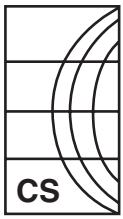

Wounded by Friendly Fire

Policy Palliatives and Internal Conflict in the Gulf War Illness Movement

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abstract: Political movements seek influence in policy-making, but are typically marked by intra-movement conflict, which, analysts argue, reduces the achievement of social change. This article examines the effects of conflict within the Gulf War illness movement on its influencing government policy-making. Using in-depth interviews, participant observation and document analyses, the article assesses the movement's policy outcome, examines the substance of the conflict and analyzes the ways in which it hampered the movement's execution of policy-relevant tasks. It is found that intra-movement conflict over activists' divergent views of the government's intentionality with regard to veterans' hazardous exposure impaired the movement's execution of tasks that would have had a critical influence on policy-making. As a consequence, public pressure was insufficient to precipitate a legitimation crisis for the state, permitting government officials to evade the movement's demands and liability while imparting the image of responsiveness through weak policy formulations and implementation. The outcome was one of policy palliatives rather than curatives.

keywords: contested environmental illness ✦ environmental hazards ✦ Gulf War illness ✦ social movements

Public policy represents the state's intentional actions to coordinate citizens' activities and resolve issues of public concern. The substance of national domestic policies ranges from product labeling and government-subsidized transportation systems to minimum wage standards and the distribution of tax breaks. Policies are fundamentally the rules made by policy-makers and their associates on who gets what in society

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(Peters, 2004). When citizens believe that what they get is unfair, they sometimes mobilize in political movements to publicize their grievances and persuade the state to redress them through policy changes. Although analysts debate the capacity of political movements to influence policy-makers, the consensus is that the probability of a movement's impacting policy is higher when the public favors the goals of the movement than when the public opposes them. The wider the public support of movement goals, the greater the pressure on policy-makers to make concessions. But some movements with public support nevertheless fail to impact policy. Why?

Analysts document that political movements challenging the state are frequently marked by internal conflict. They catalog sources of intra-movement conflict (Balser, 1997; Barkan, 1979; Foner, 1974; Gamson, 1975; Haines, 1984; Marx, 1979; Miller, 1983; Slaton, 1992; Staggenborg, 1988; Zald and Ash, 1966; Zald and McCarthy, 1980) and describe the deleterious effects of such strife on movement organizations (Buechler, 1990; Echols, 1989; Freeman, 1973; Killian, 1972; Morris, 1984; Oberschall, 1973; Rochford, 1989; Ryan, 1989). Many analysts suggest that intra-movement conflict diminishes a movement's ability to achieve social change but they do not specifically link such conflict with the policy-making process.

In August 1990, Iraqi troops invaded Kuwait and instigated a United Nations (UN) resolution that mobilized an international coalition of armed forces. Fighting took place in January and February 1991. Some forces remained in the region but most returned home. Nearly 30 percent of US veterans soon confronted a new enemy: unexplained illness. They suffered an array of medical symptoms that many attributed to various hazardous exposures incurred during military service. When the federal government rejected claims for medical care, many veterans mobilized in 1992 to challenge the government's decision with demands for medical coverage.

We report here on our case study of the US Persian Gulf War illness movement. Our data indicate that the movement was characterized by persistent fissures among activists within and across social movement organizations (SMOs). Drawing on in-depth interviews, participant observation and government and organizational documents, we focus analytical attention on whether and how conflict affected the movement's capacity to influence the policy-making process.

The Policy-Making Process and Movement Influence

Gamson asserts that 'internal division is a misery that few challenging groups escape completely – it is in the nature of the beast' (Gamson, 1975: 99). Analyses of political movements that feature intra-movement conflict

typically examine the sources of conflict or its consequences. The sources include social control (Balser, 1997; Marx, 1979), scarce resources (Gamson, 1975; Zald and McCarthy, 1980), organizational traits such as decentralization (Gamson, 1975; Miller, 1983; Zald and McCarthy, 1980) and different tactical and ideological preferences (Balser, 1997; Barkan, 1979; Gamson, 1975; Haines, 1984; Slaton, 1992; Staggenborg, 1988; Zald and Ash, 1966; Zald and McCarthy, 1980). The consequences of conflict include initiation of a rival organization (Gamson, 1975), discreditation (Haines, 1984), failure to achieve new advantages (Gamson, 1975), organizational decline (Gamson, 1975; Miller, 1983) and squandered resources and diverted attention from goals (Miller, 1983).

This large body of work on the sources and consequences of intra-movement conflict is a substantial contribution to the understanding of political movements and social change. We extend this knowledge by analyzing the effects of movement conflict specifically on influence in the policy-making process. We examine the policy-making process and the tasks of movements to identify the overlap where movements are most likely to exercise influence. We then describe the analytical intent in our examination of intra-movement conflict in the Persian Gulf War illness movement and policy impacts.

The Policy-Making Process

Political analysts make contradictory claims about movements' impacts on public policy: movements *do* influence public policy (Berry, 1997, 1999; Cigler and Loomis, 2002; Marger, 2005; Wolpe and Levine, 1998); and movements *do not* influence public policy (Baumgartner and Leech, 1998; Burstein and Linton, 2002; Smith, 1995). Analysts in the former camp contend that movements help shape policy by defining public problems, proposing solutions, mobilizing citizens and aggregating their policy preferences, articulating demands to elected officials and reporting government actions to their supporters and the public. Analysts in the latter camp argue that movements' ability to influence policy is tightly constrained by electoral competition and the limitations of citizens' and legislators' abilities to attend to multiple issues simultaneously. Burstein and Linton (2002), for example, found that a movement's chances of an impact significantly greater than zero are about 50:50.

But even those analysts acknowledge conditions that enhance a movement's chances of shaping policy. Because elected officials court public support by responding to majority preferences, activists are unlikely to persuade policy-makers if movement goals oppose public opinion. When the public either favors movement goals or has no preference, activists may impact policy by emphasizing the consistency between the public's favorable views and movement goals or by cultivating a policy preference

among the public. We adopt the stance that, as long as movement goals do not oppose public opinion, activists have a 50:50 chance of impacting policies by moving issues onto the political agenda, influencing the contextual framing of issues and affecting public opinion.

Analysts describe the US policy-making process in five stages, or tasks (Anderson, 2000; Kraft, 2004; Marzotto et al., 2000; Smith, 2000; Switzer, 2004): problem definition, agenda-setting, policy formulation, policy implementation and policy evaluation. Movements are most likely to influence policy-makers in the problem definition and agenda-setting stages (Berry, 1997, 1999; Cigler and Loomis, 2002; Marger, 2005; Wolpe and Levine, 1998).

Problem definition is the elucidation of conditions as a public, rather than individual, problem. The task consists of describing the problem's adverse effects; demonstrating the need for government attention; identifying the problem's causes; and providing recommendations for mitigating the problem. Many problems are defined through the public as shifts in opinion occur. Sudden shifts are triggered by major events that abruptly invest issues with heightened public salience; slower shifts occur when public knowledge of a problem increases gradually. Policy-makers typically adopt problems in response to poll trends.

In the stage of *agenda-setting,* policy-makers adopt the public problem for consideration. They may or may not take formal action. When they do, the problem is adopted on a legislative or executive agenda for policy consideration. Adoption is most likely when: the problem is severe, the size of the affected population is substantial, the public visibility of the problem is high, the similarity of the problem to previously addressed problems is significant and the problem can be linked to significant national symbols (Peters, 2004).

The remaining stages of the policy process are less open to movement influence. In the *policy formulation* stage, policy-makers assess various remedies for the problem, eventually agreeing on a resolution and encoding it in congressional laws or executive orders. In the *policy implementation* stage, the law/executive order is interpreted and enforced by various government agencies. *Policy evaluation* may eventually follow through institutional process and/or public scrutiny to assess the policy's effectiveness.

Movement Tasks

Activists engage in policy-relevant tasks that can be summarized for our purposes. A primary task is the *mobilization of the aggrieved* to identify an injustice. Grievances must be articulated to demonstrate that the suffering of the aggrieved is shared – a collective, rather than individual problem – because it is the consequence of the actions/inactions of a specific institution, the target. *Agreement on movement goals* is sought to increase the chances of

ameliorating grievances by assuring that efforts and resources are distributed in the most efficient way. Activists seek agreement on the conditions that constitute amelioration and on the specific actions required of the target to secure those conditions. *Selection of tactics* is based on aiding recruitment efforts, demonstrating the aggrieveds' suffering and prodding the target. Activists decide on institutional and lawful tactics, such as demonstrations, petitions, press conferences and marches, or non-institutional and unlawful tactics, such as civil disobedience. *Mobilization of resources* is necessary to sustain the movement's challenge to the target and to educate the public. Resources range from securing funding to recruiting new members among conscience constituents, who share movement goals but are not aggrieved (Zald and McCarthy, 1980), and elite supporters who garner favorable publicity.

Fulfillment of these tasks defines a group's suffering as a social problem, describes the conditions for rectifying the suffering and engages a course of action displaying the suffering and drawing attention to the movement target. Movement definitions of the problem are promulgated in the public realm to recruit aggrieved, conscience constituents and elites and to inform the public of the group's suffering. Successful execution of tasks carries the issue to the problem definition stage of the policy-making process by defining the problem, justifying the need for government intervention and offering recommendations for its resolution. As the public learns of the problem, opinions change and are registered in public opinion polls. Shifts in public opinion move the issue to the second stage of policy-making by persuading policy-makers to adopt the problem and decide whether to take action on it. Recruitment is enhanced and adoption to the agenda more certain if the public perceives that the problem is: a severe threat to a substantial population of aggrieved, similar to other causes that received wide public support in the past and linked to important cultural values such as fairness.

Public support is the key to a movement's influence on policy-makers. The government has an intrinsic capacity to do harm because of the authority vested in it (White, 2008). Government legitimacy – 'the extent to which its actions are within its political mandate and receive the approval of the citizenry' (White, 2008: 36) – rests on public perceptions that the state is *not* harming citizens. When activists successfully execute movement tasks, a substantial segment of the public believes that the government is harming people and loses trust in its ability and will to govern fairly. This loss of public trust is the political leverage used by movements to pressure policy-makers because it challenges government legitimacy. Consequently, activists must perform movement tasks well enough not only to sustain the movement but to generate widespread belief that the government's actions are not legitimate.

Intra-Movement Conflict in the Persian Gulf War Illness Movement

Our examination of policy-making tasks and movement tasks highlights the overlaps between the two processes. Movements are most likely to wield influence in the policy-making process in the problem definition and agenda-setting stages. The tasks overlap in the following ways.

Mobilization of the Aggrieved Activists' articulation of grievances overlaps the policy task of problem definition by describing the adverse conditions of the problem, identifying the culpable institution and justifying government intervention. The size of the aggrieved membership is critical to the agenda-setting stage because it indicates the size of the affected population; the larger the affected population, the more likely the problem will be adopted on an institutional agenda.

Agreement on Movement Goals Agreement on the specific actions of the culpable institution that would ameliorate grievances further describes the problem by providing specific recommendations for the mitigation of the problem.

Selection of Movement Tactics An objective of tactic selection, demonstration of the suffering of the aggrieved group, complements an important variable associated with policy-makers' adoption of a problem on the agenda: the public visibility of victims.

Mobilization of Resources Activists' acquisition of adequate funding relates to greater success in recruitment. Activists enhance recruitment efforts by describing the problem as a severe threat, as similar to other publicly supported causes and as linked to important cultural values. Such efforts also increase the likelihood of the problem's adoption on an agenda. The recruitment of non-aggrieved individuals, such as conscience constituents and elite supporters, educates the public about the grievances. Education of the public stimulates a shift in public opinion that pressures policy-makers. With sufficient pressure to challenge the government's legitimacy, policy-makers are pressured to make policy concessions in accordance with movement demands.

Adequate execution of movement tasks influences public perceptions that government actions/inactions harm the aggrieved group and the challenge to state legitimacy pressures policy-makers to accede to movement demands. In our analysis of intra-movement conflict in the Persian Gulf War illness movement, we assess the movement's policy outcome and describe the nature of the conflict. How did conflict hamper activists' execution of movement tasks, and how did their deficient execution

contribute to the movement's inability to generate enough public pressure to gain policy concessions?

Research Methods

Data sources include in-depth interviews, document analysis and observation. The primary data are in-depth interviews with 55 core activists holding leadership positions in the Persian Gulf War illness movement. Initial interview contacts were established at a national research planning conference on Persian Gulf War illness sponsored by the Centers for Disease Control (CDC). Using purposive sampling, we began by interviewing several of the core leaders from the CDC conference. We then employed a snowball sampling technique to identify additional core activists.

Based on initial interviews, we developed an interview guide used to prompt respondents on a series of open-ended questions about their military or other relevant background, the origins of their interest in Persian Gulf War illness, their experiences with such illnesses and their movement participation. Respondents represented the movement's national organization plus 16 grassroots organizations. Grassroots organizations varied in size from one to four members to a core of about 20 members. We referred to many organizations in the analysis, but were occasionally compelled to withhold organizational names and affiliations to protect respondents' anonymity. Respondents were highly sensitive about anonymity because of their military ties and their fears that retaliation for their activism would involve eligibility being denied for any compensation programs.

Thirty-five (65 percent) of the respondents were male and 20 (36 percent) were female. Ages ranged from 30 to 65 years – the majority were under 40 years of age. Respondents represented a wide range of educational and occupational backgrounds, from blue-collar work to university professor. The health effects suffered by the respondents ranged from mild irritants and discomfort to complete disability. Their symptoms were consonant with those reported in other accounts of Persian Gulf War illness: dizziness, headaches, memory loss, rashes, chemical sensitivities, drastic mood swings, chronic fatigue and equilibrium problems.

The audio-taped, in-depth interviews ranged from one to four hours. Nearly 100 hours of taped interviews were transcribed and coded using standard qualitative data analysis techniques. We utilized an open coding process for the transcriptions designed to identify key themes that emerged in the data. We began with a line-by-line coding of key words and phrases. This process resulted in a list of dozens of key concepts from across all interviews. These codes were then grouped into major thematic categories that reflected the central issues raised by the respondents.

In addition to the interview transcriptions, we conducted document analysis of newspaper articles, organizational newsletters and government reports. We examined over 1000 pages of transcripts from the Congressional Hearings on Persian Gulf War illness, as well as dozens of government-sponsored research and review reports. Although these documents were less central to our intent than interview data, they were critical in constructing a history of events, providing a broader context for interpreting the interview data and corroborating information received from respondents.

The Persian Gulf War and Coalition Troop Exposures

Iraqi troops invaded Kuwait in August 1990. Within a week, a large international force began assembling in Saudi Arabia. The UN Security Council passed Resolution 678 allowing members states to use all necessary means to force Iraq from Kuwait, if Iraqi troops did not withdraw by 15 January 1991. Negotiations between the US and Iraq failed, the deadline passed and an international coalition mobilized nearly a million troops plus financial and other forms of support from: Afghanistan, Argentina, Australia, Bahrain, Bangladesh, Belgium, Canada, the Czech Republic, Denmark, Egypt, France, Germany, Greece, Hungary, Honduras, Japan, Italy, Kuwait, Morocco, the Netherlands, New Zealand, Niger, Norway, Oman, Pakistan, Poland, Portugal, Qatar, Saudi Arabia, Senegal, South Korea, Spain, Syria, Turkey, the United Arab Emirates, the United Kingdom and the United States. Coalition forces initiated a massive air assault against Iraq on 17 January, followed on 24 February by a land offensive. Iraqi forces fell into disarray, and the UN coalition declared a ceasefire on 28 February.

Coalition war casualties were relatively light: 240 soldiers killed and 776 wounded. But many returning soldiers subsequently developed health problems. Comparing their symptoms with one another, veterans discovered a striking series of common complaints: abdominal pain, diarrhea, fatigue, loss of concentration, insomnia, short-term memory loss, rashes, headaches, shortness of breath, blurred vision and aching muscles and joints. Many attributed their shared symptoms to their shared hazardous exposures during active service in the Persian Gulf. The most likely toxic exposures included: depleted uranium munitions, smoke from oil-well fires, paints, solvents, insecticides, petroleum fuels and their combustion products, organophosphate nerve agents and the side-effects of vaccinations against biological agents such as plague and anthrax and pyridostigmine bromide tablets to protect against exposure to organophosphate nerve agents (Institute of Medicine, 2006: 1). Within two years

of the ceasefire, the term ' "Gulf War Syndrome" was starting to be heard, first in the United States, then in Canada and in the United Kingdom and finally in Australia' (Wessely and Freedman, 2006: 721). In 1998, 17 percent of British Gulf War veterans believed they were suffering from the syndrome (Chalder et al., 2001). By 1999, more than 200,000 US veterans had sought symptom relief from Veterans Administration hospitals (Arbuthnot, 1999).

Although data are sketchy, it appears that veterans' illness claims were rejected by their governments frequently enough that many veterans mobilized in political organizations to influence policies related to medical coverage and compensation.

Ill UK veterans formed the Gulf War Veterans Association (www.gulfveteransassociation.co.uk). The Ministry of Defence refused veterans' requests for medical tests. Seventy veterans protested in 1998 by publicly returning their medals to the Ministry. After pressure from veterans and European NATO allies, the Ministry reversed its position in 2001 and agreed to conduct medical tests for depleted uranium contamination on tens of thousands of veterans from the Balkan and Gulf wars (see website).

French veterans formed Avigolfe to demand recognition of the Gulf War Syndrome. In 2002, the Paris prosecutor's office opened an inquiry into the Gulf War Syndrome following veterans' complaints (AP, 19 July 2002).

Canadian troops in 1993 formed the Canadian Gulf War Veterans Association (www.jetnet.ab.ca./gulfwarva/).

We found no evidence of an Australian veterans' organization, but located a news article about Australian veterans' complaints about service-related illnesses with reference to a 2003 government survey of Australian veterans (www.news.com.au/story/0,23599,23438873–421,00.html).

US Mobilization and the Policy Outcome of the Movement

Coalition forces serving in the Persian Gulf War included about 700,000 US military personnel. Nearly 200,000 of those veterans experienced the symptoms referred to as Gulf War Syndrome. Although active duty veterans received health care coverage and care through the military system, discharged troops were ineligible for coverage and care through the Department of Veteran Affairs (VA). Congress in 1992 passed Public Law (PL) 102-585 Persian Gulf War Veterans Health Status Act, establishing the VA Persian Gulf War Health Examination Registry and providing veterans with free physical examinations at all VA medical centers. When veterans complained of illnesses from hazardous exposures, Congress followed up in 1993 with PL 103-210 Additional Authority for Health Care for Veterans of the Persian Gulf War. This Act authorized priority care for

VA medical services to veterans claiming exposure to toxic substances and/or environmental hazards on a par with Vietnam veterans' claims about Agent Orange exposures (www.archives.gov/federal-register/laws/past/).

But veterans found eligibility difficult to establish. Faced with dwindling incomes and mounting medical bills, many formed movement organizations to express their grievances against the government and demand changes in federal policies to recognize veterans' illnesses and grant them adequate medical coverage and care. The movement consisted of two components: small grassroots groups and the professionalized National Gulf War Resource Center. Dozens of grassroots groups across the country operated through volunteers and with limited resources. Beginning as support groups for sharing scarce medical information, the groups subsequently became political organizations. The National Gulf War Resource Center, a professional dues-supported organization with paid staff, was formed by veterans in 1996 as, according to a respondent, 'a kind of an umbrella organization' to serve as the central organization for veterans. Headquartered in Washington, DC, the Center organized annual national conferences, lobbied in and testified before Congress and disseminated information. The Resource Center maintained a website and listserv subscribing veterans, family members, congressional staffers and journalists.

Analysts agree that policy-makers, as elected officials, respond to majority preferences, and, consequently, that movements are most likely to impact policy when the public acknowledges activists' grievances. Activists influence policy-making by emphasizing the consistency between the public's views and movement goals and by conveying information directly to legislators. The wider the public support of movement goals, the greater the pressure on policy-makers to make concessions. The Persian Gulf War was widely supported around the world. In the US, the minority who opposed the war, apparently learning from the divisiveness of Vietnam, clearly distinguished between their opposition to the *conflict* and their support of *troops*. A movement, then, composed of patriotic combat veterans who battled a popularly perceived foreign bully and came home only to be denied health care for illnesses potentially linked to war would appear to be destined for success in influencing policy-makers.

In a search of the US Federal Register's archives of public laws passed after movement mobilization began, we identified only five pertaining to Persian Gulf War veterans' health care (www.archives.gov/federal-register/laws/past/).

PL 103-446 the Veterans Benefits Improvements Act of 1994 was intended to provide compensation to Persian Gulf War veterans with certain illnesses that caused at least a 10 percent disability for at least six months, if the illness manifested within 10 years of active service, and had at least a 50 percent probability of being war-related. Most applicants were deemed

ineligible for compensation. The relatively few applicants who established eligibility complained that disability compensation rates were inadequate: at the highest rates in 2006, a totally disabled veteran and spouse received only US$30,336 per year (www.VA.gov/GulfWar), more than 30 percent below the 2004 median household income of US$45,817 per year (www.census.gov/prod/).

The 1994 *PL 103-452* Veterans Health Programs Extension Act extended the VA's authority to furnish inpatient and outpatient care to veterans for compensable medical conditions related to exposure to toxic substances or environmental hazards during active duty service in the Persian Gulf. The Act applied only to the small pool of eligible veterans.

The frequent dismissal of veterans' symptoms as psychological problems was reflected in the passage of *PL 104-262* the Veterans Health Care Eligibility Reform Act of 1996, which provided coverage for readjustment counseling. The Act placed further parameters on health care eligibility, extending coverage to those with service-related compensable disability rated at less than 50 percent only if they were released from military service because the disability was incurred or aggravated in the line of duty. The Act provided for evaluation of the health status of spouses and children of Persian Gulf War veterans without promising health care coverage.

When a 1997 General Accounting Office report confirmed and amplified activists' charges of bias in federal investigations relating to the determination of veterans' eligibility for compensation, Congress in 1998 passed *PL 105-277* the Persian Gulf War Veterans Act and *PL 105-368* the Veterans Programs Enhancement Act. The former instructed the VA to *presume* a service connection when sound scientific and medical evidence indicated associations between veterans' symptoms and exposures to biological, chemical or other toxic agents, environmental wartime hazards and/or preventive medicines and vaccines used in military service. The latter law directed the VA to establish a formal review process of the scientific and medical literature on veterans' health problems to establish credible evidence.

The VA contracted with the National Academy of Sciences' Institute of Medicine (IOM) for a comprehensive evaluation and summary of available scientific information on the connections between various exposures/combinations of exposures and adverse health effects. Between 2000 and 2007, the IOM released five volumes that confirmed, *in general*, links between exposure to certain substances and adverse health effects. But the reports asserted the near impossibility of determining the link between an *individual's* exposure and illnesses:

> Estimating veterans' health risks associated with particular environmental exposures is challenged by lack of exposure monitoring and of biomarkers to quantify individual exposures of veterans during the deployment retrospectively. (Institute of Medicine, 2006: 2)

We conclude from our examination of relevant public laws that the policy outcome of the veterans' movement efforts was palliative rather than curative: policies failed to ameliorate substantially veterans' burdens of high medical bills and inadequate medical treatment. Although several factors no doubt contributed to policy failure, our interest concerns the particular contributions of the Gulf War illness movement to that failure.

Research indicates that a movement's influence on policy-makers is determined in large part by the public's agreement with the movement's aims. Activists must persuade the public that government actions/inactions are harmful to the aggrieved and so generate a majority's expressions of disapproval and distrust of the government's handling of the group's grievances. The government's predisposition to retain public trust in attention to Persian Gulf War veterans' needs was strongly signaled by the congressional passage of PL 102-585 and PL 103-210 *before* veterans organized. But activists failed to capitalize on that momentum with a focus on the inadequacy of policies and an articulation of grievances that persuaded the public of government failure to provide for ill war veterans.

Most illnesses associated with environmental exposures are characterized by a pervasive ambiguity that derives from deficient exposure histories, imprecise measurements of dose–response relationships and the unknown synergistic effects of exposure combinations (Kroll-Smith et al., 2000). Ambiguity fosters multiple definitions of illnesses, allowing powerful contenders to promote the definition that most suits their interests (Brown et al., 2000, 2003; Vyner, 1988). The Gulf War movement failed to fulfill movement tasks sufficiently to generate public pressure that threatened government legitimacy, leaving policy-makers free to exploit the inherent ambiguity of veterans' illnesses and attribute their symptoms to psychological deficiencies. We contend that intra-movement conflict substantially contributed to the movement's failure.

The Substance of Intra-Movement Conflict

Differences on two critical issues provoked intra-movement conflict: the level of intentionality attributed to the state for troops' exposures to hazardous substances, and the degree to which the national movement organization accurately and democratically represented the interests of grassroots veterans' groups.

Conflict over State Intentionality

Most of the conflict was generated by activists' disagreement over the extent to which their hazardous exposures and inadequate medical care resulted from the state's *deliberate* actions/inactions. Criminologists address

such issues with the concept of state crime (Chancer and McLaughlin, 2007; Cohen, 2001; Green and Ward, 2004; Kauzlarich et al., 2003; Rothe and Friedrichs, 2006; Ward and Green, 2003; White, 2008). Definitions of state crime vary because they 'cannot rely upon strict legal definitions in so far as such definitions derive from the State itself' (White, 2008: 36). Kauzlarich et al. (2003) define state crime as an action or inaction by the state or state agencies that: harms individuals, groups and property; violates an assigned or implied duty; and serves the interests of the state or elites. They suggest a 'complicity continuum of state crime' which differentiates state behaviors by the extent to which the harm done is deliberate. One end of the continuum represents deliberate state crimes such as genocide, while the other end represents the state's failure to act against preventable harm such as the acceptance of injuries associated with inequality.

We use this model to differentiate activists' views of state culpability in their exposures and inadequate medical care. Respondents described their views in three narratives that represent locations on a complicity continuum: the exposures resulted from the state's deliberate actions; the exposures were unintentional but the state acted deliberately to cover up mistakes; and the exposures were unintentional and the state was unintentionally slow to recognize health effects and offer adequate medical care.

Deliberate Hazardous Exposures Activists from five of the 16 groups believed that the government had deliberately exposed veterans to hazardous substances A leader of a local branch of Operation Desert Shield/Desert Storm Association described his position:

> [We] think the government actually knows and even ordered it . . . almost like we are their test. And they sit back and document what happens. I think it is that cut-and-dried – we are just statistics.

Some activists who believed that exposures were deliberate claimed that the government distributed the experimental drug, pyridostigmine bromide, to test its battlefield effectiveness against chemical and biological warfare agents because the Food and Drug Administration (FDA) had not yet approved it. Activists claimed precedent for such actions: 'There is a history of using soldiers as guinea pigs for experimental drugs.' Another activist concurred: 'This is not the first time the FDA used soldiers as their guinea pigs to test new drugs and their effects.'

Other activists viewed the exposures as deliberate because the government had sold weapons of mass destruction to Iraq prior to the war:

> The government used to sell this stuff to them and used to support them, up until six months before the war started. A lot of people profited here in the States – everybody from Schwarzkopf and up, the President and all those people. They did not want to admit that any kind of nerve or biological gases

were used against us because it would open up the door to claims against our government. So, they are waiting for us to die off.

Another activist supported his stance with references to documented government abuses:

> . . . any number of other cases of government abuses. I mean, Waco, Oklahoma City . . . the list goes on and on. I feel, from what I see on the internet and from just talking to people on the street, very few people have any trust in the federal government anymore.

These activists were angry, and some agreed with the activist who exclaimed: 'What the government has done to the Gulf War community is criminal – absolutely criminal!' Many felt betrayed by their government, as indicated by this outspoken respondent from the Northern California Association of Persian Gulf Veterans:

> We believe in our country. What we *don't* believe in is our government. They've lied to us – they've betrayed us! We were told, 'Go fight for your country and we'll take care of you.' We soon found out we were dispensable.

Perceptions of deliberate state actions shaped not only grievance articulations but also tactical preferences. Activists believing that the government had deliberately exposed troops to hazardous substances were more likely than others to express a preference for non-institutional protest tactics that involved direct and publicized verbal attacks on the government. A more radical activist from a smaller state organization indicated the breadth of political change he sought by stating, 'I think we need a revolution!' The tactics sparked heated debates among activists, and many refused to associate with those holding the government-conspiracy position.

Unintentional Exposures, Deliberate Cover-Up The most common narrative was that the hazardous exposures were unintentional, but the government deliberately abused its power by hiding mistakes through a cover-up that unjustly denied veterans access to medical treatment. Activists representing 10 of the 16 organizations believed that government officials had made wartime mistakes in subjecting military personnel to unsafe exposures but withheld that information. An activist declared, 'They lied about it to begin with, and they don't want to lose face by coming up years later and saying, "We're sorry, we lied."' An activist from Veterans for Integrity in Government explained:

> People like Powell and Schwarzkopf and a whole host of others made a series of really bad decisions. Like the decision to use PB [pyridostigmine bromide] pills. And other decisions to bomb these chemical and biological facilities, and the heavy use of pesticides. What I have seen, is what I call a genuine cover-up.

Another activist described the government's damage control efforts:

> I think, by late 1992, early 1993, a lot of people in the Pentagon began to understand that serious mistakes had been made, and then they went into damage control mode: trying to basically deny the problem existed in the hopes that it would go away. And it didn't – it only escalated.

A third was more succinct: 'I feel that the government is trying to cover its own backside!'

Recognition of a deliberate government cover-up was painful, as indicated by this Gulf War veteran nurse and activist from the Desert Storm Justice Foundation:

> For a long time I didn't believe they would do it. I didn't believe they would lie like they did. Now I've got a jaundiced view: it's about individual power plays. I think a lot of people compromised themselves on a high level and excused it.

Another activist described her shock at learning that the government used similar strategies in previous wars:

> When we started looking at this [Gulf War illness] . . . this stuff happened clear back in World War I! They used mustard gas and then denied it! Good Lord! That's been our government's regular MO – to do this stuff and then deny it!

Activists reported significant changes in their attitudes toward the government because of their treatment as veterans. A long-time activist from the National Gulf War Resource Center explained:

> It was only after I got sick and tried to get treated that my impression started to change. As I have gone through this god-awful cycle of dealing with the VA and the DOD [Department of Defense], I have gotten tired and bitter. My eyes have been opened considerably, especially since I found out that this existed in wars before us. It has changed my impression of our government.

These activists relied primarily on institutional tactics but included some non-institutional tactics in their protest repertoire, such as demonstrations. They filed numerous Freedom of Information Act (FOIA) requests for the release of government documents suggesting the existence of data sets on wartime exposures and Gulf War illness symptoms. They countered government claims of inadequate data with these FOIA documents and publicized the information via the Internet, newsletters, news releases and congressional testimony.

Unintentional Exposures, Unintentional Slowness to Respond Activists from only one of the 16 groups, the United Veterans of America, held that

neither hazardous exposures nor inadequate medical care were the results of deliberate government actions. They maintained that the government unknowingly exposed troops to hazardous materials and was unintentionally slow to respond to veterans' illness claims. They mobilized to prod the government into recognizing the health effects of the exposures and rectify them.

This narrative led activists to prefer institutional tactics, working within the system to foster greater awareness of veterans' problems. Their goal was to educate and inform the government, encouraging officials to acknowledge Gulf War illness as a medical diagnosis. An activist described his vision of movement success – a formal government statement:

> The government could just say, 'Today, what we need to do is to go forth and explain that we thought we were doing right, but now see that we were wrong. So we have to admit that and provide adequate care and compensation.'

The activists objected to more radical tactics, believing them tantamount to betrayal. A former Marine scout sniper and veteran explained, 'We won't do some of these [tactics] that other veterans' organizations are doing. I'm not saying they are right or wrong, but they can't betray their own!' Another activist expressed similar concerns, explaining that radical activists are 'looking at it from a different perspective, that anything they can do to destroy, or bring about the changes – even destruction and protest [is acceptable]'. A veteran explained that, in contrast, her group's efforts were geared toward improving government credibility: 'What we're trying to do is re-establish credibility in the government and the military. They're [other groups] just looking at blowing everything wide open.'

Conflict over Democratic Representation by the Resource Center

To a lesser extent, a second issue provoked intra-movement conflict: the degree to which the national movement organization accurately and democratically represented the interests of veterans in grassroots groups. Activists founded the professionalized National Gulf War Resource Center to mitigate the disadvantages of decentralization by representing all Persian Gulf War veterans' groups. A founding member explained that the group's intent was to exhibit a united presence to the VA and to the public: 'That was one thing that we wanted to make clear when the organization was formed, that we would try and act as a national organization and a representative voice of our member groups.'

But many grassroots activists believed that the Center continuously overrode veterans' concerns. Instead of polling veterans to determine the issues most important to them, grassroots activists charged that Center activists unilaterally identified the issues they would pursue and then

demanded veterans' support for them. A respondent illustrated the problem by comparing the operation of her grassroots group, Gulf War Veterans of Connecticut, to that of the Resource Center:

> If I go down to Washington and I'm speaking, I call up the 20 or so members who are always around and say, 'Hey, I'm going down to Washington, what do you want me to do?' I speak on behalf of these people. It's not my own opinions. Well, the Resource Center doesn't do that. They go after the issue of whoever is paying them the most money. They no longer work for the veteran community.

An activist from a state chapter of Operation Desert Shield/Desert Storm Association described an example: one evening she arrived home from work to find a faxed request from the Center for her immediate endorsement of a congressional bill. She explained to us: 'I won't endorse a bill until I talk to the veterans to see if it is what they want.' She contacted group members to assess their views:

> I was on the phone until 3:00 a.m., and then I did endorse it. But I wouldn't do something like that without consulting the veterans first. This is their cause. I just happen to be the spokesperson for it. That's what the Center has gotten away from.

How did conflict hamper activists' execution of movement tasks? How did deficient task execution contribute to the movement's inability to generate a legitimacy crisis for the state?

Discussion and Conclusions

The US Gulf War illness movement mobilized veterans across the country into grassroots organizations and a national lobbying group to press the government for recognition and treatment of Gulf War Syndrome. Veterans enjoyed widespread public support – even war protestors distinguished between their opposition to the war and their gratitude to soldiers. General support extended beyond national boundaries since the war was a UN conflict and not unilateral US aggression. Despite such backing and the cultural force of patriotism, the movement achieved only limited policy concessions: the few policies passed were largely cosmetic – policy palliatives rather than resolutions to problems.

Multiple variables likely contributed to the result of policy palliatives: ill activists were unable to maintain consistent physical efforts; and some veterans opposed mobilization because of cultural constraints such as patriotism, solidarity with fellow soldiers and reluctance to admit illness (Shriver et al., 2002). But we contend that intra-movement conflict substantially hindered activists' fulfillment of the movement tasks most vital for influencing policy-making. Analysts have frequently noted that conflict

detracts from the movement's impact by drawing activists' attention and energy from pressing their case. Our analysis extends the literature by specifying the overlap between movement tasks and policy-making tasks and illuminating more specifically the ways in which conflict hampers task execution and reduces policy impact.

We found that the *nature* of intra-movement conflict, rather than simply the presence of conflict, severely detracted from activists' ability to influence policy-makers. Most of the conflict flared up over divergent views of the deliberateness of government actions leading to veterans' grievances. The tensions that surfaced over the Center's representation of grassroots veterans are best interpreted as a corollary of intentionality: activists who believed that the government deliberately exposed veterans to hazards likely had different interests than activists who believed that the government had merely fumbled the ball. Consequently, the Center's pursuit of *any* agenda was likely to trigger complaints from some quarter.

The conflict was particularly divisive in the activist community because it concerned the fundamental component of grievances: identification of the practices of the responsible institution that generated veterans' problems. Compromise and consensus were intrinsically impossible. No middle ground was definable: the government's actions were either deliberate or not deliberate.

Conflict over grievances effectively fractured activists' efforts to accomplish the central movement task of establishing and presenting a uniform articulation of veterans' grievances. Different views of the deliberateness of the state's actions imparted the appearance of multiple grievances, detracting from the notion of shared suffering from a collective problem. Unclear grievance articulation diminished efforts to recruit not only the aggrieved but also conscience constituents and elite supporters. Agreement on goals was negated because, without a clear delineation of culpable government actions, ameliorative government actions could not be determined. The conflict manifested in disagreements in tactical preferences: activists who believed that their hazardous exposures were deliberate felt justified in adopting radical tactics, while those who believed the exposures and inadequate health care were *not* deliberate insisted on working within institutional norms.

Activists' diminished capacity for executing policy-relevant movement tasks kept them from significantly impacting the problem definition and agenda-setting stages of the policy-making process. Because policy-makers court the public, public support is paramount in a movement's quest to define an issue as a collective problem and to secure policy-makers' attention to it. But, because of deficient task execution, the problem was not clearly defined: neither the problem's causes, its substantial harmful effects and its similarity to previously addressed problems, nor recommendations

for the problem's mitigation were sufficiently elucidated to persuade the public that the government failed to live up to its political mandate in respect of ill veterans. Without sufficient public support as pressure threatening the state's legitimacy, policy-makers were able to exploit the ambiguity attending Gulf War illness and produce policies that may have appeared to non-veterans as adequate responses to the problem but actually failed to aid the aggrieved in meaningful ways. The consequence was policy palliatives.

Our case suggests that public policies are fundamentally *political* techniques for resolving social problems – the intention most often is to ameliorate conditions in limited and incremental ways that frequently fail to alleviate the grievances adequately. This view of public policies as political techniques helps to explain the longevity of the labor, civil rights and women's movements – their cycles of activity and abeyance – and suggests that substantial social change will only occur with persistent pressures from social movements.

Our analysis has focused on veterans' mobilization in the US. At least 40 nations supplied armed forces in the Persian Gulf War who, in all likelihood, were exposed to the same substances as US troops and suffer from the same illnesses. Did veteran mobilization vary with a nation's form of government or with differences in health care systems? Universal health care, for example, would negate a government's need to deny responsibility because culpability would not involve compensation. If veterans received health care and coverage, mobilization would not be necessary. Such comparative studies of the experiences of ill veterans would add substantial depth to our understanding of government responses to veterans' illness claims.

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