INTRODUCTION

In June 1993 the UK television programme *Newsnight* featured a story about American soldiers who had fought in the Gulf War, soldiers who were now reporting a plethora of mysterious ailments. Fatigue, diarrhoea, hair loss and cancer were some of the reported symptoms, but the list included more unusual things like vomit that glowed in the dark and semen that burned. Formerly strong, fit and healthy soldiers were becoming weak and frail. The story spread through the UK Gulf veteran community like wildfire: suddenly the malaise that they had been silently experiencing had a name. They were not alone and they were not going mad, as many of them had suspected they were. For months many veterans had struggled to understand what was happening to them: why was it that they were so tired, so irritable, so unable to cope? Many were experiencing symptoms and illnesses that they found difficult to explain. Now they had a name for what ailed them: Gulf War Syndrome (GWS).

There was a flurry of media reporting which followed the *Newsnight* broadcast as more and more UK veterans came forward to report their particular symptoms and experiences. Many Gulf veterans became convinced they were suffering from a unique and new disorder which was attributed to: exposure to chemical warfare agents, vaccinations, NAPS (Nerve Agent Pre-treatment Sets) tablets, toxic fumes from burning oil wells, depleted uranium (DU) used in projectiles and tank armour and/or organophosphate insecticides. The story was a good one, as far as the media were concerned: healthy soldiers sent to war to fight for their country and defend Kuwait from the evil clutches of Saddam Hussein only to return ill and suffering. Not only were these soldiers ill in an inexplicable way, what was even more shocking was that it was widely suggested that it was not the enemy, but their own government who were responsible for their plight: a government that was refusing to listen to them or accept any responsibility for the illness. Even more compelling was the story that children were now being born to these soldiers with horrific birth defects.

It had all the components of a modern-day tragedy. However shocking and upsetting the thought was that the government could be negligent in giving potentially dangerous vaccines and medications to their soldiers – or worse, that they did it on purpose as a vast medical experiment – it remained a believable story. In the aftermath of mad cow disease,[1] the debate over GM (genetically modified) foods and in the climate that led to the MMR (Measles, Mumps and Rubella) scare, there is widespread distrust of the government and in science and medicine. Scientists themselves are seen as the purveyors of anxiety and risk. Science seems uncertain: you can always find one study to support or dismiss a claim to truth. With this decline in the authority of science comes the decreased authority of doctors. Individuals now are more likely to question and mistrust their doctors. They diagnose themselves, often with the help of a media story, the Internet and/or friends. People feel vulnerable and this is felt bodily. Our immune systems, the key to our health and well-being, are constantly challenged by the increasingly toxic world. It is in this climate that GWS emerged: a story about soldiers becoming ill, their immune systems damaged, as the result of vaccines or toxins administered by a guilty government. It is a story of conspiracy, of secret chemicals and dangerous medicines. There are heroes pitted against villains and innocent children wronged. The story of GWS even has an evil dictator with his hand on the button, ready to destroy the world with chemical and biological weapons.

From September 1990 to June 1991, the UK deployed 53,462 military personnel in the Gulf War (Coker et al. 1999). Results clearly show that a proportion of individuals who served in the Gulf feel their health to be 'significantly worse than comparable military personnel' (Unwin et al. 1999). In 1998, 17 per cent believed they have something specific called 'Gulf War Syndrome' (Chalder et al. 2001*)*. There is no disputing the fact that many Gulf veterans are ill and yet the reasons for this suffering remain unclear. There is a vast body of literature about the health of Gulf War troops, but very little include sufferer's accounts. Medical and epidemiological studies have gone as far as they could in explaining GWS; this book argues that a new perspective is vital. An anthropological approach is needed to better understand how sufferers perceive and live with this illness. By looking at the various narratives that surround GWS, through analysing the comments and views given by veterans, insight will be gained into the cultural, social and psychological dimensions of the construction of the illness and into the ways in which this has influenced sufferers' understandings.

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1. Bovine spongiform encephalopathy (BSE)

The GWS debate quickly became polarised, with various parties holding differing views about the question of its existence. At the heart of this discussion was the authenticity of GWS as a unique, physical condition. Despite veterans' conviction of the organic nature of their illness and the media's support, medical investigations produced no compelling evidence of a physical syndrome. Studies showed that veterans did not have increased rates of mortality, that there was no single cause and no distinct set of symptoms, suggesting that there was no specific syndrome (Gray and Kang 2006; Ismail and Lewis 2006). The suggestion is that this pattern of ill health is not unique to Gulf veterans. The consensus of the international scientific and medical community is that there is insufficient evidence to enable this ill health to be characterised as a unique illness or syndrome. Thus, the MoD, the government and medical institutions do not recognise "Gulf War Syndrome" as a medical condition. In this book I argue that biomedicine has a rigid, limited view of illness and suffering that is unhelpful and often obscures our understanding of illnesses such as GWS, thereby preventing therapy and recovery. Central to this inadequate standpoint is the dichotomy within biomedicine that sees illness as either physical or psychological.

There is no doubt that GWS has striking similarities to illnesses seen in other postcombat situations (Jones and Wessely 2004, 2005). The same symptoms are seen in UK military personnel who did not deploy to the Gulf as well as in the wider population. What is clear, however, is that soldiers who were involved in the Gulf conflict report more symptoms than comparable military cohorts. Indeed, I found that any symptom, illness or problem could be considered by veterans and/or their supporters as an indicator of GWS (Appendix I and II). The range of symptoms presented by sufferers is vast, but the most common are chronic fatigue, joint and muscle pain, problems with memory and concentration, stomach and bowel problems, and loss of sexual drive. There is considerable overlap with other new illnesses found in the general population, such as Chronic Fatigue Syndrome (CFS) and Irritable Bowel Syndrome (IBS), with veterans often suggesting that these illnesses are part of their overall condition. The biomedical community has focused on the similarity between GWS and these other illnesses, which are labelled functional somatic syndromes or medically unexplained syndromes, and are defined as physical syndromes without an organic disease explanation, demonstrable structural changes or established biochemical abnormalities. As no physical cause can be found, these conditions are often seen as somatising conditions: the expression of psychological problems through bodily complaints.

I suggest that the medical community's position on GWS as part of a larger group of psychosomatic, somatising conditions is both limited and flawed. Whereas biomedical interpretations of somatisation often rest on the presumption that it is an expression of psychiatric disturbance, anthropologists have shown that it need not be limited to expressions of psychiatric distress (ie see Kirmayer and Young 1988; Kleinman and Kleinman 1985. There are a number of problems with the medical interpretation of GWS and other contested illnesses. Somatisation is used as though it is an explanation in and of itself and often represents the end of the search for explanation. Concluding that this illness is a form of somatisation is simply not good enough. Instead, one must go further and investigate the symptoms themselves and the specific composition of the illness: the way in which GWS is an expression of particular beliefs and experiences. GWS is not the bodily expression of a psychological problem. Instead, it is a complicated manifestation which reveals the way illness is a combination and intertwining of natural, biological, social, cultural and psychological factors.

We all express ourselves through our bodies and somatic symptoms. This need not be limited to the expression of suffering, but can also be a way to comment upon social or individual dilemmas or merely to convey experience. Somatic symptoms are the most common individual expression of social problems and emotional distress (Kirmayer and Young 1988) and are referred to as 'idioms of distress' (Nichter 1981; Kirmayer 1996). Idioms of distress are culturally understood ways of communicating. They are commonly experienced symptoms or problems that are recognised within the culture as indicating personal or social difficulties (Nichter 1981), yet may not be related to psychological problems. Symptoms are used to talk about and negotiate matters other than bodily illness (Kirmayer 1996).

I would agree that GWS shares many features with other medically unexplained syndromes, making it necessary to see it as part of a broader family of contemporary disorders. The cultural influences that shaped GWS are the same forces that helped to construct illnesses such as CFS, IBS and Multiple Chemical Sensitivity (MCS) and, thus, their similarities are deeply relevant. Just as GWS can be seen as part of a larger family of new and contested illnesses, it should also be understood against the backdrop of increasing anxiety about health in the present cultural milieu. Health scares, spurned on by media attention, provide a constant backdrop to twenty-first century Euro-American life. We live in a society perpetually fearful of toxins, allergens, chemicals and viruses that are seen as constant threats to health (Chapters 1, 2 and 3), mainly via their effect on the immune system (Chapter 4). Part I and Part II focus on GWS explanatory models and theories of causation and the way in which these resonate with more widespread cultural health beliefs and anxieties.

Although it is necessary to contextualise GWS by situating it amongst other new illnesses and widespread health beliefs, there is a need to bring back the particular. I argue that lumping these conditions together as manifestations of the same thing disregards the uniqueness of these illnesses. Biomedical analysis ignores the differences between these very diverse illnesses and by so doing lacks a real understanding of the conditions themselves and the unique factors which gave rise to them. In order to balance this generalising trend, Part III focuses on the symptoms and themes that make GWS a unique condition.

In this book I draw attention to the more collective aspect of symptom and symptom language. Central to this is the way that, as an anthropologist, I look at and interpret individual symptom reporting differently to researchers from other disciplines. Illness symptoms are not only 'biological entities', but can also be conceptualised as a form of communication whereby the individual, having troubles in various areas of life, conveys these in bodily terms (Scheper-Hughes and Lock 1986: 138–39). That is to say, physical symptoms can be seen as part of a process of making meaning out of experience. Of central importance is understanding what symptom reporting is conveying, rather than focusing on uncovering the objective truth of them. Burning Semen Syndrome, impotence and infertility have all become entwined with GWS narratives and become powerful markers of it (Chapter 6) and, thus, are clearly communicating something meaningful (Chapter 7), yet these symptoms are unlikely to be picked up by epidemiological and medical inquiry. The body is a site of angst and resistance. I argue that GWS can be interpreted as the expression of a collective social angst and is a kind of shared bodily language, an expression of social distress as well as a form of commentary. This book seeks to make sense of the cultural circumstances, specific and general, which gave rise to the illness.

By enlisting the methods and theories of anthropology, with its focus on nuances and subtleties, this book provides an additional interpretation of GWS. Between September 2001 and November 2002 I conducted fieldwork amongst the UK GWS community.[2] During this time I interviewed those involved in the GWS movement: core activists, Gulf War veterans and their family members, as well as

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[2] I also conducted a small amount of fieldwork into the Canadian GWS community during a short visit to Ottawa.

doctors and scientists. My main focus, however, was on the sufferers themselves and what they had to say about their illness. I conducted 93 interviews,[3] 67 of which were with UK Gulf veterans – the vast majority of whom described themselves as GWS sufferers. In addition to interviews,[4] contact was maintained with informants to allow for more informal discussions and observations. The veterans were very welcoming and a small number of them were kind enough to allow me to stay with them in their homes. I also spent five days at one of the associations' Annual General Meeting and Respite week, where I met with many GWS sufferers and advocates.[5] These and other interactions, such as attending meetings, enabled me to immerse myself in the GWS community.

Aware that theories of GWS are constantly being negotiated and altered as new research emerges, I am interested in the way in which some information is accepted in some circles whilst completely dismissed in others. It is clear that GWS is being constructed and framed differently by different groups and that this process is ongoing. In order to explore the construction of GWS more fully and assess if, and how, knowledge, information, practices and language concerning GWS are mediated, appropriated and transformed, I planned to include selected non-medical sites, namely veterans' organisations. Although there are a number of associations, I focused on one in order to better contextualise the narrative on a smaller level. Also interested in the way GWS was being constructed in the medical and government settings, I conducted fieldwork at the Gulf Veterans' Medical

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[3] Other formal interviews included: eight Canadian veterans, four partners (not including those who were part of the research in a more informal way), fourteen non-soldier "experts"/advocates, and three focus groups, which were conducted with groups of veterans.

[4] Most were one-off interviews conducted in the home of the veteran. An interview schedule was used to prompt respondents, who were asked a series of questions regarding their experiences with GWS and other health beliefs. Questions were broad, designed to provide respondents with space to describe their experiences, beliefs and assumptions. Informants were also asked to discuss their military and employment background. The interviews ranged from two to four hours and were audiotaped and transcribed at a later date.

[5] The majority of informants were members of the veterans' association and were contacted through the organisation; others were accessed by other means: the MoD website and newsletter, Soldier magazine, and other veterans' associations. In order to find a wider selection of informants, the GVMAP selected 39 patients: 13 of whom were not ill; 13 who were ill, but did not attribute their illness to GWS and 13 who were suffering from GWS. The clinician wrote to them informing them of my work and asking if they would be willing to be interviewed. Of those contacted, 21 responded (20 agreed to be interviewed one declined). Four could not arrange interviews for various reasons and, thus, 16 were interviewed.

Assessment Programme (GVMAP), based in the Baird Health Centre at St Thomas' Hospital.[6] I hoped this would enable me to observe the cultural parameters along which medical narratives of GWS were being negotiated. It soon became clear that fieldwork does not always follow a plan and that GWS moves through arenas and society in a fluid way. So instead of focusing on sites, I studied the phenomenon of GWS in a variety of settings by following GWS itself into a variety of contexts in which it was being discussed. A methodological design is thus used which works across 'texts, practices and contexts' (Franklin 1998: 5). This type of approach is perhaps best exemplified in Martin's study of the notion of 'immunity' in America that links seemingly disparate field sites and research tools (1994).

Established in 1993, the GVMAP is run by the MoD in response to veterans' health complaints. Veterans are subjected to a full physical examination by one of the two consultant physicians and given a battery of tests (see Appendix Three). The GVMAP became the arena in which I observed the dialogue between sufferers and medical practitioners and the way in which GWS has been constructed, in part, out of this dialogue. This setting provided me with a way to observe the MoD and official medical position on GWS. When a veteran came into the centre to be assessed he or she would be asked by the clinician if they would be willing for me to sit in on the session. If they agreed, I would observe the entire assessment and often discuss the case briefly with the clinician at the close of the interview: 18 assessments were observed in this way. I also spent time at the GVMAP chatting informally with the people who worked there.

In exploring the arenas GWS inhabited, I attended a number of pension tribunals and large events such as meetings and conferences,

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[6] My funding from and endorsement by the MoD made some fieldwork opportunities, such as this contact with the GVMAP, possible. However, the funding opportunities offered to me also produced ethical dilemmas. As I was part-funded by the ESRC, the MoD and the Canadian Department of National Defence, I was concerned I could be seen as being biased in my research by the veterans and others. It was my opinion that the only way to tackle this issue was by being as transparent as possible. As I was offered funding before my fieldwork was underway I was able to approach the leaders of the veterans' associations, with whom I had already made contact, to see if they would still be prepared to co-operate with my research if I were to accept the funding. I made it clear to them that although I would be funded by these bodies, I would be free from interference and would remain an independent researcher, something that I was able to establish with all funding institutions. Both associations said that they would be happy to continue participation. Although concerned with the potential problems MoD and DND funding could produce, I decided to accept their financial support and I was grateful for it.

where veterans, advocates, scientists and others were in attendance. Scientists and clinicians also acted as informants; doctors' notes, diaries, symptom lists, letters and other documents were given to me by informants and added to my body of data. Media files (print, radio and television) from the past and present were explored, given the great attention GWS has received in this medium. Thus, I drew on a variety of sources to understand the condition better: using veterans' accounts, but also enlisting other resources to build a picture of the wider world in which the veterans and those around them lived.

This book describes and reports the way in which GWS has emerged and become characterised by specific motifs. It examines how GWS is a product of the way society is organised – an artefact of the particular culture in which it emerged. Illnesses can be seen as generating their energies from already present cultural anxieties and fears of a particular group. As an anthropologist, I am describing a system of thought. As Littlewood wrote about Multiple Personality Disorder (MPD),

> [W]hether at this point we read multiple personality as an idiom of distress, as a psychological defence against sexual abuse or as a creative fantasy, whether we grant it some existence as a distinct psycho-physiological entity, socially induced or requiring public acceptance to bring it into the open, its local context and meanings are significant. As Sahlins notes in a not unrelated context, cannibalism is always "symbolic" even when it is real. (Littlewood 1996: 22)

Similarly, whatever we say or believe about GWS, its context and meanings are significant. It is not the anthropologist's role to decide whether or not something is rational, it is our job to make it intelligible (Firth 1985).

Central to this discussion, however, is the concept of rationality. Overing suggests that anthropologists investigate moral universes, with their basic duty being to "understand the intentions and objectives of actors within particular social worlds, as well as what these actors say, understand, believe truth and those worlds to be, a task in metaphysical description" (1985: 4). Firth (1985) argues that it is the role of the investigator to capture both the sense and the sensibility of behaviour. The anthropologist unfolds the *intelligibility* of behaviour, and not so much its 'rationality'. Firth shows the way in which what at first appears to be irrational behaviour takes on a different face, a blend of reason and affective reaction, when placed in context. What does seem significant is whether it is capable of being understood by an anthropologist from another cultural setting, with a curiosity to enquire after meanings (Firth 1985: 33). Following Firth, I contextualise GWS by looking at the cultural circumstances that gave rise to it, in order to show how it makes sense.

Similarly, the philosopher/sociologist, Gellner (1974) suggests that concepts and beliefs do not exist in isolation, in texts or in individual minds, but in the life of people and societies. Context must be known. The real essence of Durkheim's doctrine, according to Gellner, is the view that concepts as opposed to sensations are only possible in a social context, and that they can only be understood when the social context is known. Context refracts the line of interpretation, but "tolerance-engendering contextual interpretation calls for caution: that as a method it can be rather more wobbly that at first appears … [T]he prior disposition concerning what kind of interpretation one wishes to find, determines the range of context brought in" (1974: 32).

When we contextualise what people say, it makes sense. The wider we follow the phenomenon out the more sense it makes. I look at the narratives of sufferers and those around them to unravel how the illness is both a unique expression and way of making sense of the experiences of a particular group of people as well as a product of wider social issues. GWS is wider than the Gulf War; it is characteristic of the anxieties and beliefs of late twentieth-century life. There are other things happening in the lives of these men and women that they are trying to explain, and the package is unique. I examine the way in which illnesses are formed by fitting into the existing illness models. GWS emerged and gained media attention because it both responded to and conformed to existing illness beliefs and anxieties. Simultaneously, it was formed by these pre-existing cultural beliefs.

An illness movement "will take only if there is a larger social setting that will receive it" (Hacking 1995: 40). In order for an illness to gain legitimacy it must resonate with a larger cultural framework which makes it intelligible. Illness representations spread throughout a population: a sort of "epidemiology of representations", the circulation and contagion of ideas and anxieties (Sperber 1985). Hacking (1992b) points out that certain disorders result from the interaction between individuals and their cultural and medical surroundings. The individual may not be representing a mirror of society, but instead the fault lines of the culture. GWS has been constructed, framed and articulated by particular themes that are relevant to the society. This book investigates the cultural themes and anxieties that allowed GWS to emerge and, in turn, help to construct it.

Sociologists and medical anthropologists have focused on the way in which metaphor informs illness through its relationship with physical experience (Lakoff and Johnson 1980) and the way in which certain metaphors become prevalent tropes for illness (Sontag 1978; Hacking

1992a; Littlewood 1998). Our language and our very ideas about illness become so intertwined with these metaphors that we are no longer consciously aware of the meanings they convey. This will, however, impact on the way we experience our bodies and our illness. There is no "sharp distinction between metaphors, attributions and sensations; even a conventional metaphor or attribution may shape perception so that the corresponding symptom is actually felt" (Kirmayer 1996: 4).

Although Sontag felt that metaphor should be stripped away, I would maintain that one cannot easily strip away metaphorical thinking, for no one ever "experiences cancer as the uncontrolled proliferation of abnormal cells. Indeed, we can experience anything at all only through and by means of culturally constructed socially reproduced structures of metaphor and meaning" (DiGiacomo 1992: 117). As we can only experience and understand illness through these culturally constructed structures, it is pertinent that we investigate them to understand a condition such as GWS fully. It is only through analysing the use of metaphor in GWS narratives that we can reach a more complete understanding of the illness and how it is experienced. Thus, I investigate what the metaphors are that inform the language and experience of GWS – what metaphors have become embedded in the stories and accounts of the illness. Discussions of GWS incite the passions of people who, at first glance, one would not expect to have a stake in it. GWS is symbolically very juicy – a "hot" topic on which most people have a political view. The symbolic wealth of GWS is that it is about much more than itself: this book explores the way GWS has become a potent symbol and a means by which to talk about a plethora of issues, anxieties and concerns.

Sontag warns against disease being translated into metaphor, while anthropologists warn against the opposite: translating metaphors of experience into biomedical entities (Scheper-Hughes and Lock 1987). The "individual body should 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 1987: 31). Anthropologists have argued that physical bodies are shaped by culture – partly by means of widely held models, images and metaphors. Metaphor not only arises out of embodied experience but, conversely, becomes embodied. Thus, we should investigate the "psychophysiology of metaphor" (Kirmayer 1992: 226). The relationship between metaphor and illness is fluid and travels in both directions. Metaphor informs illness and certain metaphors become dominant tropes for illness., Illnesses are also metaphors of experience, though. Metaphor can be appropriated to draw attention to and comment upon a dilemma, thus becoming a social and political critique (Scheper-Hughes and Lock 1987; Kirmayer 1992; Lock and Scheper-Hughes 1996). I will argue that GWS symptom reporting can be interpreted as a vehicle to draw attention to and a means to communicate concerns of the people it affects. These include issues such as trust, life within a dramatically changing military, gender roles and toxicity (Chapter 6 and 7). GWS is an expression, both social and personal, of the experiences of those it affects and of contemporary issues.

Illnesses can be seen as an organising feature, a way to make sense of life events and distress. In this book I show that subscribing to a diagnosis of GWS is a way to make sense of a set of experiences (Chapter 5). Through the explanation of GWS all experiences of misfortune and illness are linked together and made intelligible. Here I turn to Evans-Pritchard, for which anthropologist can think of cultural responses to misfortune without thinking of *Witchcraft, oracles and magic among the Azande* (1937 [1976])? For the Azande, immediate and natural causes were understood to cause misfortune and illness, yet there was a further aspect which answered the 'why', the reason for the association in time and space. Such an explanatory system can be seen as similar to Gulf veterans' understanding of their illness. One veteran explained to me that he walked with a walking stick because he had a bad leg. He had a bad leg because of a motorcycle accident, but he was disabled because the leg did not heal properly because of GWS. Veterans create theories of causation that help them to make sense of their world.

The special contribution that anthropology can make to the study of GWS is in seeking to contextualise and investigate what else is happening in the lives of these people, besides their malaise. Importantly, such an approach introduces elements of which sufferers might or might not be aware. Whereas medical studies of GWS focus on the individual, their body and also the narrow boundaries of their war experience, an anthropological approach widens the frame and looks at other relevant aspects of a person's life. Thus, I look at GWS within the context of veterans' lives: within the war, the military and more widely. In addition, I widen the context outwards in order to see GWS within the realm of twenty-first century health anxieties and beliefs in the UK.

Researchers investigating contested illnesses such as GWS will constantly be asked: "Does it exist?" "Is it real?" Hacking (1995) reported a similar situation when he studied multiple personality disorder (MPD). He pointed out the fallibility of the questions: a real what? Of course it is real, Hacking put forth, in that there are people who fit the criteria of MPD. Similarly, I suggest that of course GWS is real; but what is it? In his work on the creation of the category of posttraumatic stress disorder (PTSD), the medical anthropologist Young (1995: 5), wrote:

> If, as I am claiming, PTSD is a historical product, does this mean that it is not real? On the contrary, the reality of PTSD is confirmed empirically by its place in people's lives, by their experiences and convictions and by the personal and collective investments that have been made in it. My job as an ethnographer of PTSD is not to deny its reality, but to explain how it and its traumatic memory have been made real, to describe the mechanisms through which these phenomena penetrate people's life worlds, acquire facticity and shape the self-knowledge of patients, clinicians and researchers.

In the same way, this book is an attempt not to explain GWS away, but instead to provide an ethnography of the illness and the place it has in the lives of those it affects. I argue that this question of the reality of GWS is redundant: of course this illness is real in that people understand themselves to suffer from it. Being interested in the way it has been socially constructed does not mean that the illness does not exist. As Hacking (1999) suggested, social construction and reality do not seem especially at odds with one another. With this in mind I would argue that the reading of this book would not be altered if, one day, a physical cause of GWS is positively identified.

When the question of the reality of GWS is posed, it generally comes with certain connotations. Those involved are forced to take sides: either you believe it exists and all that goes with it or you are a non-believer. Either GWS is physical or it is in the veterans' minds. The world of science, and often, correspondingly, the Euro-American worldview, assumes a world of black and whites. Yet this artificial system of either A or not-A does not reflect reality, where there are not two extremes but infinite shades of grey in between (Kosko 1994). GWS discourse is polarised along two lines: there are those who think it is a unique, physical illness caused by Gulf War toxins and those who argue it is likely a psychological condition that can be seen as part of a larger group of illnesses. The debate that surrounds GWS reflects a continuing bias within biomedicine, in which illnesses are seen as either physical (more real and more worthy of attention) or psychological (more the fault of the sufferer, less real and possibly "imaginary"). Entwined in this latter perspective are notions of GWS as a form of hysteria or somatisation.

We, therefore, are left with a situation where discussions of GWS are divided along two opposing sides where any findings or suggestions put forth by one side are immediately attacked, derided or, more often, ignored by the opposing side. Because of the rigidity of medical classifications, the debate was bound to become stagnant and unhelpful. Biomedicine has too narrow a view of illness and suffering, which makes it difficult to understand and respond to illnesses such as GWS. Seeing illness as either physical or psychological is not only reductive and unhelpful, but incorrect. Furthermore, when we medicalise we ignore the social and cultural aspects of illness, thereby losing sight of the complicated factors that not only shape, but give rise to suffering. An anthropological approach enables one to go beyond this mindset and investigate the reasons behind an illness, how it arose and what is happening in society that contributes to its development. GWS is neither physical nor psychological, but both. Moreover it is a social, cultural and personal phenomenon. GWS must be seen in context; a reading of this illness must take into account wider social issues whilst bearing in mind the subtleties that make it unique. Moving beyond the dichotomy of either physical or psychological, anthropology enables one to inhabit and explore the grey areas that illnesses such as GWS inhabit and by so doing, understand them more fully.