

Leaky Bodies & the Gendering of Candida Experiences

Alissa Overend¹, Grant MacEwan University

KEY WORDS: CANDIDA, YEAST, UNDEFINED ILLNESS, ELIZABETH GROSZ, GENDERING OF ILLNESS EXPERIENCES

The medical case of Candida remains a highly contentious illness category within the boundaries of biomedical science. Following some of the wider interrogations posed by feminist poststructural theories of the body and of illness, my concern in this paper is not about whether Candida 'actually' exists. My concern in this paper is in exploring the production of gendered experiences with the yeast-related disorder of vague symptomatology. Based on a series of 24 semi-structured interviews, I attend to how people talk about their experiences with Candida and I read these experiences alongside wider feminist discourses concerning leaky female and contained male corporealities – most notably, though not exclusively, through Elizabeth Grosz's (1994) analysis of men's seminal fluids and women's menstrual flows. Yeast, as read through the case of Candida, can be understood as gendered and gendering, particularly as it reinscribes dominant discourses concerning leaky female and contained male embodiments.

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 and candid (Whitaker, 2005). Contrary to its etymological roots, the medical case of Candida remains a highly contentious illness category within the boundaries of biomedical² science. Also referred to throughout wider literature as chronic candidiasis, candidiasis hypersensitivity, Candida-related complex, fungal-type dysbiosis, the yeast syndrome, yeast allergy, yeast overgrowth, yeast problems and recurrent thrush, Candida is classified by Malterud (1992) as an "undefined disorder" (p. 302) – as an illness with no objective, pathological trace. While biomedical practitioners

¹ Direct all correspondence to Alissa Overend, Department of Sociology, Grant MacEwan University, City Centre Campus, 10700-104 Ave. Edmonton, Alberta. E-mail: overend@macewan.ca.

² I use the term biomedicine to refer to the biologically oriented and institutionally accredited medicine that dominates Western cultures (Hahn, 1995).

confirm the presence of *Candida* yeasts in human digestive flora (Calderone, 2002; Liao, 2002; Saltarelli, 1989), there is much skepticism concerning the idea of chronic, systemic yeast.

The *Candida*-yeast hypothesis was first put forth in 1978 by Dr. Orion C. Truss in the *Journal of Orthomolecular Psychology* (although Truss claims that manifestations of *Candida* were described by Hippocrates over 2000 years ago). Truss's hypothesis states that naturally-occurring *Candida* yeasts can multiply as the result of the overconsumption of antibiotics and immunosuppressant medications and the overconsumption of yeast-producing foods (namely wheat, yeast and sugar), as well as wider environmental factors (including stress and poor air and water quality). Once overgrown, *Candida* yeasts can spore through the intestinal wall, where they are normally contained and begin to infect multiple bodily systems. A polysymptomatic disorder, *Candida* reputedly "attacks all over" (Crook, 2003, p. 1) and, as such, is suspected to cause a wide range of yeast-related health concerns. A review of the existing biomedical and alternative medical³ literatures on *Candida* suggests that its overgrowth can produce 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,

³ I use the term alternative medicine to refer to all non-biomedical accredited health practices. This can include naturopathy, homeopathy, traditional Chinese medicine, acupuncture and so on.

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).

For Truss (1978, 1980, 1981, 1983 & 1984), as well as those who have since taken up his work, Candida is a serious health concern. According to Moore (1998), Candida affects as many as 60% to 80% of Americans and Canadians. It was furthermore identified by the Institute of Medicine Report “as an emerging pathogen” (Liao, 2002, 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.

Despite support for Truss’s hypothesis by parts of the biomedical community (Cater, 1995, Crook, 1985, 2000 & 2003, Liao, 2002) his hypothesis has also received much skepticism. As detailed by one medical website, in the 33 years since Truss’s description of this condition “there is still a great deal of controversy surrounding exactly what Candida is” (*Candida: Diagnostic & Therapeutic Approaches*, n.d., 4). The American Academy of Allergy, Asthma and Immunology (AAAAI) strongly criticizes the concept of Candida as a disease category. 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 & 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” (quoted in Moore, 1998, p. 2).

Following some of the wider interrogations posed by feminist poststructural theories of the body and of illness, my concern in this paper is not about whether Candida ‘actually’ exists. Proceeding from the ontological and epistemological assumption that there is no single, inherent, or universal authority and that all positions and/or claims to truth—including here, those concerning the undefined medical case of Candida—are necessarily contingent upon the social, historical and political systems in which they come to be known (Belsey, 2002), my

concern in this paper is in exploring the production of gendered experiences with the yeast-related disorder of vague symptomatology. 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* its gendered and gendering illness experiences. Instead of assuming that gender is something that interacts with Candida, I argue for the ways in which leaky and contained gendered discourses produce gendered and gendering experiences of Candida. I attend to how people talk about their experiences with Candida and I read these experiences alongside wider feminist discourses concerning leaky female and contained male corporealities—most notably, though not exclusively, through Elizabeth Grosz's (1994) analysis of men's seminal fluids and women's menstrual flows.

METHODOLOGICAL NOTES

This research is based on a series of 24 semi-structured interviews with people who self-identified as having Candida. Given Candida's speculative medical status, my concern was not with whether the people with whom I interviewed actually 'had' Candida; my concern was with *how* people spoke about their undefined illness experiences. I inquired into such areas as their illness symptoms, their encounters with the medical community, their networks of social support (if any) and how they understand their own health. Interviewees were selected based on whoever was willing to participate, in the order in which they contacted me. I posted requests for these 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. The Canadian Women's Health Network was created in 1993 and is housed in Winnipeg, Manitoba as a voluntary national organization helping to improve the overall health and lives of girls and women across Canada. 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.

Given that many of the participants resided in various cities across Canada and the United Kingdom, 14 of these interviews were conducted over the phone and 10 via email. 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 gave greater voice to the researcher and enabled participants to engage in a conversation about their illness experiences. My phone interviews ranged between 30 and 90 minutes and were transcribed verbatim. My email interviews ranged from one paragraph to two pages and did not need to be transcribed as they were sent electronically. While email interviews were intended to be more convenient for people to respond to, they unfortunately did not generate the same kind of detail as the phone interviews⁴. Because of the overall lack of detail in many of my email interviews (as mentioned, some email interviews were as short as one paragraph), when including narrative excerpts throughout this paper, I draw substantially – though not exclusively – from phone interviews.

My interviewees ranged in age (from late 20s to late 60s), 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. I chose these stories as opposed to others found online and in blogs, because they are backed by the institutional presence of the National Candida Society. These stories are referred to as 'Steve's' and 'Dean's' stories. I refer to the other people with whom I spoke by pseudonym (which each participant had the opportunity to choose), except for the six participants who preferred to use their real names.

I analyzed individual narratives using a Foucault-inspired notion of discourse. Foucault (1972) 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. By focusing on the constitutive role of language, shaped by discourse, I explore how stories about Candida come to be told, how particular meanings come to be formed and how experiences of illness come to be shaped. I interpret individual narratives through the choice of words used, the concepts drawn upon, the repetition of common experiences, emphasis and detail,

⁴ Kaler (2003) notes a similar difference between in-person and web-based interviews in her research on women with vulvar pain.

as well as the organization of individual narratives (Tonkiss, 2004; Wood & Kruger, 2000). My aim is not to represent the entirety of peoples' experiences with Candida, nor for these experiences to account for all people's encounters with the yeast-related disorder. My aim is to offer an analysis of the ways in which dominant leaky and contained gendered constructs come to structure some of the illness experiences of the people with whom I spoke. To begin this analysis, I turn to the work of Elizabeth Grosz (1994) and to the hegemonic masculine ideal of contained corporealities.

Candida & Contained Male Corporealities

Analyzing men's seminal fluids and women's menstrual flows, Grosz (1994) 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). She argues that despite men having many of the same capacities to leak, seep and ooze as women, it is female bodies that are consistently portrayed in terms of leakiness, uncontrollability and seepage. When leaky male bodies do enter discursive representation they are either in reference to male bodies with HIV/AIDS, which are quickly reinscribed back into feminized embodiments, or they are in reference to male ejaculation, which, as Grosz claims, is rarely viewed in terms of its potential for messiness and/or pollution; she 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 perpetually displaced in discourse onto its properties, its capacity to fertilize, to father, to produce an object. (Grosz, 1994, p. 199)

Regardless of the fact that men release thousands of sperm per ejaculation and regardless of the potential pollution of sperm as a carrier of an STD or STI, the liquidities of sperm are restored into something concrete, solid and productive. I use Grosz's arguments to think through the production of the gendered experiences in the case of Candida.

At first glance, Candida in men may seem like an instantiation of leaky male bodies. In the words of the men with whom I spoke, Candida is experienced 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 illness 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). However, a closer reading of these illness experiences yields that while many of these symptoms may not render male bodies productive in the same that male ejaculation can be seen to do, they do render these bodies solid, contained and perhaps most importantly, effectively distanced from the leaky corporealities most commonly attributed to women.

Of the symptoms discussed by the men with whom I spoke, all but two of these symptoms are “physical” in the sense that they tie to biological and not to cognitive or emotional experiences. With the exception of Steve, *no* emotional or cognitive symptoms were mentioned (a point of analysis I will return to). The overall physicality of men’s symptoms in the case of Candida is significant because it renders Candida—to recall, 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 *irrationality* and *uncontainability* we will see in the case of Candida in women. The physicality of men’s symptoms in the case Candida is not only discussed by the men with whom I spoke, but is further identifiable in wider medical literatures on Candida in men.

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. 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 body odor, etc.) are not necessarily rational in any strict sense of the term, but they are, nevertheless, *rationalized* in the case of Candida in that they link men’s symptoms to the physical body. In linking men’s symptoms almost-exclusively to physical manifestations, men’s bodies are once again effectively distanced from the emotionality often attributed to women and women’s bodies, serving to perpetuate what Jansz (2000) refers to as the “restrictive emotionality” expected of heterosexual, westernized forms of male embodiment (p. 166). While historically it has been women’s bodies that have been more commonly allied with biology, corporeality and nature that men’s (Grosz, 1987), in the case of Candida, men’s alignment with biology through the near-exclusive physicality of men’s symptoms serves to distance male bodies from the leaky corporealities we will see in the case of Candida in women.

Even when men do experience a range of emotional and cognitive symptoms, their symptoms are detached from overt associations with femininity. In returning to Steve's case, he states:

At 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. I struggled on over the next few years suffering mood swings, depression, headaches, lack of concentration, chronic fatigue, bloating [and] fungal infections.

Despite experiencing emotional and cognitive symptoms—and despite experiencing emotional and cognitive symptoms that are conventionally associated with feminized forms of embodiment such as mood swings, depression and chronic fatigue—Steve distances his story from those of women by the opening line of his narrative, wherein he states: “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 constructed feminized forms of embodiment.

The men included in this study not only claimed to experience fewer (and often no) emotional symptoms, but they also claimed to experience fewer symptoms overall. As indicated by one of my male participants, “the *only* symptom that I can clearly identify [with Candida] is my itchy ass” (Will). 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, on one men's health website that discusses Candida in men, it states quite explicitly that in the case of Candida in men *sometimes there are no symptoms* (*Yeast Infection In Men*, nd.). If we recall the seemingly endless list of possible Candida symptoms outlined above—symptoms that range from headaches to insomnia and from diarrhea to moodiness—the latter claim that men experience *no* symptoms is truly quite remarkable.

Moreover, despite Candida being a *yeast*-related illness, the word ‘yeast’ is rarely linked to male bodies, or pertinently, to male genitalia. Detailed by the medical literates 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—one of the male body's most distal points. While the penis is also one of the quintessential signifiers of masculinity (if not *the* quintessential signifier), the medicalized term "balanitis" as opposed to the lay term 'yeast' further distances any obvious and 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.

The dissociation of men from corporeal leakiness is further evidenced across other cases of bodily flows. In examining men's attitudes towards bodily flows, Longhurst (2001) points out how one of her male participants referred to his penis using the pronoun 'she' after his penis lost control while urinating. 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 appropriately remarks 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 effectively distanced from female leakiness and lack of corporeal containment and control. In John's case, we can see how the discourses of "solidity and rationality become linked to masculinity", despite the obvious presence of male leakiness (p. 31). The obfuscation of male corporealities that do leak, combined with the consistent and familiar representations of leaky female bodies, enable (mostly heterosexual, white, monogamous) men "to retain their position as rational and untainted by the messiness of corporeal flows" (Longhurst, 2001, p. 67).

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. To borrow from Grosz, it is men's liquidities that they "seem to want to cast out of their own self-representations" (p. 203). Despite male leakiness in the case of Candida, men's leakiness is dissociated from the leakiness normally attributed to women. The permeability of male bodies in the case of Candida is disguised by the physicality and thus rationalization, of men's symptoms and by the distancing of yeast from associations with male bodies and male genitalia. While men may experience Candida differently than women, these experiences cannot be understood outside

already-prevailing discourses concerning contained male and leaky female corporealities. Candida in the instances discussed here, is an instantiation of how male flows get reduced “to the solid” (Grosz, 1994, p. 199) and how they are removed from the messy, abhorrent and, to borrow Grosz’s term, *volatile* forms of embodiment normally attributed to women. It is to these leaky forms of embodiment to which I will now turn.

Candida & Leaky Female Corporealities

In contrast to male seminal flows, Grosz contends that women’s menstrual flows reveal markedly different discursive connotations. Menstrual blood is rarely valued for its reproductive, potentially life-forming, capabilities; it is, instead, almost always tied to a woman’s hormonal cycle and, as such, reinforces female bodies as “excessive, expansive, disruptive and irrational” (Grosz, 1994, p. 200). Unlike men’s seminal fluids, which are often produced as clean, contained and rational, menstrual flows are often produced as both excessive and lacking. “The female body”, through menstruation, “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” (Grosz, 1994, p. 200). Women both fail and exceed hegemonic masculine ideals that bodily fluids be harboured inside the body.

Female bodies in the case of Candida 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. Among the women with whom I spoke, Candida is often described in overtly leaky terms. Aurora explains that “for years nothing stayed inside me. Food went in and came out, because I was so full of the Candida”. Meena describes how “everything inside me is caving in [...] how everything inside me is completely disintegrating”. For Amy, because of urinary frequency, she “had to be near a toilet at all times”. And Diana, in reference to the lack of control she experienced over her bowels, quite candidly states that she “would run to the bathroom [next door] and 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 female bodies, 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 can be further understood as excessive when considering the number of symptoms many of the women with whom I spoke associate with its overgrowth. Diverging once again from the experiences of Candida in

men discussed above, Candida in the women included in my study is not singular, nor is it rational. When asked to describe any symptoms she had experienced, Trish, 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, athlete's 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.

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 read as neither rational nor contained. Based on the sheer number of Trish's symptoms, her physical symptoms read as excessive and disproportionate for a singular etiological cause. They are further rendered ‘excessive’ because they are paired alongside a wide range of emotional and cognitive symptoms including apathy, temper flare-ups, mood swings, crying, self-pity and irritability.

Many of the other women with whom I spoke also listed a wide-range of Candida-related symptoms. As indicated in the following three passages:

I get a lot of gas and bloating. My tongue is always white – it's always been white for as long as I can remember. I've been diagnosed with Generalized Anxiety Disorder. I'm tired all the time. [I have] 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, 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 get sick every time I get stressed. I think that's probably the majority of them (Star).

My sinuses are congested and my nose is inflamed. [I get] nail infections. My throat and larynx are sore. I cough all the time. My thyroid is also very sore. My head is – I think it's full of lead. It feels like I have a very heavy cold or allergies all the time. I can't concentrate or retain information. I'm very tired. I feel exhausted, but I don't sleep very well. I've got all this mucous. All of these things I am absolutely convinced are Candida (Aurora).

I'm absolutely exhausted. I find it very difficult just to walk up stairs. I also get a lot of dizziness. My head feels like there is constant mud in it. I can't think clearly. I'd get very confused and forgetful and also very irritable. My blood sugar drops and I feel very grumpy and agitated and then after eating I feel exhausted. I can sleep 12 hours and still feel very exhausted. I also have pains in my bowels and my guts are always aching. I have all sorts of rashes – ringworm and other fungal infections – and lots and lots of thrush (Kiri).

Pertinent here is not only the sheer number of symptoms that many women attribute to Candida overgrowth, but moreover, the range of symptoms included. As indicated by Trish, Star, Aurora and Kiri, Candida manifests a breadth of cognitive (i.e. brain fog, loss of memory, dizziness), emotional (i.e. depression, irritability) and physical (i.e. diarrhea, thrush) symptoms. Candida not only fails to be contained by female bodies as indicated by the overall leakiness of many female symptoms, but also as indicated here fails to be contained within any one symptomatic manifestation. The permeability of Candida in women is further paralleled by wider medical discourses.

In comparison to the purely physical symptoms in men outlined above by Crook (2003), he lists 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. Unlike the predominantly physical symptoms experienced in men, six of these symptoms (i.e. PMS, fatigue, depression, irritability, being 'spaced out' and poor memory) are either emotional and/or cognitive. Of the remaining eight, four symptoms tie to sex organs and sexual dysfunction (i.e. menstrual irregularities, loss of sexual feeling, vaginal problems and infertility). Because of the production of progesterone, PMS is the suspected cause of Candida, as well as 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.

Furthermore, while the word '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. As indicated by wider medical sources, "the health problems of women are often *yeast*-connected" (Crook, 1985, p. 173, emphasis added), "females develop *yeast* connected health problems more often than males or children" (Crook, 2003, p. 190, emphasis added) and "women are more susceptible to *yeast*-related illnesses" (Adams, 1985, p. 10, emphasis added). Notice in these passages the conflation between the word yeast and the systematic overgrowth of *Candida*. The word yeast is not only explicitly linked to women, but it is often explicitly linked to women's anatomy. According to both Crook (2003) and Wallace (2004), women are particularly susceptible to yeast overgrowth because the vagina is understood to be an ideal breeding ground for yeasts to proliferate. 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 female genitalia. Feminized manifestations of yeast are deemed leaky not only because they lack containment and control (in contrast to the hegemonic masculine norms of corporeal containment), but also because this 'leakiness' emerges alongside already-dominant and prevailing discourses that posit vaginas as sites of infection and contamination.

Reading the historical discourses of menstruation, Andrew Shail (2007) notes that female bodies (and specifically female genitalia) come to be understood as leaky—and through their leakiness also as dirty and dangerous—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). In similarly productive terms as Grosz's analysis of semen, according to early medical conceptualizations, menstruation was deemed active 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 18th 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 menstruate), but also in putting forth the assumption that women's bodies are somehow inherently leakier than men's. Framed as a problem of hygiene, menstruation became conceptualized as that which needed to be dealt with—in other words, as that which needed to be cleansed and contained.

Shail (2007) discusses how, 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” (p. 79). Eighty some-odd-years after this 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 happen for most women throughout the month. The implication of the everyday liner is to contain the flow of other vaginal discharges, of which yeast is likely a part. Guised in the rhetoric of hygiene, these discourses further naturalize “the exclusivity of female flows and the associated idea of a female-only waste-producing bodily activity” (Shail, 2007, p. 91). Important for Shail, as well as Grosz and, ultimately, for my purposes here, 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 dirty) *by* signifying systems.

These arguments are further upheld by Pliskin (1995) in her study of the asymptomatic shedding of genital herpes. Asymptomatic shedding refers to “an infected person shedding the virus without having any of the signs or symptoms associated with herpes” (Pliskin, 1995, p. 481). Revisiting the threat of the *vagina dentata*—a metaphorical mouth with “teeth ready to bite off or castrate the penis” (p. 490)—Pliskin (1995) asserts that “the problem of asymptomatic shedding of genital herpes among women is not simply a physiological phenomenon” (p. 484). She contends rather that the gendered assumptions of asymptomatic shedding need to be understood as “a selective rendering of nature” (Hubbard, 1990, quoted in Pliskin, 1995, p. 480). Working against the dominant medical misconception that women are the primary shedders of genital herpes, Pliskin teases out the gendered discourses outlined as to *why* women unknowingly transmit genital herpes. Detailed by the medical doctors and health care professionals interviewed in her 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* and as that which emerges from within women’s bodies and specifically, from within women’s genitalia.

These discourses are not isolated to the case of asymptomatic genital herpes. Gilman (1988) has similarly argued that the threat of the disease-ridden *vagina dentata* is pervasive in the case of venereal disease. For many of the same reasons outlined by Pliskin (1995), Waldby (1996) likewise addresses this issue when examining HIV/AIDS safe sex campaigns targeted to women. While STDs and STIs are transmittable between partners, in these cases of heterosexual sex and sexual practices, it is female genitalia that are often deemed the carriers of danger and disease. The same, I contend, holds true in the case of Candida.

Despite one woman stating that “[she] never had Candida until [she] met [her] current husband” (Star), this was not a recurring interview theme; more common was the tendency to attribute yeast overgrowth to women and to female genitalia. As Ann explains:

I would mostly notice it [Candida] when comes to having sex and specifically during intercourse. I would be dryer and there would be a think egg-y sort of smell. There would also often be a bit of discharge on the guy's penis. I thought OK, this is yeast. And I knew I wasn't going to cure it with a cream because it was something coming from inside me.

Ann does not attribute the yeast she notices on the guy's penis to the guy. Rather, she attributes the yeast on the guy's penis to that which is coming from inside her and pertinently, to that which is emerging from the presumed dirty and dangerous depths of her own genitalia. Dean makes a similar speculation when he states that he “suspect[s] that [his] initial yeast exposure was most likely sexual in origin”. Without knowing Dean's sexual orientation, or the specific sexual practices involved, given what we already know concerning the threat of leaky female bodies the inference is that Dean contracted his Candida from a female partner, via sexual intercourse. If this speculation is 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 seems to relegate *his* yeast overgrowth to a woman and, most notably, to her genitalia. 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 attributed to women's presumed leaky and infectious seepages.

In speaking to the symbolic dangers of female flows, Grosz (1994) reminds us 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). Despite Candida affecting both men and women and despite both men and women being able to pass it between partners, it is women who are usually blamed for its transmission. Consistent with past studies on asymptomatic genital herpes, HIV/AIDS and venereal disease, in the case of Candida we can see once again 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.

IMPLICATIONS & CONCLUSIONS

Working against the humanist claim that the ill self can speak and be spoken outside constitutive frames of knowledge and power, my aim in this paper has been to understand peoples’ experiences with Candida as situated in and through wider discourses concerning contained male and leaky female corporealities. While feminists of the body and illness have long been concerned with the expulsion and retention of bodily flows, primarily of sexualized flows, they have perhaps curiously neglected to examine the case of yeast. 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. Kristeva (1982), who is also centrally concerned with “the sticky, viscous or amorphous things which are associated primarily with the female and more particularly with the maternal body” (p. 81), too makes no reference to yeast. 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). Yeast, as read through the case of Candida, can also be understood as gendered and gendering, particularly as it reinscribes dominant discourses concerning leaky female and contained male embodiments.

Using Grosz’s arguments about the ways in which male and female secretions come to be shaped in and through different discursive structures, I explored the gendered and gendering terms in and through which the men and women included in my study come to perceive and experience their symptoms differently. In the instantiations of Candida in men analyzed above, Candida manifests fewer (and often no) emotional and cognitive symptoms, as well as fewer symptoms overall. The issue, as contended, is not that male bodies with Candida fail to leak. The issue is that when male bodies with Candida do leak, their fluidities are often effectively cleansed and contained, thus distancing associations with leaky feminized forms of embodiment. In the examples of Candida

in women analyzed above, Candida manifests a wider range of emotional, cognitive and physical symptoms, as well as a wider range of symptoms overall. The de-centralization of Candida in women's bodies is significant because it renders female bodies excessive and irrational when compared to the hegemonic male norms of corporeal containment. The overall lack of containment and control in the case of Candida in women instantiates Grosz's (1994) claim that "female corporeality is inscribed as a mode of seepage" (p. 203). It is through this overall constructed lack of containability that women's bodies in the case of Candida come to be experienced not only as leakier, but also as dirtier and more threatening.

While men and women can and do experience Candida differently, these experiences do not – and cannot – exist prior to medical pathology. The predominantly leaky female and contained male experiences of Candida discussed above are not found to reside inherently in the materialities of the gendered body, but can be found to reside in the very discursive structures in and through which these experiences come to manifest. This point of contention matters not only in an attempt to rethink individuals' experiences with Candida beyond any seeming-essentiality of gendered corporealities, but matters also at a time when chronic undefined disorders like Fibromyalgia, Myalgic Encephalomyelitis, Chronic Fatigue Syndrome and centrally here, Candida, continue to exist largely as feminized disorders (Barker, 2005, Cooper, 1997, Espwall, & Olofsson, 2002, Malterud, 1999, Richman & Jason, 2001, & Ware, 1992). By understanding that these disorders come to be feminized (at least in part) because they fail to conform to the hegemonic masculine ideal that illnesses and their symptoms be contained within the boundaries of the physical body, feminists of the body and illness can also begin to re-conceptualize these disorders as somehow inherently female problems. As chronic disorders like Candida continue to emerge as "undefined" forms of illness within the boundaries of biomedicine, the urgency lies, I contend, not only in making sense of the many nebulous symptoms, but also and perhaps most critically, in understanding how these symptoms are themselves symptomatic of wider and ongoing gendered and gendering relations.

REFERENCES

- Adams, M.L. (1985, Summer). Candidiasis: Beginning to understand a new disease complex. *Healthsharing*, 53 (6), 9 - 12.
- Anderson, J.A., Chai, H., Claman, H.N., Ellis, E.F., Fink, J.N., Kaplan, A.P., Lieberman, P.L., et al. (1986). Candidiasis hypersensitivity syndrome. *Journal of Allergy & Clinical Immunology*, 78 (2), 271 - 273.

- Barker, K.K. (2005). *The Fibromyalgia Story: Medical Authority & Women's Worlds of Pain*. Philadelphia: Temple University Press.
- Belsey, C. (2002). *Poststructuralism: A Very Short Introduction*. Oxford University Press.
- Calderone, R.A. (2002). *Candida and candidiasis*. Washington, DC: ASM Press.
- Candida: Diagnostic & Therapeutic Approaches*. (n.d.). Retrieved January 31, 2006, from <http://www.positivehealth.com/permit/Articles/Colon%20Health/abraham62.htm>
- Cater, R.E. (1995). Chronic intestinal candidiasis as a possible etiological factor in the chronic fatigue syndrome. *Medical Hypotheses*, 44, 507 - 514.
- Crook, W. G. (1985). *The Yeast Connection – A Medical Breakthrough*. Jackson: Professional Books.
- Crook, W. G. (2000). *The Yeast Connection Handbook*. Jackson: Women's Health Connection.
- Crook, W. G. (2003). *The Yeast Connection & Women's Health*. Jackson: Professional Books.
- Cooper, L. (1997). Myalgic encephalomyelitis and the medical encounter. *Sociology of Health & Illness*, 19 (2), 86 - 207.
- Espwall, M. & Olofsson, N. (2002). Legitimacy aspects of social network relations in a group of women with undefined musculoskeletal disorder. *Women & Health*, 36 (4), 85 - 100.
- Foucault, M. (1972). *The Archaeology of Knowledge*. New York, NY: Pantheon Books.
- Gilman, S. (1988). *Disease & Representation: Images of Illness from Madness to AIDS*. Ithaca: Cornell University Press.
- Grosz, E. (1987). Notes toward a corporeal feminism. *Australian Feminist Studies*, 5, 1 - 17.
- Grosz, E. (1994). *Volatile Bodies: Towards a Corporeal Feminism*. Bloomington: Indiana University Press.
- Hahn, R. A. (1995). *Sickness & Healing: An Anthropological Perspective*. New Haven: Yale University Press.
- Jansz, J. (2000). Masculine identity and restrictive emotionality. In A. H. Fischer (Ed.). *Gender & Emotion: Social Psychological Perspectives* (pp. 166-186). Cambridge University Press.
- Kaler, A. (2003). *Asking sensitive questions on the web: Preliminary reflections on epistemological and methodological comparisons of web-based and in-person interviews about vulvar pain*. Presented as part of the David E. Pierce Research Symposium, University of Alberta, October, 2003.
- Kristeva, K. (1982). *Powers of Horror: An Essay in Abjection*. New York, NY: Columbia University Press.

- Liao, R., S. (2002). *Vitality & mortality of Candida albicans* (Doctoral dissertation. Retrieved from ProQuest Dissertation and Theses AATNQ81223).
- Longhurst, R. (2001). *Bodies: Exploring Fluid Boundaries*. New York, NY: Routledge.
- Malterud, K. (1992). Women's undefined disorders: A challenge for clinical communication. *Family Practice*, 9, (3), pp. 299 – 303.
- Malterud, K. (1999). The (gendered) construction of diagnosis: interpretation of medical signs in women patients. *Theoretical Medicine & Bioethics*, 20, pp. 275 – 286.
- Martin, J. (2000). *The Complete Candida Yeast Guidebook: Everything You Need to Know About Prevention, Treatment & Diet*. New York: Random House Inc.
- Moore, C. W. (1998). The Candida syndrome: Health nemesis or myth? *Natural Life Magazine*, 60, 12 – 18.
- Pliskin, K.L. (1995). Vagina dentata revisited: Gender and asymptomatic shedding of genital herpes. *Culture, Medicine & Psychiatry*, 19, 479 – 501.
- Reuter, S. Z. (2002). Doing agoraphobia(s): A material-discursive understanding of diseased bodies. *Sociology of Health & Illness*, 24 (6), 750 – 770.
- Richman, J.A., & Jason, L. A. (2001). Gender biases underlying the social construction of illness states: The case of Chronic Fatigue Syndrome. *Current Sociology*, 49 (3), 15 – 29.
- Saltarelli, C. G. (1989). *Candida Albicans: The Pathogenic unguis*. New York, NY: Hemisphere Publishing Corporation.
- Schumacher, T. & Lund, T. (2001). *Candida: The slow killer*. Gilmer, TX: Schumacher Inc.
- Shail, A. (2007). 'Although a woman's article': Menstruant economics and creative waste. *Body & Society*, 13 (4), 77 – 96.
- Tonkiss, F. (2004). Analyzing discourse. In C. Seale (Ed.), *Researching Society & Culture* (pp. 245 – 260). Thousand Oaks, CA: Sage.
- Truss, C.O. (1978). Tissue injury induced by candida albicans: mental and neurological manifestations. *Journal of Orthomolecular Psychiatry*, 7(1), 17-37.
- Truss, C.O. (1980). Restoration of immunologic competence to Candida albicans. *Journal of Orthomolecular Psychiatry*, 9, 139-153.
- Truss, C.O. (1981). The role of candida albicans in human illness. *Journal of Orthomolecular Psychiatry*, 10 (4), 228-238.
- Truss, C.O. (1983). *The Missing Diagnosis*. Birmingham, AL: The Missing Diagnosis, Inc.
- Truss, C.O. (1984). Metabolic abnormalities in patients with chronic candidiasis. *Journal of Orthomolecular Psychiatry*, 13, 1-28.

- Waldby, C. (1996). *AIDS and the Body politic: Biomedicine & Sexual Difference*. New York, NY: Routledge.
- Wallace, H. (2004, January 20). Spotlight on yeast infections. *Alternative Medicine*, 53, 32-39.
- Ware, N.C. (1992). Suffering and the social construction of illness: the delegitimization of illness experience in Chronic Fatigue Syndrome. *Medical Anthropology Quarterly*, 6, (4), pp. 347 - 361.
- Whitaker, W. (2005). *Words Latin-to-English Dictionary*. Retrieved April 4, 2004, from <http://ablemedia.com/ctcweb/showcase/whitakerwords.html>
- Wood, L. A. & Kruger, R.O. (2000). *Doing Discourse Analysis: Methods for Studying Action in Talk & Text*. Thousand Oaks, CA: Sage Publications.
- Wunderlich, R. C. (1997). *The Candida-yeast Syndrome: The Spreading Epidemic of Yeast-Connected Diseases*. Los Angeles, CA: Keats Publishing, Inc.
- Yeast Infection In Men*. (nd.). Retrieved March 20, 2007, from <http://www.clivir.com/lessons/show/yeast-infection-in-men-male-yeast-infection-symptoms.html>

Copyright of Women's Health & Urban Life is the property of Women's Health & Urban Life and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.