

## **Bodies in Conflict**

### **A Critical-Interpretive Analysis of Gulf War Syndrome**

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#### **Introduction**

The host of medical symptoms collectively referred to as Gulf War Syndrome cannot be understood outside of the social and political contexts from which have they emerged and continue to exist. This paper will employ a critical-interpretive approach in order to examine the individual, social, and political bodies enmeshed in the symptoms attributed to Gulf War Syndrome by veterans of the United States armed forces, illustrating the powerful and salient linkages between each.

Beginning with an analysis of the veterans' narratives, the emotions contained within each will be examined in order to reveal the lived experience of the veterans affected by Gulf War-related illnesses. Evidence of economic strain due to a lack of consistent government compensation and employment, as well as emotional distress and psychological dysfunction will be emphasized. Social isolation of ill veterans will be shown to have arisen from both.

It will be demonstrated that the symptoms and explanations offered by veterans are strongly influenced by the social context in which they have materialized. Concern that compromised mental health may negatively affect one's career and perceptions that acceptance of a stress diagnosis may also represent an omission of personal responsibility will be shown to be of particular importance. Further, organic explanations offered by veterans will be identified as an attempt to shift the responsibility for their suffering to the military command of the United States government. In particular, the use of drugs and vaccines not approved by the FDA, and exposure to pesticides known to cause neurological dysfunction will be framed as negligent. In addition, a lack of candour on behalf of the Department of Veterans Affairs (VA) and Department of Defence

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and the provision of limited compensation will be shown to be construed as indicative of political indifference.

Symptom reporting will be further revealed to operate on a metaphorical level. Disharmony within the social realm will be shown to mirror the conceptions of the individual body. Particular attention will be paid to conceptions of the malfunctioning immune system and its relation to political inaction. Further, notions of femininity and frailty employed to describe the bodies of ill veterans will be shown to be of importance in emphasizing the perversion of traditional social roles.

It will further be demonstrated that the fractured body images of ill Gulf War veterans reflect a division within the body politic. Limited support for the war, stemming from a concern regarding economic depression and a lack of perceived necessity within the general public, will be shown to have undermined political solidarity within the United States. Concern over the economic motivations for the US-led war will be shown to be indicative of ideological uncertainty regarding the motivations behind the conflict. It will also be shown that veterans' search for an organic cause for their suffering is paralleled by a search for an acceptable moral cause in combat.

In light of the literal and metaphorical significance attached to veterans' symptoms, it will be shown that Gulf War-related symptoms can be understood as idioms of distress, as "symbolic and affective associations which take on contextual meaning in relation to particular stressors" (Nichter 1981:379). Symptom-reporting will be understood as an effective means of transferring private sentiment into the public domain in a legible yet secure manner via the manufacture of metaphorically significant symptoms. It will be stressed that, despite its association with extreme personal anguish, such symptom reporting does not arise out of a psychological pathology. Rather, Gulf War-related symptoms will be shown to be simply a localized illustration of the ways in which the social and political contexts serve to inform the perception of personal distress amongst all ill individuals, regardless of their demographic profile.

The conclusion that will be offered is that in order to fully understand Gulf War-related symptoms, one must afford a voice to the veterans suffering from them and consider the wider contexts in which they are situated. Only when the social and political realities

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associated with Gulf War illness are addressed, will the individual suffering of thousands of US veterans truly be appreciated and the necessity for political response be revealed.

### Symptoms

Almost immediately following the end of the Persian Gulf War on April 11<sup>th</sup>, 1991, veterans in countries such as the United States, Canada, and the United Kingdom began reporting a variety of psychological and physical symptoms (Institute of Medicine 2000; Unwin et al. 1999; Goss Gilroy 1998). In the United States, both the US Department of Defence and Department of Veterans' Affairs responded by establishing nation-wide registry programs through which veterans could receive diagnostic evaluations (Institute of Medicine 2000). Of approximately 697,000 United States troops deployed as part of Operations Desert Shield and Desert Storm in 1990 and 1991, almost 125,000 of them had undergone registry health examinations by March 1999 (Institute of Medicine 2000).

The symptoms reported by these veterans are similar within each of the two registries and include a wide range of complaints such as fatigue, skin rash, headache, muscle and joint pain, memory loss, sexual dysfunction, difficulty breathing, sleep disturbances, gastrointestinal disruption, chest pain and bleeding gums (Institute of Medicine 2000). Two veterans have even claimed to be shrinking as a result of their service within the Persian Gulf (Showalter 1997). The illnesses underlying these symptoms have also had adverse effects on the family and spouses of the affected veterans. Although not corroborated by epidemiological studies, several veterans have reported birth defects in relation to their service in the Gulf War (Showalter 1997; Shriver et al. 2003). The three most commonly reported symptoms within the VA registry include fatigue (20.5%), skin rash (18.4%), and headache (18.0%) (Institute of Medicine 2000).

Innumerable studies have attempted to catalogue and group these symptoms as a first step towards determining any causal agent(s). Principal factor analysis, a statistical data reduction technique, has been employed in an attempt to reveal subtle associations underlying this seemingly chaotic array of symptoms (Haley et al. 1997a; Fukuda et al. 1998). A study by Haley et al. (1997a) identified six factors or "syndromes" underlying the symptom reporting of Gulf War

veterans. Of these six, the three factors summarizing the most commonly reported symptoms are: *Impaired Cognition*, characterized by problems with attention, memory and reasoning as well as insomnia, depression, drowsiness and headache; *Confusion-Ataxia*, characterized by impaired thinking, disorientation, balance disturbances, vertigo and impotence; and *Arthro-myo-neuropathy*, characterized by joint and muscle pain, fatigue, difficulty breathing and extremity paresthesias (Haley et al. 1997a).

Although more recent studies have suggested a revision of the number of factors and the organization of symptoms within each, the prevalence of these symptoms has consistently been shown to be elevated amongst deployed veterans when compared to military personnel who did not serve in the Persian Gulf (Iowa Persian Gulf Study Group 1997; Fukuda et al. 1998; Hallman et al. 2003). Further, the majority of research acknowledges the continued impact of these symptoms on the health, functional status and well-being of affected Gulf War veterans and their families (Haley et al. 2002). When compared to both healthy individuals and those suffering from a variety of common illnesses for which substantial negative impacts have been previously documented (ex. congestive heart failure, type 2 diabetes and clinical depression), affected veterans display far higher levels of impairment in standardized clinical evaluations (Haley et al. 2002).

### **Biomedical Aetiology**

By 1998, roughly \$115 million US had been used to fund some 121 government inquiries into Gulf War Syndrome (Lashof and Cassels 1998). There have been countless independent medical inquiries within the academic setting. Much of this research has been directed towards elucidating a possible cause for these symptoms. The symptoms reported have been investigated by both government-funded research committees and by the medical community in both the civilian and military settings. Despite a diversity of opinions, it is possible to make several generalizations regarding the nature and the causes of veterans' symptoms.

Although Gulf War veterans report such complaints on the order of twice as often as their non-deployed peers (Deahl 2005), some researchers express reluctance to identify a distinct illness category under which to group these symptoms. Simply put, they are unwilling

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to concede that a Gulf War Syndrome exists. According to these researchers, the variety of symptoms and their appearance within veterans not deployed to the Persian Gulf, preclude the possibility of this host of symptoms being indicative of a new syndrome (Ismail et al. 1999; Institute of Medicine 2000). In a 1999 comparison between UK veterans of the Gulf War and those having served in Bosnia, Ismail et al. (1999:81) concluded that although the frequency of symptom reporting was elevated amongst Gulf War veterans, there was no evidence for a unique Gulf War Syndrome since “the underlying structure of the correlations between symptoms was similar to other cohorts”. These findings are in keeping with the conclusions of earlier United States government panels which concluded that symptoms attributed to service in the Persian Gulf War parallel those reported by veterans of other conflicts (NIH Technology Assessment Workshop Panel 1994; Committee to Review the Health Consequences of Service During the Persian Gulf War 1995; Committee on the Department of Defence Persian Gulf Syndrome Comprehension Clinical Evaluation Program 1995).

Furthermore, although Gulf War veterans continue to report greater frequencies of dysfunction, these self-reports have not been born out in clinical settings. Investigation into physical maladies underlying reported symptoms has failed to find a consistent association between mild to moderate or even severe cases and “clinically significant physical examination or routine laboratory test abnormalities” (Fukuda et al. 1998:986).

Unable to organize these symptoms into a coherent pattern, many researchers have been reluctant to create a new illness category (Zavestoski et al. 2004). Instead, both government committees and medical researchers have attempted to explain these symptoms with reference to pre-existing illness categories. Both chronic fatigue and fibromyalgia, two other illnesses also characterized by a constellation of diffuse and contested symptoms have been explored as possible explanations (Zavestoski et al. 2004). However, to date the explanatory focus within the biomedical community has been on the role of stress in such symptom reporting.

Numerous government sponsored panels and research have concluded that stress is an important contributing factor to the illnesses reported by veterans of the Gulf War (Presidential Advisory Committee on Gulf War Veterans' Illnesses 1996; Marshall et al.

2000). They note that stress can manifest itself in numerous ways, leading to both physical and psychological dysfunction. Prolonged exposure to stressful situations in which there exists a perception of threat is seen as the most likely explanation for physical deterioration among Gulf War veterans (Presidential Advisory Committee on Gulf War Veterans' Illnesses 1996). Possible stressors include:

Short deployment notice, uncertainty about the mission and length of deployment, harsh and crowded living conditions, long work hours, separation from loved ones and indigenous populations, concern about polluted environmental conditions, fear of missile attack, prolonged anticipation of chemical and biological weapons attack, and indirect exposure to combat and its often horrifying aftermath... (Marshall et al. 2000:68).

The historical precedent of psychological dysfunction amongst veterans from other conflicts, in particular veterans of the Vietnam conflict, is alleged to further strengthen these conclusions. In particular, the medical category of Post Traumatic Stress Disorder has been cited as a possible explanation for Gulf War veterans' symptom reporting (Marshall et al. 2000).

In this way, veterans' maladies are presented as arising from the combined psychological trauma of deployment rather than from any physical injury sustained during combat (Brende and Parson 1985). Such aetiology views the veterans' physical symptoms as the result of the maladaptive physical responses to perceived threats within the immediate environment (James and Brown 1997).

### **Veterans' Response**

The veterans' responses to the findings of the above research reveal a deep-seated reluctance to accept the biomedical and governmental psychological or stress-related explanations for their symptoms. Instead, veterans groups and veteran-funded research have focused on possible organic causes for their unexplained symptoms.

Over fifty grass-roots organizations of affected Gulf War veterans exist today (Shriver et al. 2003). Many group members made contact with each other over the internet, a resource that has allowed veterans to share information and remain connected despite large geographic divides (Shriver et al. 2003). A veteran-run website known as the Gulf War Resource Pages provides links to numerous such organizations including the National Gulf War Resource Centre and

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the American Gulf War Veterans Association, each of which represents numerous smaller organizations (National Gulf War Resource Center 2003). In addition to their function as avenues of emotional and social support, the focus for such groups has largely been to pressure government and military officials to acknowledge the many chemical, biological and infectious agents to which soldiers were exposed during service and their possible role in self-reported symptoms among a large percentage of veterans (Shriver et al. 2003). Members of such groups list a variety of possible explanations including:

1. Exposure to biological agents including bio-weapons such as anthrax.
2. Exposure to chemical weapons in the possession of the Iraqi military including sarin and mustard gas.
3. Administration of experimental drugs and vaccines by the US military prior to deployment including pyridostigmine bromide (a chemical used to block the effects of the nerve agent soman), as well as anthrax vaccine and *botulium toxoid* vaccine.
4. Exposure to depleted uranium, a radioactive material used to construct casings for many of the munitions used by the US military in its aerial bombing campaigns.
5. Exposure to fumes from oil well fires.
6. Exposure to pesticides such as DEET.
7. Exposure to endemic diseases such as leishmaniasis, brucellosis, and cholera (National Gulf War Resource Center 2003; Golomb 1999).

Veterans feel that multiple low-dose exposures to any of the above factors or some synergistic combination of multiple factors are the most likely explanation for their illnesses, and they believe there is scientific evidence to support this assertion (National Gulf War Resource Center 2003; Pennisi 1996). They adamantly deny psychological dysfunction and stand firm in their belief that their physical symptoms constitute a novel and unique syndrome directly related to their service in the Middle East (Shriver et al. 2003). Unsatisfied with biomedical characterization of their illness symptoms, they have engaged in self-diagnosis and actively sought out a minority of physicians willing to entertain the notion that

physical disease processes may be to blame (Zavestoski et al. 2004). Veterans have pressured their government for access to relevant medical reports and military medical records, in the hope that, with enough research, organic causes for their suffering will be revealed (Zavestoski et al. 2004; Caress 2001; Brown et al. 2001).

### **Theoretical Perspective**

In order to fully understand the import and meaning of the diagnostic struggle surrounding Gulf War-related symptoms, it is necessary to situate both the illness and the veterans within the larger political, social, and economic spheres, while referring to the historical particularities of the time. However, in so doing, one must be careful not to obscure the lived experience and tangible suffering of the veterans reporting these symptoms. Their faces must not be lost in the crowd. As such, this paper will employ a critical-interpretive anthropological analysis of Gulf War Syndrome.

Originally outlined by Lock and Scheper-Hughes (1986), such an approach considers the body to be a multi-layered image, reflecting and reacting to personal, social, and political pressures. Rather than accepting a dualistic biomedical view of the body in which the body and mind are considered separate entities, such an approach acknowledges the influence that each may exert on the other (Lock and Scheper-Hughes 1986). Further, the body is seen as a marriage of three constituent bodies: the individual body (the lived self), the social body (the symbolically significant body shaped through relations with others), and the political body (the body shaped by notions of acceptability and correctness) (Scheper-Hughes and Lock 1987). A critical-interpretive approach stresses the effect that turmoil outside of the individual body has in shaping the existence and perception of personal distress (Scheper-Hughes and Lock 1987). It argues that the individual body can be seen as “the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle” (Scheper-Hughes and Lock 1996:71). Illness is therefore seen as a socially, politically, and personally significant event meant to broadcast distress on a literal and metaphorical level (Scheper-Hughes and Lock 1987). Symptom reporting is recast as a universal means of communicating dissent open to all human beings (Lock and Scheper-Hughes 1996).



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A critical-interpretive analysis of illness requires one to examine the personal, social, and political implications of its symptoms. In opposition to the political economy of health studies, which depersonalize the subject matter and render culture subordinate to class distinctions, such an analysis holds that personal narratives are essential to an adequate treatment of illness meaning (Scheper-Hughes and Lock 1986). Lock and Scheper-Hughes (1986:138, 139) stress that “while illness symptoms are biological entities they are also coded metaphors that speak to the contradictory aspects of social life, expressing feelings, sentiments, and ideas that must otherwise be kept hidden”. In times of personal and social unrest, illness symptoms may act as “idioms of distress”, presented in order to voice one’s dissatisfaction in a socially and politically acceptable manner (Nichter 1981). Thus, symptom reporting allows one to communicate distress yet simultaneously navigate social constraints.

While such a perspective draws parallels with the “expression of personal and social distress in an idiom of bodily complaints and medical help-seeking” referred to as somatisation, this term will not be used to describe the psychosocial aspects of veterans’ illnesses (Kleinman and Kleinman 1985:430). Somatisation has received much attention within the biomedical community in relation to psychological dysfunction wherein it has been framed as a means of communication employed predominantly by marginalized individuals of lower socio-economic status or those subject to traumatic life events (Biderman et al. 2003). This runs counter to a critical-interpretive perspective, which holds that *all* illness symptoms are deserving of social and political inspection (Scheper-Hughes 1994). In order to avoid victim-blaming, symptom reporting is not understood to be indicative of personal pathology nor is it framed solely as the result of socio-economic distress.

The remainder of this paper will examine both the social and political bodies overlaying individual symptom reporting by Gulf War veterans. The analysis will begin with an exploration of the phenomenological experience of symptomatic veterans. Veterans’ experiences will then be used to illuminate the social and political forces shaping their personal perceptions of Gulf War-related illness.

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**The Individual Body***The Lived Experience*

The personal voice in this conflict is best understood through an examination of the narrative of individual veterans. This is a logical starting point for an analysis that hopes to account for macroscopic social and political realities informing and shaping patterns of illness among veterans. In their own voices, what are the concerns of veterans? What do they feel should be done to alleviate their suffering? These are important questions from a critical-interpretive perspective in that personal emotion acts as a mediatrix of the three bodies, affecting “the way in which the body, illness, and pain are experienced and are projected in images of the well or poorly functioning social body and body politic” (Scheper-Hughes and Lock 1987:28).

Interviews with affected veterans reveal a great deal of physical suffering. As mentioned above, the breadth and severity of symptoms reported is staggering. Veterans are faced with debilities ranging from skin rashes to gastro-intestinal malfunction (Hallman et al. 2003). Psychological disorders such as depression and anxiety are also extremely common (Hallman et al. 2003). These symptoms have affected the lives of veterans in myriad ways.

*Economic Strain*

“...we live on a little over a \$1,000 a month. If I didn't live in my parents' home, we would be out in the streets-literally. We can't even feed the kids on what we get!”

-Wife of an ill veteran (quoted in Shriver et al. 2003:645).

Few Persian Gulf veterans are still serving in the military (Haley et al. 1997a). Further, of those soldiers who have retired, few who report severe symptoms are able to hold civilian jobs (Shriver et al. 2003). This means that many veterans face their illnesses with diminished income and no medical coverage, as the cost of medical treatment is compensated by the military only so long as they are able to demonstrate a link between exposure events during service and specific symptoms (Shriver et al. 2003; Department of Veterans' Affairs 2000). Furthermore, the families of military personnel are offered medical coverage only so long as they serve within the military (Shriver et al. 2003). Unable to secure military assistance,

the costs of medical treatment often surpass household income for many veterans (Shriver et al. 2003). A lack of employment and medical insurance conspire to push veterans and their families closer towards financial disaster, driving some families to bankruptcy (Shriver et al. 2003).

Although a Veterans Assistance Bill was passed in 1994, this legislation offers only limited compensation to veterans. For those who are eligible, structural impediments further impede compensation. Many ill veterans do not fit the strict set of criteria set by the VA and are therefore denied care and benefits (Caress 2001). In order to be eligible for compensation a veteran "must have served on active duty between August 2, 1990 through a date yet to be determined in one of these countries: Iraq, Kuwait, Saudi Arabia, the UAE, Bahrain, Qatar, Oman, the Gulfs of Aden and Oman, the Persian Gulf, the Arabian Sea, as well as the airspace above these locations" and all symptoms must be manifest before December 31, 2006 and have continued for a period of no less than six months (National Gulf War Resource Center 2003:75). This stipulation is particularly frustrating in light of research that suggests a prolonged latency period prior to neurological symptoms becoming manifest following exposure to organophosphates (Department of Veterans' Affairs 2000; Haley et al. 1997b).

In order to qualify for assistance, veterans must also undergo a clinical examination by a physician (National Gulf War Resource Center 2003). It is also up to the veteran to initiate and complete all proper procedural protocols regarding a claim. This means gathering one's own mental health, medical and service records, both civilian and military, and getting statements from all physicians and medical providers (National Gulf War Resource Center 2003). It is clear that filing a claim with the Veterans' Association in order to receive compensation can be a difficult process. Moreover, the outcome of an application is never certain. Much of the veterans' compensation simply never reaches those in greatest need of financial assistance (Shriver et al. 2003).

### *Social Disintegration*

"My life is going in a different direction than their life is. You don't have much in common... You're fighting for money, you're fighting to survive."

-Anonymous Gulf War veteran (quoted in Shriver et al. 2003:653).

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For many veterans, the disruption caused by their symptoms has extended into the social sphere. Financial hardships created Gulf War related illnesses, coupled with the emotional distress associated with their suffering, often serves to amplify marital distress. Many veterans report marriages ending in divorce (Shriver et al. 2003). Furthermore, many affected veterans report a feeling of social isolation and a feeling of alienation from former friends. There is a sense amongst affected veterans that their illnesses have left them altered and isolated (Shriver et al. 2003). Thus, for many, Gulf War illnesses have metastasized into social withdrawal and familial dysfunction.

Although veterans' groups provide emotional support and act as a vehicle through which their members may ultimately bring attention to their suffering, they may also at times re-enforce the feeling of social disconnection veterans feel. There is a sense that only those within such groups truly understand the suffering of ill veterans (Shriver et al. 2003). The feeling that only ill veterans can appreciate the magnitude of distress associated with Gulf War-related symptoms causes some veterans to neglect commitments of prior importance, ultimately exacerbating the atrophy of personal and familial relationships (Shriver et al. 2003).

### *Depression and Anxiety*

"It got so bad-the depression. I tried to kill myself a couple of times. It all got too much for me to handle."

- Anonymous veteran (quoted in Shriver et al. 2003:646).

It is not surprising that many ill veterans report suffering from depression and anxiety. Feelings of helplessness and shame are related to both the physical and psychological symptoms as well to the social disintegration that veterans experience (Shriver et al. 2003). Depression and sudden mood changes were the two most commonly reported symptoms in a study by Hallman et al. (2003) of 1161 veterans within the Veterans' Association Health Registry. The social situations, in which they have been placed, along with a perceived lack of efficacy, exist in a synergistic relationship with personal dysfunction and have made psychosocial distress a reality for many Gulf War veterans. Nevertheless, as mentioned above, veterans are reluctant to focus on psychological symptoms as a hallmark of Gulf War illness.

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The above excerpts from veterans' testimonies provide evidence of the personal, financial, and social decay associated with Gulf War-related symptoms. These narratives make it clear that the physical and psychological maladies with which veterans present to physicians are but one aspect of the trauma visited on them. Personal and social disruptions are inseparable. Just as social structures have precipitated veterans' symptoms by placing them in harm's way, so too have social norms constrained the very act of symptom reporting, augmenting veterans' perceptions of their illness.

### **The Social Body**

#### ***The Acceptability of Stress***

"Couldn't get along with nobody...Couldn't even get out the house...Post-traumatic stress, my black ass."

- Gregory Jaynes, Gulf War veteran (quoted in Showalter 1997:135)

Despite acknowledging the anxiety and depression associated with their illnesses, veterans have largely rejected psychological explanations for their distress (Showalter 1997; Brown et al. 2001; Shriver et al. 2003; Kilshaw 2004). This may be due in part to the general and pervasive Western stigma surrounding mental dysfunction (Porter and Johnson 1994). Accordingly, stress as an explanatory model is unacceptable to veterans on multiple levels.

Thus, the stigma surrounding psychological dysfunction is a likely determinant of symptom reporting within the armed forces (Porter and Johnson 1994). Within the military context, there exists the perception that an evaluation leading to a diagnosis of compromised mental health can negatively affect one's career (Porter and Johnson 1994). Fear arises from the knowledge that the results of any and all medical examinations are permanently stored as part of one's service record and that each member's commanding officer has access to such records (Porter and Johnson 1994). Military men and women may therefore be reluctant to accept psychological diagnoses out of a concern that doing so may degrade the social bonds essential to military service, retard their movement up the ranks, or even result in discharge (Porter and Johnson 1994).

Acceptance of a stress diagnosis may also be seen to represent an admission that the veterans' suffering is "all in their heads", and that being linked to a constellation of symptoms without an organic cause, it is somehow less *real*. Such a perception emerges out of the

Cartesian division of the mind and body operationalized within Western biomedicine (Scheper-Hughes and Lock 1987). It is certainly not limited to military culture. Rather, there exists a feeling within much of North American society that mental health illnesses are confined to the mind and therefore have neither physical symptoms nor physical origins. Mental disorders are rarely granted the same legitimacy as bodily ailments (Kirmayer 1999 cited in Kilshaw 2004:156). Without bodily origins or symptoms, mental illnesses may also be seen to be under individual control. As such, a stress diagnosis may ultimately blame the victims and reflect poorly on the character of veterans, irrespective of their illness [for a more complete treatment of the materialist nature of biomedical intervention and its influence on the public perception of personal health see Scheper-Hughes and Lock (1987)].

Darwinian notions of adaptive fitness may also inform veterans' opposition to a stress-related diagnosis. In biomedicine, stress is seen as both a physiological and psychological response to potential threats within the immediate environment (James and Brown 1997; Blakey 1998). Within an evolutionary context, such "fight-or-flight" responses are adaptive, as they prepare an organism to deal with impending dangers (James and Brown 1997). However, when these responses persist over a prolonged period they may have a detrimental impact, increasing the likelihood of poor health (Marshall et al. 2000). In this context, a stress response becomes harmful to the individual and within the evolutionary spectrum may be viewed as maladaptive.

Potential threats were ubiquitous within the Persian Gulf. In particular, military officials point out that soldiers were informed of the threat of exposure to chemical and biological weapons prior to deployment and that chemical attack sirens often sounded several times a day inside US military barracks (Marshall et al. 2000). However, they are quick to add that, with rare exceptions, such dangers never materialized (Marshall et al. 2000). US soldiers were not exposed to high levels of chemical or biological agents, as these would have produced severe acute symptoms or even death, neither of which was encountered during the war (Augerson 2000). Military and civilian medical researchers point out, however, that the mere perception of a threat may be sufficient to produce a stress response amongst deployed soldiers (Marshall et al. 2000). Research giving rise to stress-related explanations may therefore imply that illness

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symptoms have arisen from veterans' own misunderstanding of the wartime environment. Veterans' responses are therefore framed as not only maladaptive but ultimately born out of an overactive imagination. In either case, the locus of responsibility is situated squarely with the individual soldiers. They are blamed for their own illness.

The treatment of veterans of the Vietnam conflict following their return from combat may also inform the reluctance of Gulf War veterans to accept stress-related diagnoses for their symptoms. Obvious parallels exist between the plight of Vietnam veterans and that of Gulf War veterans. Following their return from combat, both groups became engaged in diagnostic struggles against the United States government for acknowledgement of exposure to harmful chemical toxins during service (Bonior et al. 1984; Scott 2004). During the Vietnam conflict eleven million gallons of Agent Orange, a mixture of two synthetic herbicides, 2,4-D and 2,4,5-T, were used by US troops as a defoliant (Scott 2004). One of the chemicals in Agent Orange, 2,4,5-T has been shown to cause cancer and elicit other harmful side effects in humans (Scott 2004; Cornell University 2005). Yet at the time, the legislative focus remained on stress-related dysfunction rather than on chemical exposure, delaying compensation for veterans. It was not until 1984 that Bill HR 1961 providing compensation for exposure to Agent Orange was passed; an event that took place nine years after the end of the conflict and four years after the psychological nature of veterans pathologies had been recognized and accommodated by the creation of a new diagnostic category known as Post Traumatic Stress Disorder within the *Diagnostic and Statistical Manual of Mental Disorders, DSM-III*, (Scott 2004; Bonior et al. 1984). Gulf War veterans may anticipate similar legislative stagnation should they emphasize the psychosocial aspects of their distress.

Ill Gulf War veterans may also fear potentially negative social responses associated with such diagnoses. In the past, Vietnam veterans who accepted and even fought for stress diagnoses related to their combat experiences were met with social stigma arising in part from fear of the erratic and aggressive behaviour associated with Post Traumatic Stress Disorder (Brende and Parson 1985). Today, as in the past, such behaviour may make similar stress diagnoses both socially and personally undesirable. Gulf War

veterans may therefore amplify the physical symptoms of their suffering out of fear of negative public perceptions.

It is clear that constraints within the social realm have shaped veterans' symptoms. Notions of acceptability and connotations of personal responsibility have made acceptance of stress-related diagnoses inappropriate for veterans. Yet resistance to explanations focusing on psychological dysfunction also stems from perceptions of government responsibility. Biological and chemical explanations offered by veterans focus on physical harms visited upon them during deployment, shifting the liability for their suffering to the military command and ultimately their government.

### *Implicating the Government and Military Command*

“We believe there’s a cover-up”

- Vic Sylvester, Gulf War veteran (quoted in Showalter 1997:135)

Prior to deployment to the Persian Gulf, soldiers were administered vaccines to protect them against possible chemical and biological weapon attacks by Iraqi forces (Rettig 1999). Amongst these were pyridostigmine bromide, a drug thought to inhibit the actions of certain nerve agents, and *botulinum* toxin, designed to protect against botulism. It is important to note that the Food and Drug Administration had not approved either of these drugs at the time of their administration to the troops (Rettig 1999). Instead, an “Interim Rule,” allowing military use of the drugs without informed consent or clinical testing was established (Rettig 1999). In the absence of both consultation and consent, deployed soldiers were therefore exposed to untested drugs, the effects of which were unknown.

During the war, military officials also employed a number of pesticides designed to target a variety of insects. Included amongst these was DEET, a broad-spectrum insecticide used to control arthropod-borne disease which has been linked to cardiovascular and nervous-system dysfunction in animal trials; Lindane, a de-lousing agent known to cause hyper-excitability tremor, seizure and coma; and various organophosphates (ex. Diazinon and Malathion), a “group of chemicals that bind to and inhibit the normal action of acetylcholinesterase,” an enzyme that acts as a chemical messenger in the brain and central nervous system (Cecchine et al. 2000:xxiii). While exposure to any of these chemicals may have adverse affects,



organophosphates in particular have been implicated in the generation of Gulf War-related symptoms (Haley and Kurt 1997; Wickelgren 1997). Following an evaluation of both potential exposures and the neurological symptoms of veterans, Haley et al., (1997b) and Haley and Kurt (1997) reported that organophosphate-induced delayed polyneuropathy (OPIDP) is a plausible explanation for the three factor-derived syndromes reported earlier (Haley et al. 1997a; McCarthy 1997a).

The explanations offered by veterans are of significance not only because they resist a stress diagnosis but also because they implicate the government. More than negligence, veterans feel that they were knowingly placed in harm's way (Shriver et al. 2003; Showalter 1997). They see their illness as something caused by the actions of a military and a government that saw them as dispensable, as necessary and acceptable costs of war rather than valuable individuals (Shriver et al. 2003). Continued denial of responsibility has been compounded by a lack of candour on behalf of the Department of Veterans Affairs and Department of Defence, regarding logs showing contact with Iraqi chemical weapons. Existence of such records was not made public until 1996, following a lengthy court battle in which a support group known as the Gulf War Veterans of Georgia won access to them under the Freedom of Information Act (Caress 2001). The subsequent revelation that munitions destroyed by allied forces inside a large storage complex outside Khamisiyah in March of 1991 contained both sarin and cyclosarin, and that between 20,000 and 100,000 troops may have been exposed to these nerve agents has fuelled further speculation of a cover-up on the part of the military (Institute of Medicine 2000:172-173; Caress 2001; Chelala and McCarthy 1997; McCarthy 1997b).

For veterans, a picture has emerged of a government whose initial negligence and subsequent indifference have both precipitated and perpetuated their suffering. Their symptoms and the explanations they attach to them are indictments of an indifferent regime. They have become living testimonies to the actions of their government. It is to the metaphorical significance of their symptoms this discussion will now turn.

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*Metaphorical Significance: Damaged Body Image*

"I think because we had a number of vaccinations in a small amount of time I think they just knocked the immune system out and damaged it..."

- Brian, Gulf War veteran (quoted in Kilshaw 2004:157)

"I think they've [vaccines] done the opposite of what they were supposed to do...It's like an army colonel planning a battle and not planning it properly and everyone going in without a clue of what to do."

- Martin, Gulf War veteran (quoted in Kilshaw 2004:158)

Veterans' narratives materialize and are reported in a social context. They are individual stories of suffering, yet they are also narratives of victimization involving groups of people. Furthermore, veterans' implications of their government operate on both a literal and metaphorical level. Scheper-Hughes and Lock (1987:19) observe that the three bodies are linked to produce a body that is "both a physical and biological artefact". Descriptions of the personal body are therefore narratives of the social body and the body politic. Yet associations between the personal and social are not immediately obvious, they are often obscured by processes of naturalization (Scheper-Hughes and Lock 1987). In this way, the language of the body exists below the surface of the skin. Linkages must therefore be explored through a symbolic analysis of body image, defined as "the collective and idiosyncratic representations an individual entertains about the body and its relationship to the environment" (Scheper-Hughes and Lock 1987). In this regard, a metaphorical analysis of the symptoms and explanations of ill veterans is imperative.

Veterans' narratives reflect a damaged body image. They cite injury to the immune system as a major consequence of the harms to which they were exposed during combat (Kilshaw 2004). Many believe that chemical and biological insults visited upon them in the wartime environment have degraded and corrupted their immunological defences, turning their own bodies against them. Such an explanation allows veterans to reconcile the variation in symptom reporting amongst veterans (Kilshaw 2004). Differences in the variety of symptoms reported, as well as in the timing and location of toxic exposures are accommodated by a model in which the diminished capacity of the immune system is met with different

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pathological response for each unique individual (Kilshaw 2004). Furthermore, such an explanation emphasizes that although Gulf War veterans share a sense of victimization, that each is unique. In this way, the social body does not obscure the individual body.

Veterans' discussions of a corrupted immune system also offer a metaphorical glimpse into a perverted political and moral order. Individual explanations of illness often emphasize a malfunctioning immune system as a cause of both physical and psychological discomfort (Kilshaw 2004). There is a belief that the immune system, designed to protect an individual from harm, has turned against the very body it is sworn to protect. This explanation for personal suffering parallels the strong sense of betrayal felt by soldiers. Rather than acting to guard the interests of its citizens, veterans feel their government has turned against them, first by placing them in harm's way and later by ignoring their suffering (Kilshaw 2004). Thus, the metaphor of the immune system reveals a military and government at war with itself, in which both soldier and command have begun to engage one another in combat, albeit within the political and judicial arenas (Kilshaw 2004). To emphasize this metaphor, veterans point out that more US soldiers were killed by friendly fire during the Persian Gulf War than by enemy fire (Kilshaw 2004; Mueller 1994). Of 148 American battle deaths, a maximum of 56 were killed by Iraqi defenders (Mueller 1994).

Veterans' narratives also reveal damaged body images. When discussing their own bodies, veterans concentrate on the frailty and femininity of their post-combat selves. Their symptoms are framed as those of "old women", inappropriate for male soldiers - and young ones at that (Kilshaw 2004:155). Irritable bowel syndrome, sexual dysfunction, and osteoporosis are singled out as inappropriate pathologies that threaten both the masculinity and youth of a soldier (Kilshaw 2004). Gone are the fitness and youth of the prototypical soldier, replaced by a fragile, feminized shell. Ideals of strength traditionally derived from gender and age are threatened and overturned by the illnesses reported.

The metaphorical thread uniting these is a strong sense of inversion in both the political and social realms. The very diagnostic struggle in which soldiers are engaged itself signals a reversal of the appropriate social order: Formerly obedient soldiers have begun to question the authority and judgment of their government. Once

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passive patients have now offered their own diagnoses in opposition to that of the medical community. Muted constituents have found a collective voice and pressured their government for legislative responses to their suffering. Metaphors of inversion visible on the individual body are woven into the political and social fabric.

### **The Body Politic**

#### ***The Political-Economic Environment***

“I saw so *many* injustices, not just in the Gulf War. It goes into state programs...It’s not just a VA issue. It’s how the state handles things.”

- Wife of an ill veteran (quoted in Shriver et al. 2003:652)

The symptoms reported by Persian Gulf veterans also reflect the political environment in which these illnesses became manifest. The insistence by veterans that their symptoms not be grouped under existing medical categories, particularly that of Post Traumatic Stress Disorder, mirrors an unwillingness to divorce the disease from the historical and political context. This is very much a disease of Gulf War veterans, rooted in a particular temporal and geographic setting. Just as disharmony within the individual bodies of Gulf War veterans are metaphorically linked to social inversions, they are also intimately tied to division within the body politic.

Public opinion polls indicate that despite the successful vilification of Saddam Hussein prior to the US declaration of war in January of 1991, President Bush was “not notably successful at generating increased support” for war (Mueller 1994:23). Furthermore, despite the apparent solidarity in the political establishment regarding conflict with Iraq, US citizens’ support for the war actually declined over the course of the five-and-a-half month conflict (Mueller 1994:24).

Economic concerns were paramount during this period. In the five months leading up to the war, the percentage of those polled listing the economy as the single most important issue facing the United States was consistently higher than that of those listing the Middle East (Mueller 1994:203, 204). Several Gallup polls in the winter of 1990 indicated that the protection of US oil interests was perceived by US citizens to be the primary reason for US involvement in the Iraqi situation and the deployment of troops (Mueller 1994:243). While economic security rather than a moral duty to protect Kuwait was seen to be the primary reason for the US invasion

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of Iraq (Mueller 1994:244). Yet of the major justifications for war, the protection of economic interests consistently scored the weakest (Mueller 1994:39). Despite strong domestic concern over the state of the US economy, international actions aimed to protect those interests abroad were not deemed sufficient to risk the lives of US soldiers.

Although public perception of Saddam Hussein was not favourable, the necessity of war was uncertain. Both ideologically and literally, the Iraqi forces occupying Kuwait were not seen as a direct threat to Americans, as had been the case in World War II and the Vietnam conflict (Mueller 1994:64). Despite being billed as a fight for democracy and freedom, many were unconvinced of the need for war. This uncertainty was likely tied to the perception that there existed a viable alternative to war in economic sanctions (Mueller 1994). This lack of ideological justification and domestic cohesion was reflected in discussions of a “rush to war” within the media and the public.

By the end of the war in April of 1991, Americans were less likely to express confidence in the future of their country than they had been since the mid-1980's (Mueller 1994:95). Despite an overwhelming victory for US forces in Iraq, celebration and optimism were clouded by a failing economy and a sense of disappointment in the cessation of hostilities prior to the capture of Saddam Hussein (Mueller 1994:267-269). A major source of support for the war had been the removal of Saddam Hussein from power. A declaration ending the war prior to his capture therefore undermined public perception of US success (Mueller 1994:269).

It is clear that there was a lack of unity within the body politic at the time of the war. A discord existed between the political priorities of US citizens and their government executive. Citizens were far more concerned with domestic economic issues than they were with Middle East conflict. Furthermore, they were not ideologically convinced of the necessity of a war based on economics rather than morality. Rather than being viewed as a moral victory, the Persian Gulf War was perceived as an economic decision and a poor one at that. The body politic was in turmoil.

Arguably, therefore, the political uncertainties of the time are reflected in the symptoms of US veterans whose own perceptions of their purpose in the war were destabilized. Although public support

of troops remained consistently high in the United States during and after the war, the lack of overwhelming public support for the war itself likely undermined the bravery and heroism associated with military service (Mueller 1994). Veterans may feel their service was unnecessary and underappreciated, making their aforementioned exposure to dangerous and stressful situations all the more offensive. In the body politic, their search for an organic cause for their suffering is therefore paralleled by a search for an acceptable moral cause in combat.

### Theoretical Conclusions

In this discussion, Gulf War symptoms are framed as idioms of distress indicative of social, political, and personal anguish rather than as forms of somatisation and therein merely hallmarks of an unfavourable social position. A number of geographically and culturally disparate settings illustrate the function of such idioms of distress. Thus in India, South Kanarese Havik Brahmin women with poor social support networks report dizziness, headache, and general weakness during times of personal and social disruption (Nichter 1981). Feelings of apprehension prior to a marriage, impending family division, and economic crisis are strongly correlated with general signs of distress (Nichter 1981). In Costa Rica, the condition known as *nervios*, associated with headache, insomnia, lack of appetite, depression and disorientation, is a culturally acceptable means of communicating of suffering, providing a “socially-sanctioned vehicle for the expression of distress” (Low 1988:415). Symptoms associated with *nervios* are recognized by physicians as indicative of familial distress and a perceived lack of efficacy on the part of patients. As such, “cures” centre on finding solutions aimed at restoring control to the individual within the household setting (Low 1988).

In both of the above examples, illness symptoms, although grounded in physical dysfunction, are metaphorically significant means of communication speaking to the wider political and social contexts. It is suggested that Gulf War symptom reporting can be understood in a similar manner. Although complaints emphasize personal distress, they are also socially significant signs that tie the veterans to a war they believe to be responsible for their complaints. These metaphorical linkages implicate the government in their

suffering, through initial neglect and persistent indifference. Public dissent regarding the motivations for war and its eventual outcome is also reflected in veterans' illnesses. The name attached to these symptoms is therefore significant. This *Gulf War Syndrome*, a syndrome of social disruption, is tied to the historical period from which it emerged, operating at the social, political, and personal levels. The broken bodies of veterans are powerful signs reflecting the broken social and political bodies within the United States.

Such a conclusion must be tempered with a certainty that the physical and psychological suffering of veterans is real. One need only examine the preceding testimony of veterans to arrive at this conclusion. It must also be emphasized that while the social and political bodies deserve examination, these bodies should not eclipse the proximate personal and social realities of ill veterans. Given the vehemence with which veterans have resisted stress-related diagnoses, an anthropological analysis of the political, economic, and historical particulars of Gulf War Syndrome is of little utility if it only serves to implicate distress within the social and political spheres in their suffering. Stress is stress. To this end, it should be made clear that veterans' suffering is grounded in real dysfunction. However, an acknowledgement of the social and political bodies serves to integrate the personal lives of ill veterans into the wider social and political arena.

The aim of this critical-interpretive analysis has not been to determine a cause for Gulf War symptom reporting, merely to demystify the social and political realities surrounding this phenomenon. In so doing, the locus of control has been shifted away from veterans to structures within the larger socio-political sphere. The utility of such an analysis lies largely in the conclusion that both the biomedical community and legislators would do well to investigate the organic causes highlighted by veterans, rather than to naturalize their suffering as an expected malady associated with exposure to traumatic events. The powerful social and political motivations behind such aetiologies preclude the acceptance of an alternative explanation. Only when government and military negligence is comprehensively investigated will the healing begin.

Veterans' voices speak of personal suffering, yet they also tell of social and political infirmity. From veterans' narratives and the emotion contained within them, it is clear that Gulf War-related

symptoms are associated with profound suffering. However, veterans' anguish is not simply their own; rather, it is tied to that of other veterans and to the wider United States public. Veterans speak of personal symptoms yet they also emphasize social, economic, and political disruption. The common thread uniting these maladies is a strong sense of inverted natural order regarding the actions of the US government during the Persian Gulf War. To ignore these symbolic and literal linkages is to misunderstand the symptoms and the veterans suffering from them.

### **A Call to Action**

In illness, as in health, veterans exist as dynamic entities, shaped by and in turn shaping their environment. The above critical-interpretive analysis has attempted to build a social and political understanding of their illness grounded in personal perceptions of health. It is suggested that such a socially and politically situated analysis of individual health is imperative to their treatment.

Yet in an examination of illness, one must see both the crowd and the people in it. However, one must also go further. One must see that mouths are moving and ensure that they are heard. A true critical-interpretive analysis makes no claim of objectivity. Rather, it acknowledges the protest contained within illness symptoms and amplifies them so that they may be heard (Scheper-Hughes 1994). Accordingly, this discussion concludes with a call to action.

Government representatives and military officials must acknowledge and investigate the impacts of potential acts of negligence before the injuries of the Persian Gulf War can be healed. In veterans' eyes, the stress diagnoses offered by government officials contest the legitimacy of veterans' suffering and implicate soldiers in their own misery. Such diagnoses are unacceptable in the military context wherein stigma attached to psychological dysfunction has the potential to ruin careers and corrode valuable social ties. Nor are they appropriate within a civilian arena in which stress is perceived as maladaptive and indicative of trauma-induced psychological dysfunction worthy of fear.

A persistent reluctance to investigate the causal role of the harms to which soldiers were exposed during their service in the Persian Gulf, including chemical and biological weapons, pesticides, noxious fumes and infectious disease, is seen by many veterans as an



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extension of wartime offences and an admission of guilt on the part of the government and military command. It is therefore in the interest of the United States Department of Veterans' Affairs to provide full financial compensation and medical coverage to ill veterans and their families, regardless of their ability to demonstrate an association between their symptoms and particular exposure events. Such action would be a first step towards remedying the financial strain and social disruption felt by veterans and would therefore represent an acknowledgement that war-related injuries extend into the household and to the wider social sphere. Moreover, such compassion would heal political wounds, restoring a sense of ideological certainty regarding the intent of the United States government to protect its own citizens against harm, on both the international and domestic stages.

This discussion has revealed how personal illness is ultimately a public event, reacting to and in turn shaping social and political realities. Consequently, it has demonstrated that the treatment of individual suffering is simultaneously an act of social and political healing. Within the United States, a necessity exists for both.

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