation of food "so compelling, so engaging and so strangely popular" (p. viii).

Diet as Disciplinary Regime

> I avoid caffeine, all sugars—cane sugars, honey, maple syrup, refined sugars—any kind of alcohol. No beer, no barley, no malt, no yeast, no wine. No oranges, no tomatoes, no dried fruit because of the yeast. No beef. No pork.
>
> Meena

I kept diaries of my food intakes.
Rosemary

I have to check everything I consume.
Martha

I don't eat a lot of sugar, but I have to watch even the minutest amount.
Rosemary

I don't eat sugar, wheat or cow's milk. Or anything yeasty or fungal. I try and stay away from mushrooms or anything fermented. I don't eat any processed foods. I make everything from scratch.
Amy

As a way into the topic of docile bodies, Foucault (1977) describes the body of a soldier. He begins with the obvious with the way in which the soldier's body is "the blazon of his strength and valour" (p. 135). But then Foucault (1977) goes on to detail something much more unassuming: "a calculated restraint [that] runs slowly through each part of the [soldier's] body, mastering it, making it pliable [and] turning silently into the automatism of habit" (p. 135). The ways in which disciplinary power operates through bodies as an active, productive force is critical to Foucault's notion of docility. A docile body is a body that "may be subjected, used, transformed and improved" (Foucault, 1977, p. 136). Reconceptualizing power from the passive, unidirectional grip of Marxist configurations (discussed in Chapter 1), Foucault (1977) contends that power is never simply inscribed *onto* bodies, but is rather critically *used by* bodies through disciplinary practices. Discipline, in other words, is one way power comes to be exercised.

As indicated in the narrative passages included above, Candida diets often involve the strict self-regulation of food. In the words of the people with whom I

spoke their dietary regulations involved: “avoiding”, “minimizing”, and “keeping track” of food intakes. Describing her food restrictions in noteworthy detail, Sue explains:

> For breakfast I have oats with pumpkin, sesame, sunflower and flax seeds, and I have that with filtered water. Everyone goes “yuck” when I say that, but I have gotten used to it. Sometimes at the end of the summer when I’m feeling really well, I might put some goat’s milk in it. And then for my lunch I usually have a jacket [baked] potato with either mackerel in sunflower oil, or tuna fish, and sometimes I’ll have a little bit of goat’s cheese. And then for my evening meal, I eat all meats except pork. I don’t eat beef very often. So, I have chicken or fish with potatoes that are cooked with sunflower oil, and I can have most mixed grilled vegetables. That’s it, really. Oh, and I do have—you know the Smith’s Crisps [potato chips] with the little bag of salt?—I have a bag of those after my supper. That’s my treat.

Sue’s dietary practices appear highly restrictive, so much so that the idea of oats and seeds in water induces reactions of disgust. While practices of discipline are never separate from the normalizing discourses in and through which bodies come to be shaped, they also cannot be removed from the nutritional science discourses which posit “healthy” food as “clean” and “wholesome”. Despite the discourses of nutritional science at work in Sue’s dietary practices, this should not keep us from recognizing the ways in which bodies are also instruments and vehicles of disciplinary power.

In order to explore the ways in which bodies are rendered docile through the positive and productive effects of disciplinary power, Foucault (1977) encourages attention towards the "meticulous, often minute techniques" that form, what he terms, the "new micro-physics of power" (p. 139). Departing yet again from Marx, Foucault (1977) argues that power is best analyzed not "*en masse* 'wholesale', as if it is an indissociable unity, but of working it 'retail', individually" to grasp the tactics of its subtle coercion, and the "infinitesimal power over the active body" (p. 137, emphasis in original). In returning to the often meticulous daily accounts of food outlined by the people with whom I spoke, I trace the minute and subtle coercions of their food practices in order to understand the ways in which Candidad-bodies are rendered docile via the disciplinary mechanisms of diet in a Foucauldian sense. Disciplinary regimes of diet are not merely restrictive, prohibitory practices; they are also active and productive means of regulating ill (and here, Candidad) bodies.

Diet was discussed in the lives of the people who participated in this study not solely in terms of what it proscribes (i.e. the various restricted foods), but also in terms of the actions it entails. Indicated in the epigraph above, Martha "checks everything" she consumes, Rosemary keeps "diaries of her food intakes", and watches even "the minutest amount" of sugar entering her system, and Amy "makes everything from scratch". The verbs deployed here—checking, keeping, watching, and making—are tangible examples of the way disciplinary power can be conceptualized as an ongoing and dynamic process operating *through*, and not

necessarily *on*, Candidad-bodies. Further articulating the active manifestations of disciplinary power in the Foucauldian sense, is Meena who states that:

> [f]or my daily life [Candida] means discipline. I have to lead a very disciplined life. I have to make sure I grocery shop regularly, that I always have enough food to eat at home. I always have to feel that I have enough food in the fridge or the cupboards that I'm not gonna be all of sudden hungry and not have options or snacks. It means when I go to work or go to school I have to cook almost every day because I can't just grab a bagel or a slice of pizza. So it's discipline in terms of having enough food and making sure I have time to cook and make sure I take food with me if I'm going to be out of the house for a long time. It means my time is very…there's a lot of structure to my life that's necessary to maintain a certain degree of physical balance. I have to be organized. Be on top of what I'm gonna eat. I have to plan it. I can't just say: "oh I'll eat when I'm hungry. I'll just decide what I'm gonna eat then". There's no such thing.

What I find especially pertinent is the way in which diet structures many aspects of Meena's life. Adherence to the Candida diet not only entails action, but also, here, pro-action—going grocery shopping, stocking the fridge, preparing meals in advance and even leaving the house with food. Not unlike the soldier's body that is rendered docile through three broad disciplinary tactics—the regulation and organization of space, time and activity (see Foucault, 1977)—we can similarly see how Candidad-bodies are regulated and rendered docile through the same three disciplinary strategies.

While Foucault (1977) is predominantly concerned with the cellular enclosure of space (evident, for instance, in the architectural structures of prisons and hospitals), space is nonetheless organized in the dietary practices of Candida. In Meena's narrative there is a clear division made between the physical space of her home, where she knows Candida-friendly foods are available, and the "outside world" (i.e. work, school, running errands), where the ever-accessibility of fast food threatens her daily disciplinary practices. This was a common trope across other participants' narratives as well. Diana, for instance, explains how she "takes packages of crackers" with her when she goes out. Sue "makes sure to bring food with [her] wherever [she] goes, which is just as well, because there would have been plenty of times where [she] would have been left with nothing to eat". Space is not strictly enclosed in the case of Candida, but is nonetheless dictated by—and regulated through—the (perceived) availability of Candida-friendly foods.

References to time also figure quite strongly across many of the narratives concerning the Candida diet. To draw again from Meena's passage, we can see how much of her time revolves around buying and preparing healthy food. Time becomes not something passed, but something consumed by the regulation of diet. Meena states quite clearly that her "time is very structured", but that this structure is "necessary to maintain a certain degree of physical balance". While the people with whom I spoke made little reference to the strict use of timetables used in the disciplining of soldiers discussed by Foucault (1977), time was still ordered by the preparation of food. In Sue's case, we can see how food was further regulated

by the divisions of mealtimes—parceling her food consumption according to breakfast, lunch, dinner (as well as post-dinner treat).

The third of Foucault's (1977) disciplinary tactics is the regulation of activity. The regulation of activity is not achieved simply through mastery over the activity or object, but rather through what Foucault (1977) terms, "body-object articulation" (p. 152). Foucault explains that "discipline defines each of the relations that the body must have with the object that it manipulates" (p. 152). In the case of the soldier, the object that is manipulated is the rifle. In the case of Candida, the object that is manipulated is food, but notably, not without the equal manipulation of the body's actions (and pro-actions). Enacted through the disciplinary regulation of diet, food and bodies become mutually regulated, and also, mutually rendered docile. Critical to Foucault's (1977) notion of disciplinary power is that body-object articulations (i.e. disciplinary tactics) are followed as means in and through which to produce bodies that "can be subjected, used, transformed and improved" (p. 136), which begs the question: in what ways, and to what ends, are Candidad-bodies being rendered docile? I argue that Candidad-bodies use discipline through the strict daily regulations of diet as a means of creating certainty and control in bodies where there is otherwise little control.

In reference to the aggravation of not knowing what was plaguing him, Will explains that diet was one way to create a sense of control over his life and his body. In his words: "my anger developed because I didn't have any outlet, or positive steps I could take [for Candida]. So even though the treatment was a bit of a pain, it was so much better having something I could apply my energies

toward". Beleaguered by the ambiguity of Candida, dietary practice was one way in which Will could establish a sense of control and/or order over the activity. By directing his energies towards something concrete, and tangible, he was able to appease some of the uncertainty he experienced, and create a sense of control where little existed beforehand. Sue similarly discusses diet as a means of creating control and certainty; she states: "I think it's recognizing the fact of the trigger. You know, writing down and keeping a diary of what you eat so you can refer back and map out…oh yeah, I had that and that and that's what triggered it". Sue illustrates that the practice of keeping a food log can provide a degree of certainty in bodies otherwise haunted by strange and mysterious symptoms. After pondering why these "perfectly formed circles" had appeared on her face, Sue deduces it to something she had eaten. As she convincingly states, "ah ah, I bet it was the chocolate"! Whether or not it was the chocolate that caused her allergic reaction is of less concern that the ways in which diet is used to create (whether actual or not) certainty and control in the face of bodily indeterminacy.

Anorectic bodies also use diet as a means of creating control and certainty. In parallel terms to Candida's ghostly matter discussed in Chapter 3, Bordo (1993) points out that "many anorectics talk of having a 'ghost' inside them" (p. 155). Closely related, as Chernin (1985) argues, are the "feeling[s] of emptiness" (p. 20) and "confusion[s] of identity" (p. 36) that anorectics often discuss. In describing her own experiences with anorexia, Knapp (2003) maintains that the feeling that "something is missing…[is] as close as [she] can come to naming the sensation […] of a great hollowness left where something lovely and solid used to

be" (p. 165). Like Candidad-bodies, food is often used by anorectic bodies as a regulatory agent in the face of ghostly uncertainty. Appetites in the case of anorexia function to "give specificity to the inchoate and shape to the formlessness; they're the feelings that bubble up from within and attach themselves to the tangible and external, turning elusive sensations (longing, yearning, emptiness) into actions, behaviours, substances, [and] things" (Knapp, 2003, p. 14). Bordo (1993) likewise contends that because hunger is often experienced "as a dangerous eruption from some alien part of the self", that the "growing intoxication with controlling that eruption" is achieved through the regulation of food (p. 143). Anorectic bodies, like Candidad-bodies, may not be able to control events outside them, but "they can control the food they eat" (Bordo, 1993, p. 153). The anorectic realizes that "the diet is the one sector of her life over which she, and she alone, can yield total control" (Bordo, 1993, p. 149).

While anorectic bodies are haunted by themes of powerlessness, lack of identity and the body as alien/not-self (Bordo, 1993), Candidad-bodies are haunted by the lack of a diagnosis. Despite the important nuances between Candidad and anorectic bodies, both can be understood in parallel terms as using diet to create a sense of control in the ghostly face of ambiguity, uncertainty, and lack of control. The regulation of diet in the case of Candida likewise functions to give "specificity to the inchoate" and "shape to the formlessness". Disciplinary power in the case of Candida works to produce docile bodies—bodies that are marked by a "calculated restraint", that can be "mastered", made "pliable", and turned "silently into the automatism of habit" (Foucault, 19877, p. 135); they are

in this sense, soldiers of nutrition. Through the regulation of diet, Candidad-bodies are subjected, used, transformed and improved in attempts to create a body with certainty, and control—a body that can be predicted, and as I now discuss, a body that can also be known.

Turning to Foucault's (1986) later arguments concerning practices in the care of the self, diet as disciplinary regime is not the only tactic at work in the dietary regulation of Candida. Important for Foucault, is that disciplinary regimes are not solely about rendering the body docile, but that they also index deeper strategical pursuits. I contend that the Candida-control diet is not solely about appeasing symptoms and creating a sense of control, but it is also a practice in the care of the self. Entwined with the disciplinary pursuits of diet and the aspirations to produce a clean, contained and controlled body, are also the "active, creative sense of self-development, mastery, expertise and skill that dieting can offer" (Heyes, 2007, p. 78). Following Heyes' (2007) critical assertion that feminist understandings of dieting practices "might be better theorized through Foucault's final work" (p. 77), I too contend that dieting (here, illness dieting) should also be examined and understood as a practice in the care of the self.

Diet as a Practice in the Care of the Self

> I think [Candida] is always there in the decisions I make in terms of what kind of life I am going to create for myself. I know I need a life that is sustainable.
> Meena

> My aspirations have changed since I've had Candida. I'm not as focused on material gains. I'm more focused on being happy.
> Janine

> Candida has helped me gain a greater understanding of how my body works.
> Sophie

> It's really to recognize and know your own body.
> Sue

> Candida has made me very aware of my body and listening to what it says and what it needs and keeping it in balance and being very reflexive about how I deal with stress.
> Amy

In the last phases of Foucault's work, he turns to ancient philosophy—namely Greek, Hellenistic and Roman philosophies—to explore questions concerning the care of the self. While the exact trajectories of his final work remains necessarily speculative (given that the completion of *The History of Sexuality* was interrupted by his death in 1984), Foucault (1985) was undoubtedly concerned with the care of the self as "an exercise of oneself in the activity of thought" (p. 9). According to Coveney (2000), Foucault's final work explored "those strategies by which one develops […] rapports à soi" (p. 11). According to McGushin (2007), who writes extensively on Foucault's final works, Foucault's purpose "was to transform himself, to let himself be altered by the activity of thinking, and to offer his experience of self-transformation to those who would come in contact with his work" (p. xi – xii). Foucault's transition to thinking about creative possibilities of working on the self does not detract (or negate) his earlier contentions against humanist notions of selfhood.

McNay (1992) asserts that Foucault's "practices of the self must be understood as a modification of [his] previous intellectual concerns rather than a *refutation* of them" (p. 48, emphasis added). Speaking to the perceived tensions

between practices of the self and discursively-produced subject positions, Foucault himself details the following:

> I would say that if I am now interested in how the subject constitutes himself in an active fashion, by the practices of the self, these practices are nevertheless not something invented by the individual himself. They are models that he finds in his culture and are proposed, suggested, imposed upon him by his culture, his society and his social group (quoted in Downing, 2008, p. 97).

Sexist language notwithstanding, Foucault is by no means abandoning his earlier arguments concerning constrained discursively-structured subjectivities. McGushin (2007) likewise contends that "we ought to read Foucault's last project as an outgrowth of his problematization of modern relations of power and knowledge" (p. 16), and not as an invalidation of his earlier work.

Putting forth practices towards the care of the self, Foucault (1985) returns to the ancient Greek notion of askēsis. In its ancient Greek context, the word askēsis broadly meant to exercise, to train and/or to develop. Removed from the self-renouncing Christian notions of asceticism, the Greek notion of askēsis also critically entailed a productive and positive sense of working on the self. In Greek philosophy "the self was constituted as an object of pragmatic, not theoretical knowledges" (McGushin, 2007, p. 32). It was through askēsis that Foucault was able to move from the notion of knowledge as a form of accumulation, and towards an understanding of knowledge "as a kind of exercise" (McGushin, 2007, p. xiii). More than disciplinary regimen askēsis entails "perfecting oneself,

developing one's capacities, and becoming who one is" (McGushin, 2007, p. xiii). In short, it is an exercise of the self.

Interested in the ways in which dietary regimens can be deployed as an "art of living" (Heyes, 2007, p. 63), Heyes takes up Foucault's asketic pursuits in relationship to her own interests and practices with WeightWatchers® commercial weight-loss dieting. Echoing Foucault's (1980) famous query that if "power were anything but repressive, if it never did anything but say no, do you really think anyone would be brought to obey it" (p. 119), Heyes questions why commercial weight-loss practices continue to have "the phenomenal cultural resonance that they do"(p. 77)? While typically theorized by feminists as a repressive, prohibitory force (most often) towards female bodies, weight-loss dieting, according to Heyes (2007), should also be examined as an ethical practice in the care of the self. Moving beyond merely repressive hypotheses typically used by feminists who employ Foucauldian theories of docility and discipline to the practices of dieting (see for instance, Bartky, 1990 and Bordo, 1993), Heyes (2007) contends that "feminists intent on characterizing dieting as an oppressive disciplinary regime, may have elided the details of the capabilities it can develop" (p. 78). Heyes (2007) wants "to approach weight-loss dieting not only as a quest for the ideal body type, but *also* as a process of working on the self" (p. 63).

I too am curious about what other practices might be at work in the dietary regulations of food. What facets of the self might be overlooked if we focus too intently on dieting as a practice of docility? Without denying the value of the docile-bodies hypothesis of dieting, I also urge that we should supplement this

familiar hypothesis with recognition for the ways in which dieting can also be construed as an ethical practice for the care of the self. Despite any obvious differences between commercial weight-loss dieting (undertaken to lose weight), and illness dieting (undertaken to rid the body of disease), I read Candida-dieting alongside weight-loss dieting as a type of asketic pursuit of the self. I approach Candida-dieting practices, not solely as a means of discipline, containment and/or control of yeast overgrowth, but also as an ethical practice in and through which autonomy and care of self are fostered, developed and exercised through the regulation of food.

Taking up Foucault's askēsis, Heyes notes how *hupomnemata*[37] are integrated at various levels of the WeightWatchers® program—"leaflets handed out at meetings, magazine articles, Web-site materials, and even cookbooks" (p. 81). These practices not only "carefully exploit key asketic themes from a popular culture preoccupied in more or less ethical ways with care of the self" (p. 81), but they also cultivate self-awareness. Speaking about her own experiences at WeightWatchers®, Heyes (2007) explains how she "found the counting and recording of foods eaten for the purposes of self-evaluation quite satisfying and illuminating" (p. 78 – 79). We know already that dieting entails a kind of invigilation over the activity. But what Heyes (2007) is arguing, via Foucault, is that these practices of regulation not only foster docile bodies. They also foster a kind of reflexivity and "attentiveness towards the self" (p. 81). "Care" for

[37] *Hupomnemata* has "a very precise meaning: it is copybook, a notebook" (Foucault, quoted in Heyes, 2007, p. 81). *Hupomnemata* are intended "not to pursue the indescribable, not to reveal the hidden, not to say the unsaid, but, on the contrary, to collect the already-said" (Foucault, quoted in Heyes, 2007, p. 81), and are, as such, used in practices of self-awareness.

Foucault, as McGushin (2007) points, "is a form of attention […] a kind of vigilance over oneself by which one keeps oneself in mind all of the time […] it is less an attitude, a cognitive or emotional relation to something, than the activities of watching over, cultivating, protecting, improving" (p. 32 - 33). Care is not simply a thought onto oneself, but also entails practices of the self.

Similar to the asketic pursuits of weight-loss dieting, asketic pursuits are also at work in the often-rigid dietary practices of Candida. Obvious in the narrative passages included above are not only detailed, rigorous accounts concerning people's daily dietary practices, but also repeated references (as evidenced in the epigraph of this section) to the ways in which the Candida diet fosters "recognition", "knowledge", "a greater understanding", "awareness" and "reflexivity" of one's bodies. Similar to the *hupomnemata* employed in practices of commercial weight-loss dieting, dieting in the case of Candida "deploys techniques of self-interrogation, of self-manipulation or interpretation through which one becomes visible to oneself" (McGushin, 2007, p. 36). In Sue's words, "it's really to recognize and know your own body". It is through asketic pursuits of diet that Amy learns to "listen to what her body says" and Sophie "gains a greater understanding of how [her] body works".

The freedom gained through asketic practices comes not only from knowing oneself, but also from thinking about oneself differently. McGushin (2007) explains that Foucault's "philosophy as a practice, a work of thought upon itself, is not a denial of oneself, even if it is a flight from oneself. A new relationship arises through this exercise—a more profound relationship marked by

a broadening of vision" (p. xiii). We see this broadened vision through people's heightened awareness of their bodies. But this broadened vision also comes from viewing the self from different vantage points, and in Foucault's words, "to regard otherwise the same things" (quoted in McGushin, 2007, p. xiii). Care of the self entails changing the ways in which we think about the self. As McGushin (2007) explains,

> [t]hought develops the conditions in which possible responses can be given; it defines the elements that will constitute what the different solutions attempt to respond to. It does this by inventing the world anew—creating new kinds of relationships, new practices, assigning new meanings to old practices and relations (p. 16).

Care of the self entails new orientations to oneself, to one's body, to one's relationships with others, and pertinently here, to one's food practices.

Changing relationships to self, through a broadening of awareness, are evident across people's Candida narratives. As Meena states in the above epigraph, Candida "is always there in the decisions I make in terms of what kind of life I am going to create for myself. I know I need a life that is sustainable". Janine similarly remarks that "my aspirations have changed since I've had Candida. I'm not as focused on material gains. I'm more focused on being happy". Notable in these two passages are existential concerns of wider life ambitions, as well as an awareness of creating an ethic of living. We saw similar tropes in the final section in Chapter 3. To recall, Kara maintains that "I think Candida has changed my life all-in-all for the good in a weird way because it's

made me aware of something I didn't know about. I would have never known how to eat healthily if it hadn't been for Candida". Similarly, Aurora asserts that Candida has "left me a different person. I'm not the same person physically, or in any way, emotionally or spiritually. I've been uprooted more or less from the life I was used to".

Asketic pursuits are not only about mastery and control, but they are also concerned with "the joy of the self in itself" (McGushin, 2007, p. 34). "Care of the self", to borrow further from McGushin (2007), is "a means to an end—it [is] preparatory work which one accumulate[s] in the concrete art of living" (p. 37). Dietary practices in the case of Candida are thus about food, about the self, and about issues much larger than food. Heyes (2007) aptly asserts that "care of the self is not an indulgence or a distraction from the affairs of the polis, but rather a necessary condition of effective citizenship and relationships" (p. 80). She goes on to contend that "we owe it to ourselves, and to others, to constitute ourselves as ethical agents through asketic practices" (Heyes, 2007, p. 80). Askēsis is the practice in and through which "the right to self relation will come to be the end in itself" (McGushin, 2007, p. 38). Given that Candida lacks a definitive biomedical diagnosis, and is largely ignored by biomedical practitioners as a "legitimate" illness category, asketic practices of caring are arguably especially important for those living with chronic undefined disorders such as Candida.

In the absence of a definitive biomedical diagnosis, Candidad-bodies also lack the biomedical (i.e. often prescription-based) protocols that commonly accompany a biomedical diagnosis. As such, practices of self-awareness and self-

knowledge foster much-needed capacities for empowerment and autonomy. Heyes (2007) notes in her research on weight-loss dieting practices that asketic pursuits are potentially heightened and/or intensified for women working in pink-collar employment "where there is little space for personal accomplishment" (p. 78). Just as diet is used by women in pink collar employment to create a powerful sense of working on the self, diet is used by Candidad-bodies as a means in and through which to construct a "good or powerful self" (Balfe, 2007, p. 141). Like Heyes, who "began to understand the satisfaction many women found not only in losing weight, but in working on themselves in however circumscribed a context" (p. 78), I too think we should remain open to the asketic pursuits of self at work in the dietary regulations of an illness that remains largely peripheral to the legitimized practices of biomedicine. Despite the many proscriptions and prohibitions of the Candida diet, the Candida diet is also about hope (recalling the hope left at the bottom of Panodra's jar)—hope for a cure, for control, for containment and certainty, as well as the existential capacities to care for oneself in the persistent face of ghostly ambiguities.

In an age where dieting practices are near-ubiquitous (whether undertaken as a means to lose weight, to cure illness or to sustain health), I concur with Heyes (2007) that we should be aware of the potential possibilities and capacities that dieting can provide as an ethical practice in the care of the self, without relinquishing the ways in which these asketic practices can also "sometimes simultaneously cultivate docile bodies" (p. 81). Attention towards dieting as a practice of the self does not remove dieting as a disciplinary regime, but it does,

however, open up dietary pursuits as practices in the care of the self. But, as Downing (2008) importantly reminds us, practices of the self should not be understood without limitation; "the social models Foucault is uncovering in the ancient [philosophical] world should not form a utopian template for restructuring our society. Rather they may offer analogous and heuristic guides for questioning the limits and possibilities of projects of self-creation today" (p. 98). As I discuss in the concluding section of this chapter, pursuits of the self are never simple, straightforward, or free from internal contradiction—they are rather active and ongoing negotiations of the self and with the self.

Negotiations of/with the Self

I cheat a little bit here. I cheat a little there. I bake a lemon loaf I shouldn't bake.
Meena

It's a really healthy diet if you can stick to it. I didn't last week. I had a cappuccino.
Janine

I had cravings for a banana. When my husband had a banana I would just stand near him and sniff it.
Sue

The biggest problem for me was sticking to the regimen. It was really hard.
Will

I have spent much of this chapter detailing the often-strict rigidities of the Candida-control diet. Without taking away from the disciplinary and asketic regimens that go into the stringent dietary regulations of Candida, I also want to make sure that I do not paint too rigid a picture of these dietary practices. As detailed in the narrative excerpts included above, the Candida-control diet (as

with most any dietary practice) inevitably entails fissures in self-control—negotiations between what one "wants" to eat, and what one "should" eat. In Meena's case this entails "baking a lemon loaf [she] shouldn't bake". In Janine's case this includes having a "cappuccino". In Sue's case this means sufficing her cravings for bananas in non-consumptive ways. And in Will's case this involves not "sticking to the regimen". Further deliberations concerning food choices across many Candida narratives included things like: "pub food" (Will), "going out for dinner with friends" (Ruth), "desserts" (Trish), "fresh bread" (Ann), "chocolate" (Sue), "a glass of red wine" (Rosemary), "alcohol" (Kiri), and "sweets with one's afternoon tea" (Rosemary).

I highlight these passages not only to speak to the ways in which disciplinary practices are never complete (arguably especially in relation to food and diet, where food is being regulated multiple times a day), but also to highlight the ways in which practices of the self are not singular, nor are they necessarily internally consistent. In contrast to the Christian forms of asceticism (operating from the Enlightenment premise of an essentialized self), Foucault's askēsis puts forth the self as a practice in the making—as "a task which remains open to itself" (McGushin, 2007, p. 42). In this sense, asketic pursuits are neither essentialized nor essentializing. As McGushin (2007) states, "one does not simply 'know' oneself—as if looking and seeing were an immediate disclosure of the self […] knowing/seeing is […] a [continual] practice" (p. 36); it is moreover a practice that inevitably changes as we change. "Rather than appearing as a unified fundamental essence, substance or form", the self in Foucault's askēsis is

"dispersed among a plurality of experiential regions" (McGushin, 2007, p. 32). Briefly put, if the truth at stake in knowing the self is not simply *a* truth, then the practices involved in caring for the self are also not singular—they entail, as I have argued, multiple and sometimes contradictory actions.

Asketic pursuits of the self in the case of Candida are both, and arguably simultaneously, an attempt to contain and control Candida's ghostly matters, as well as a means in and through which to foster self-knowledge and a broadening of self-awareness. These practices are not only prohibitive, but they are also sometimes indulgent. Care of the self is not merely or consistently regulatory; it also sometimes entails a lack of regulation, a letting go of discipline, regulation and regimen. While we will never be able to fully step outside the dominant discourses of nutritional health—discourses which oversimplistically posit healthy food with a healthy self—Foucault's askēsis does offer some potential to use these discourses in non-essentializing, creative and potentially even autonomous ways.

I began this chapter with the many curious paradoxes that food occupies within contemporary western culture. I conclude this chapter by highlighting the many curious paradoxes food also occupies in the lives of the people with whom I spoke. Operating within the discourses of nutritional science, food in the case of Candida is both a pathogen, and a cure; a means of docility, and productivity; a source of prohibition, and indulgence. Diet in the case of Candida is not only about proscriptions and prohibitions, it is also about hope—hope for a cure, for control, for containment and certainty, as well as the capacities to care for oneself

in the persistent face of continued bodily ambiguity. Despite the many inconsistencies of food and dieting in an age of both sheer excess sand sheer lack, “in all its banal and brutal glory” (Knapp, 2003, p. 185), food is a practice that connects us “to the very core of our selves” (Probyn, 2000, p. 2). Beyond any simplistic nutritional health perspectives, food and dietary practice cannot be ignored as a practice of the (ill) self—a practice, which, despite consuming much of the everyday, is anything but mundane.

Interlude II: Between Health, Illness, Hope and Cure

Rosemary: I consider [Candida] definitely behind me. I hope. I mean we all obviously have a little bit in us but I hope I have a healthy balance. I get aches and pains that all human beings have. I get germs and things. But no, I just have to trust that I have beaten this nasty thing. I hope and trust it is completely gone, and that I've just got a normal balance of it. I hope I won't ever have to fight [Candida] again.

Will: When you say "Candida" it implies that there was a point in time when I didn't have it, and then a point in time when I do. I don't think of [Candida] as something wrong with me. It's just me. I wouldn't go to the doctor and say: "I've got blue eyes can you fix them"? It's uncomfortable and it's not fun but you sort of accept it and try it and move on. Do I think about myself as someone who has Candida? If you specifically asked me, yes, I would say that I do, but I don't think about it in that way most of the time. I think about it as this is the problem and the problem is the symptom. I think [Candida] is a thing you learn to live with, and that it's with you. I don't expect that it's ever going to be—that I could go back to eating tons and tons and sugar and it would be ok. I suspect that if I started doing that it would act up again.

Author's Note: *As a parallel (of sorts) to Interlude I, which spoke to people's experiences of how they first came to understand Candida, the stories included here speak to people's often ambivalent relationships to their ongoing struggles with the yeast-related disorder of vague symptomatology.*

Diana: It's pretty scary on my own because it's just me and my book. In a modern diet—even a healthy modern diet—the vegetables I eat might have been sprayed up to seventeen times by the time they reach my plate. By the time I get them in the supermarket they are never fresh; they're all factory farmed, and depleted of vital minerals. They're grown for shelf life and for appearance, not for flavour and goodness. Even if I think I am eating a healthy diet, the food I am eating has been grown in an environment high in bacteria. All in all, I know that everything I am doing is helping, even though I know I am nowhere near out of the woods yet.

Kiri: [It is hard] having to explain Candida to everyone when I don't really know myself what's going on, and when I am getting absolutely no support whatsoever from any GP. It's a lonely battle. I am going against years of habits, like I was used to having a coffee every morning and I suddenly had to give all that up and change so much. I was happy to do it because I just couldn't go on living feeling that bad, but it's a huge upheaval.

While these narratives speak to the ways in which, as Susan Sontag (1978) famously asserted, "illness is a more onerous citizenship" (p. 3)—a citizenship that consumes us, alters our once taken-for-granted (healthy) realities, and changes the ways in which we negotiate the world—these narratives also complicate any simplistic relationship between health and illness, hope and cure. It is not that "everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick" (Sontag, 1978, p. 3), but that in cases of chronic undefined disorders like Candida oftentimes these "citizenships" are held, albeit tenuously, in tandem.

Phil: I've accumulated an entire bookshelf with books on Candida, arthritis, alternative therapies, herbal therapies, enzymes, autism, Crohn's [Disease], colitis, autoimmune conditions, special diets etc. I bought a book that I am using as a bible right now. I had already thought of everything you can possible think of and tried everything out there. I've spent a fortune on trying to get better. I had nothing to lose, so I gave this book a try, and I was doing everything that I thought I'd never do again. I'm eating bread. I'm eating potatoes. I pushed the boat out a little bit by eating biscuits and stuff like that. I was fine. A few days later, I tried some flapjacks [pancakes]. And I was fine. The only thing I still avoid—with the exception of a little butter on a flapjack—is milk.

Rachel: I consider myself healthy because I get past things, and because I know how to take care of my health. I don't feel victimized. I go ahead and do something about it. I know I can have a great life if I look after myself. That's my theory. I know I have to be very careful. I have to be open to modern medicine, but I also have to be careful and look after my health in more natural ways, more holistic ways, and with a better diet. I need to include some vitamin therapy and some things to boost my immune system so that I can live a decent life. I have to be very diligent. I still keep a Candida diet. I still don't eat mushrooms. I still don't eat yeast—or I try not to. I don't eat cantaloupe, or any kind of moldy foods. I'm very careful about moldy foods. I just stay away from them. I figure I'm not going to go look for trouble. I've been here before and I'm not going back.

Given that Candida remains an ongoing struggle for many of the people with whom I spoke, the stories included here should not be read as a dénouement fait accomli—as that which was but is no longer. They should be read as a continuing negotiation between health, illness, hope and cure, and critically, of that which lies somewhere in between.

Janine: The feeling that I get from all of this is that I have to be true to myself. It has let me sort out the weak from the strong, so to speak. I am able to focus on what's important. I no longer waste time on things. I know I have to take care of myself. I have to prepare foods everyday that I can eat. I have to make sure I have enough fruit. I have to be in a bright working environment with lots of natural lighting. I have to have some fresh air everyday, if possible. I see these people who have these healthy lives and I think: "you are so lucky, if you only knew". I hear people complaining about the slightest things, and I think: "if only you could live my day, if we could just swap". I would be so grateful if somebody could just take it away from me. It's just so hard. I mean there's no other way around it: it's just hard. But I can see light at the end of the tunnel. I think. I'm fairly sure that things will improve. Although I can't say for sure what the menopause will do. I'm not planning on having any children, and I'm not planning on getting married. Those things are pressures that would interrupt my health. I am a person who needs a lot of sleep and a different diet. I don't plan things anymore. I don't like to leave the country. I just stay where I am—quite locally based. I also wouldn't dream of doing anything too physical now. I just have to take things a day at a time. And that's a big change.

Alissa: While this project began (at least in some respects) with a simple curiosity about this thing that had begun to plague me, seven and a half years later, it seems I am both far—and not far—from where I began. I still do not know exactly what plagues me.

Lynn: I would say that I am seventy percent healthy. It is the only way I can think of it because there is so much room to get better. I am of a healthy weight. I eat a healthy diet. And I have the means to a healthy diet. I have all the social determinants of health: I have a house over my head. I have access to knowledge as well as [health] services. I am healthy in all of those ways. The ways I am not healthy is too much stress, not enough sleeping, not enough exercise, and because of the stress, my emotional health could be a lot more balanced. Where do I see my health going? I see my health getting better because I know more about myself and I know that the medical model isn't the only way to figure out my health. I know I have other avenues.

Sue: At the beginning, all of my friends said that I would never do it, that I would never stick to such a rigid diet. But I have to say that when I was diagnosed, if someone had said to me: "cut off your right arm, and by chopping it off it would cure you", the arm would have gone out, because that's how ill I felt. Now, I would love to be able to say my health is good, but if it is too good I start eating what I want. I know my body and I know what I can and cannot eat. And it's a simple as that.

Despite being free of any detectable illness pathologies, my symptoms remain vague, sporadic, and uncontrollable (though less severe than they once were). I still avoid wheat, yeast and too much sugar, notably where possible, and with exception. What began with a not-so-simple story of this thing that had begun to plague me, "has led me", in the words of Aimee Van Wagenen (2004), "beyond myself" (p. 292).

Aurora: I am currently not working. I get up early but I don't really sleep. It takes me a lot longer to do things than it normally would have done before all of this happened. I feel quite good—like I can take on the world—until about 11:00am or noon, and then my energy levels start to drop. By 3:00 or 4:00pm my energy is completely gone. This kind of routine has transformed my life. I find myself in a difficult position. [My friends] talk about all these wonderful things that they've been doing, and how can I respond? I can't contribute with any thing of much, really. Who wants to listen to an illness all the time? I am now at the stage where I know what's wrong with me, but it has taken me 12 years. It has not been a pleasant experience. It's been terribly, terribly demoralizing. I expect I'll be on my diet for a lot longer than I had hoped. I know dairy is out of the question for the rest of my life. But there you have it: some things don't happen overnight. At least there's some relief with knowing exactly what I am dealing with now. [And] in the [grand] scheme of things the best thing I can do is to get well.

Derek: When I walk into a GP's office they look at me and I am not overweight, I don't smoke, and I don't drink a lot. I look quite healthy. Because I appear visually okay, they don't believe me when I say that I am unwell. [And] because I don't get any help from GP's, I have to be up on Candida myself. I am always looking on the internet for anything that may be helpful.

"My" story, which was never entirely "my" story, has led me not only to the experiences of others, but critically also, to the wider structures of knowledge and power that frame the ways in which "I" am able to speak about "my" illness experiences. What I have gained, therefore, is not a cure or a diagnosis.

Meena: I'm sure that I'm living a very different life to the one I would have been living if it weren't for the Candida. I can't run myself into the ground anymore. I can't work intensely hard. I have to have balance. I know I need a life that's sustainable. Having time to sleep, to exercise and to cook is critical for me. It is not a luxury. I have to do it just to be normal. My body is so fragile. It is so easy to topple my system. [After a setback], it takes me months to stabilize myself again and that's only if I am *really* strict with my diet. I have to be so organized. I have to be on top of what I am going to eat. I have to plan it. I can't just say: "I'll eat when I'm hungry". There is no such thing. There is a lot of structure to my life that's necessary to maintain my physical balance.

Amy: I would say that I am keeping good health, but that I am not healthy. Learning about Candida, and overhauling my lifestyle and my diet has had a positive effect [on me]. It has made me more aware of my body, listening to what it says, what it needs and keeping it in balance. I try to keep stress to a minimum and be reflexive about how I deal with stress because I understand how it manifests my physical symptoms. Before Candida I also didn't realize how much my life revolved around food. When I was first diagnosed, it felt like [my partner and I] were living separate lives. I'd cook for myself and he'd cook for himself, and that was quite hard. At the time, I felt like he was just waiting for me to get back to how I was before [before the Candida]. I don't think he really understood that this is how I'm going to have to live my life—that this is more like a permanent thing.

What I have gained is a change in perspective. Perhaps in the ongoing struggles between illness, hope and cure the goal is not to change ourselves, but rather to change our orientations to ourselves. Both far—and not far—from where I began, I am in a familiar place, but I am seeing this familiar place anew.

Ch. 6

Stories without End[38]: A Return to Difficult Knowledge

Another couple of years and Candida is going to be as widely acknowledged as ME [Myalgic Encephalomyelitis].
Aurora

There's certainly a sense of optimism that wasn't there before.
Will

Everything is a matter of perspective. There are worse diseases to have.
Meena

I think this is something they should be teaching young people.
Star

We're supposed to be one of the most prosperous countries in the world, why are we compartmentalizing our health in this way? It's like we're living in the Dark Ages.
Rachel

I've been really lucky to figure this stuff out as quickly as I have—now I can bring up my kids being aware about all of these pollutants.
Phil

I think we should have a Saint named after us.
Janine

As a way into the topic of difficult knowledge—knowledge that rethinks the very concept of what it means to "know"—Deborah Britzman (2000) takes up Meyer Levin's work on Anne Frank's *Diary of a Young Girl*. Britzman uses Levin's work on Frank as a way to reconsider how stories of trauma get used as pedagogical tools. Britzman questions not only to what ends stories of trauma are being deployed, but, as educators, how we work with stories of loss beyond the popular representations that "seem to emphasize the idealized outcomes of learning; perhaps the most common concerns the inscription of hope" (p. 28).

[38] I adapt this title from Britzman's (2000) title *If the Story Cannot End*.

Moving away from the end product of loss as some neatly packaged lesson or moral to take away from other people's experiences of trauma, Britzman "explore[s] what the work of mourning means in learning" (p. 28), questioning the very pedagogical encounter with loss. As Britzman (2000) explains,

> [i]f the question of ethicality does not begin with what is successful, ideal, or familiar about our actions and thoughts but rather with what becomes inaugurated when we notice the breakdown of meaning and the illusiveness of signification, then our pedagogical efforts must also begin with the study of the difficulty of making significance from the painful experiences of others (p. 29).

Britzman's task in pursuing difficult knowledge is not therefore to emerge with any singular truth about the experiences of loss, but to question the very difficulties and complicities in representing such experiences. And it is here where I take up, and return to, the relevance of Britzman's work to the project at hand.

In taking up Britzman's concept of difficult knowledge I am not suggesting a conflation between stories of trauma (i.e. which most often engage experiences of violence and/or abuse) and stories of undefined illness. Despite the possibility that some of the people with whom I spoke may describe their experiences with Candida as traumatic, the stories presented throughout this dissertation are not (at least overtly) about trauma. Many of these stories are, nevertheless, about loss—loss of health, loss of normalcy, and loss of intelligibility. But, as indicated in the above epigraph, the stories concerning

Candida are also about "optimism", "perspective", "awareness" and even "Sainthood". Following Pitt and Britzman's (2003) assertion that there is **"**a kernel of trauma in the very capacity to know" (p. 756), because "knowing" generally entails a reduction rather than an expansion of perspective, my aim in exploring the often difficult stories of Candida has not been about representing these stories in any singular or simplistic way. To recall, the question that foregrounded this research was: what can be learned about the social workings of illness through attending to how people talk about their experiences with Candida? My aim, rather, has been to question the discursive limits of Candida's narrative tellings.

Using a double(d) science—a mode of inquiry that "enters through a different door" (Gordon, 1997, p. 65)—I have explored how people come to speak about the yeast-related illness of vague symptomatology, and, in turn, how these statements are themselves reflections of what can and cannot be said about the yeast-related disorder of vague symptomatology. Moving away from humanist accounts of lived experience, I take up Mills' (1997) claim that "statements do not exist in isolation since there is a set of structures which makes those statements make sense" (p. 49); in the case of Candida there is a set of structures which prevent narrative statements from making sense (p. 49). By approaching people's experiences with Candida using a Foucault-inspired notion of discourse alongside Ellsworth's (1997) strategy of "thinking through" I have explored *how* the experiences of Candida come to be, and fail to be, rendered legitimate, and

considered the discursive limits in and through which experiences with Candida *come to be* shaped.

Rather than attempting to prove that Candida is real and does exist, I have sidestepped persistent questions concerning Candida's etiological existence and have examined instead how and why Candida comes to exist as a nebulous, ghostly presence. In sum, in Chapter 3 I argued that Candida fails to exist as a legitimate disease etiology because it eludes Enlightenment models of medical science—models which posit viable illnesses as those with singular, detectable and locatable pathologies. Given these wider empirical frames, Candida comes to exist in the lives of the people with whom I spoke as a ghost-like, largely invisible and possessive force. Candida is not only produced in and through the Enlightenment regimes of biomedical science, but in its very ghostly presence also calls into the question the empirical modes of visibility and locatability that rendered it ghostly to begin with.

In Chapter 4 I maintained that experiences of Candida must be examined in relation to the dominant discourses concerning gender, and specifically in relation to Grosz's (1994) claim that "female corporeality is inscribed as a mode of seepage" (p. 203). Despite the fact that both men and women get Candida, and that Candida is a yeast-related disorder of vague symptomatology affecting multiple bodily systems, Candida comes to be intra-actively materialized through existing and familiar discourses of gender. Despite the presence of leaky symptoms, Candida in men is effectively distanced from the leaky corporealities normally attributed to women through the overall physicality, and thus rationality

and containability, of men's symptoms. Despite the presence of physical symptoms, Candida in women is neither rational nor contained; it is rather intra-actively materialized through the discourses of menstruation and the vagina dentata as leaky, dirty and dangerous. The overall feminization of yeast in the case of Candida not only further reinforces female bodies as leaky aberrations of the assumed clean and contained boundaries of (heterosexual) male bodies, and thus as both voracious and volatile, but also structures the very gendered and gendering ways Candida comes to be experienced.

In Chapter 5, I contended that discourses of nutritional health also shape people's experiences with Candida. Taking up Foucault's influential reworking of Marxist theories of power, I argue that discourses of nutritional health (discourses which posit food as both pathogen and cure) are not passively inscribed onto Candidad-bodies, but are rather actively used by Candidad-bodies in efforts to contain, regulate and control yeast overgrowth. The often strict dietary regimes used in the case of Candida are both about creating a docile body (i.e. a body that is clean and contained and thus free of yeast overgrowth) and about a practice in the care of the self. In the face of much bodily uncertainty, diet becomes one way in through which Candidad-bodies can actively work on and know the self.

Working against the stubborn humanist claim that the self can speak and be spoken outside constitutive frames of knowledge and power, my aim has been to merge poststructural claims of situated experience while maintaining a responsibility to what Stockton (1994) has termed "real bodies and political rage" (quoted in Lather, 2007, p. 34)—notably at a time when the question of what is

Candida remains largely unanswered. Walking a double(d), broken line, I have sought to represent people's often nebulous experiences with Candida, while simultaneously acknowledging the complexities and complicities of doing ethnographic research from post-foundational and anti-essentialist perspectives. Rather than taking Candida narratives at face value—as that which simply reflects and represents already-existing lived realities—I questioned the discursive limits of biomedical science, gender and nutritional health that shape our experiences with Candida in the first place. In a double(d) effort to represent stories concerning Candida while simultaneously drawing attention to their discursive situatedness, I relied on two textual strategies.

I used epigraphs and interludes throughout this dissertation to convey the content of people's experiences with Candida—how they understand the disease, its symptoms, treatments and causes, and how it affects their relationships to their social worlds, their relationships, their bodies, and to the foods they eat and don't eat—while also conveying these experiences *differently*. Drawing from similar strategies used by Lather (2007) and Lather and Smithies (1997), my aim was to interrupt any simple or straightforward reading of other people's stories, or, in Lather's (2007) words, "a too-easy, too familiar eating of the other" (p. 136). Like Lather and Smithies (1997) I used "de-authorizing devices such as shifting voices and subtextual under-writing which ruptures the narrative and forces a reading in two directions" (p. 22). By interspersing the narrative accounts of the people with whom I spoke alongside—and in constant relation to the discursive analyses that ensued—my aim was to rework and rethink the very frames in and through which

illness narratives are commonly used. I wanted to visually represent these stories "on the same page", ultimately to insist on their mutual constitution. To reiterate, my concern has not been with resolving the seeming incommensurability between the desire to voice the often silenced stories of Candida, and the desire to locate these discursively-constrained illness experiences within wider structures of knowledge and power, but rather with drawing attention to the productive tensions that emerge from this seeming—yet imperative—incommensurability.

As illness narratives continue to pervade both popular and academic pursuits, I agree with Lather and Smithies (1997), that the challenge lies in following both experiential *and* discursive strands in an effort to re-think and re-tell the very stories concerning illness—and experience—that we want to tell. "Faced with a writing task that feels both urgent and as something about which I want to speak of softly and obliquely" (p. 43), like Lather (1995) I insist on displacing illness narratives beyond the message of the narrative itself. In a similar way that Gordon (1997) asserts that "life is more complicated than those of us who study it have normally granted" (p. 7), I stress the complication of illness narratives beyond the humanist and positivist frames in and through which they are most commonly framed. The experiences of Candida, as I have articulated throughout this dissertation, are more than a checklist of nebulous symptoms, even though these symptoms can often feel all consuming. The experiences of Candida are more than the often-rigid dietary treatments used to rid or control its symptoms. The experiences of Candida are more than the lived effects of the illness alone. As intimate as these experiences may be, as I have

argued throughout this dissertation, these experiences also "link an institution and an individual, a social structure and a subject, and a history and a biography" (Gordon, 1997, p. 19). Difficult knowledge can be understood not only as that which opens up what we think we want to find in the stories of others, complicating difficult stories from the common and predictable reinscription of hope, but in the words of Pitt and Britzman (2003), difficult knowledge also "emerges as a metaphor for the pushes and pulls between knowing and being known, between phantasy and reality, between one's early history and one's haunted present of learning, and between experience and its narration" (p. 769). Difficult knowledge is about thinking differently and difficultly about the experiences of others.

In the case of Candida this entails thinking differently and difficultly about questions of illness legitimacy, and understanding these questions as being constrained in and through the wider discourses of biomedicine, gender and nutritional health. Yet, just as the experiential stories of Candida extend beyond the page—beyond what can be represented in this dissertation—the discourses of biomedicine, gender and nutritional health should also not be taken as an exhaustive account of the discourses at work in the yeast-related case of Candida. As a Foucauldian approach to the study of discourse has consistently argued, discourses do not produce simple, clear-cut meanings of the object in question, but rather serve to highlight "the fluidity of the text", and in turn, "the instability of [the object's] 'truth'" (Mills, 1997, p. 17). The discourses of biomedicine, gender and nutritional health do not fully constitute, nor do they fully deny

Candida's legitimacy; they rather partially inform *some* of the ways in which we come to know, understand and experience Candida at this historical moment, and in this cultural context. But the instability of Candida's "truth", and, in turn, the instability of its discursively-constrained experiences does not imply a lack of signification; it rather signals partial truths and contingent meanings.

Butler (1995) reminds us that "to deconstruct is not to negate or to dismiss, but to call into question and, perhaps most importantly, to open up a term, like the subject, to a reusage and redeployment that previously has not been authorized" (p. 48). In an effort to think differently and difficultly about the stories of Candida (and of undefined illness more broadly), this project offers a rethinking of stories of undefined illness beyond positivist affirmations of legitimacy, and beyond humanist frames of narrative telling. "No longer feeling confident of the ability/warrant to tell such stories in uncomplicated, non-messy ways", (Lather, 2007, p. 13), this project offers a re-representation of undefined illness stories as stories which are complicated, contradictory and contingent upon wider discursive limits. Given the crisis of representation in the humanities and social sciences—a crisis which has ruptured the humanist ideal of an autonomous, free-thinking and free-acting subject—Lather (2007) is indeed correct in her assertion that "the straightforward story has become impossible" (p. 13).

But this impossibility to ever fully represent the experiences of Candida, as well as the impossibility to ever fully represent the discursive limits which come to shape these experiences, should not be understood as a failure—or at least not as an unproductive failure. Rather, the failure to ever fully represent the

discursively-constrained experiences of Candida should be understood as both inevitable and necessary. As Britzman (2000) contends, “the unfinished story is the story that pedagogy must learn to tolerate” (p. 50). The unfinished story in the chronic undefined case of Candida is also a story that many of the people who continue to live with its ongoing ambiguities must also learn to tolerate. When the promise of simple, straightforward and easy knowledge is lost what remains “is the promise of thinking and doing otherwise” (Lather, 2007, p. 13). In a culture that still largely values positivist ways of knowing and humanist frames of reference, not knowing what will be the end, living with ghostly uncertainties, and getting and staying lost is indeed difficult, but also vital if we want to move beyond the positive and humanist frames that were so limiting to begin with.

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Appendix 1. List of Interview Questions

1. Tell me a little about yourself
2. How do you understand Candida?
3. Where did you gain this understanding (i.e. doctors, books, the internet)?
4. Have you ever been diagnosed with Candida? If so, explain. If not, explain.
5. Describe any symptoms you've experienced.
6. Would you say your symptoms are more physical, emotional or psychological?
7. What do you think are the causes for your Candida?
8. What does Candida mean for your daily life? How does if affect your daily routine?
9. How does Candida affect your relationships with others? Who do you talk to you about your Candida?
10. How does Candida influence your social life?
11. Do you have a community of support to help you deal with Candida? If so, please describe.
12. How has Candida changed your life?
13. Outline or detail any other frustrations or difficulties you've experienced while having Candida?
14. Do you consider yourself healthy? Why or why not?
15. Where do you see your health in 5 years?
16. Can you think of a metaphor or an analogy to describe the illness of Candida?
17. Do you consider Candida a "gendered" illness? Why or why not?
18. What have you found to be particularly helpful in your struggle against Candida?
19. Is there anything else about your experiences with Candida you'd like to share?

Appendix 2. Symptom List (Alphabetical)

Abdominal pain
Acne
Agitation
Allergies
Anal itch
Anemia
Anxiety
Asthma
Athlete's foot
Bacterial infections
Bad breath
Belching
Bladder infection
Bloating
Blurred vision
Brain fog
Burning during urination
Chemical sensitivities
Chest pains
Chronic fatigue
Coating on tongue
Confusion
Constipation
Coughs
Cramps
Cystitis
Decreased breast size
Decreased libido
Depression
Dermatitis
Diarrhea
Digestive problems
Disorientation
Dizziness
Dry mouth
Dry skin
Eczema
Edema
Emotional problems
Environmental intolerance
Erratic vision
Exhaustion
Fatigue
Finger and toenail inflammation
Fluid retention
Food cravings and sensitivities
Frequent urination
Fuzzy thinking
Gas
Gastritis
Hay fever
Head tension
Headaches
Heartburn
Hives
Hyperactivity
Hyperirritability
Hypoglycemia
Impaired decision making
Impetigo
Impotency
Indigestion
Infertility
Insomnia
Intestinal pain
Irrational fears
Irritability
Jock itch
Joint and muscle pains
Lethargy
Loss of sexual desire
Low energy
Low self-esteem
Memory loss
Menstrual irregularities
Mental confusion
Migraines
Mood swings
Nasal congestion
Nasal itching
Nausea
Nervousness
Numbness
Panic
PMS
Prostate problems
Psoriasis
Puffiness
Quick anger
Rash
Recurring bladder infections
Restlessness
Shortness of breath
Sinus pressure
Skin infections
Skin rashes
Teeth grinding
Trouble concentrating
Urinary tract problems
Vaginal discharge
Vaginal infections
Weight gain
Weight loss
Whining

Appendix 3. Crook's Diagnostic Questionnaire (Crook, 2000, p. 15 – 16)

	Yes	No
1. Have you ever taken repeated rounds of antibiotics?	___	___
2. Have you taken cortisone?	___	___
3. Have you ever taken birth control pills?	___	___
4. Have you ever had "jock itch" or athlete's foot?	___	___
5. Do you have anal itch or rash?	___	___
6. Have you ever had "thrush"?	___	___
7. Do you drink coffee or pop?	___	___
8. Have you ever had a vaginal yeast infection?	___	___
9. Have you ever had a fungal infection around or under fingernails or toenails or on the skin?	___	___
10. Do you have silver fillings in your teeth?	___	___
11. Have you ever had a series of x-rays?	___	___
12. Do you have recurring ear infections?	___	___
13. Have you been troubled by PMS, vaginitis, abdominal pains, prostatitis or loss of sexual interest or feeling?	___	___
14. Do you crave sugar, breads or alcoholic beverages?	___	___
15. Are you sensitive to tobacco, perfumes or other chemical odors?	___	___
16. Are you bothered by recurrent digestive disorders?	___	___
17. Are you bothered by fatigue, depression, poor memory or nerves?	___	___
18. Are you bothered by psoriasis, hives or other chronic skin disorders?	___	___
19. Do you feel sick all over?	___	___
20. Are you bothered by headaches, muscle or joint pains?	___	___
21. Do you have dry mouth or sore throat?	___	___
22. Do you have bad breath?	___	___
23. Do you suffer from insomnia or drowsiness?	___	___
24. Do you suffer from diarrhea or constipation?	___	___
25. Do you have bloating, belching or intestinal gas?	___	___
26. Do you have white mucous film on your tongue in the morning?	___	___

3 – 4 "yes" answers, yeast <u>possibly</u> plays a role in causing your symptoms.
5 – 6 "yes" answers, yeast <u>probably</u> plays a role in causing your symptoms.
7 or more "yes" answers, your symptoms are <u>almost certainly</u> yeast connected.

Appendix 4. Natural Antifungal Medications (Alphabetical)

Acidophilus
Alfalfa
Aloe Vera
Astragalus
Berberine
Betaine and pepsin
Bifidus
Hydrochloride
Biotin
Black seed
Black walnut
Boneset
Boric acid
Caprylic acid
Castor bean oil
Cayenne
Chaparral
Chlorophyll
Citrus seed extracts
Cloves
Coenzyme Q10
Colloidal silver colostrums/bovine
Comfrey leaf and root
Cramp bark
Dandelion leaf
Dulse
Echinacea
Fennel seed
Fish and fish oils
Flaxseed and hempseed oil
Fructo-oligosaccharides
Garlic
Gentian formula
Germanium
Getian root
Ginger
Golden Seal
Grape root
Grapefruit seed extract
Green hull
Hyssop kelp
Lactobacillus
Larch arabinogalactan
Licorice
Marshmallow root
Medicinal mushrooms
Morinda
Nee
Neem leaf
Nicotinic acid
Ocean and fresh water algae
Olive leaf extract
Olive oil
Onions
Oregano extract
Oregano oil
Oregon grape
Para-aminobenzoic acid
Pau D'arco
Peppermint oil
Peppermint seed
Phyllium husk powder
Plant tannis
Propolis
Pumpkin seed
Quasi
Seaweeds
Selenium
Slippery elm bark
Tanalbit
Tea tree oil
Thyme
Undecylenic acid
Uva Ursi
Vitamin E
Wheat grass
Yogurt
Zinc