The Thin Line between “Crazy” and “Hero”: Exploring the Multiple Statuses of US Veterans in a Work-therapy Program

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Abstract
This study explores how US veterans who suffer from mental health problems navigate between two primary statuses: national hero and mental patient. The analysis reveals a more nuanced understanding than previous research, which has focused on a simple negative association between positive veteran identity and stigma. Qualitative evidence collected in a work-therapy program for veterans demonstrates that the status of mental patient became salient in peer-group activities, where it engendered a sense of solidarity and mutual empathy, and in interactions outside the mental health care facility, where it involved a sense of stigma. The status of being a national hero emerged in interactions with casual visitors from whom material contributions were sought, but did not reinforce a sense of positive veteran identity because veterans were aware of its instrumental nature. When leaving the program, a strong sense of stigma emerged despite the possibility of embracing the veteran identity.

Keywords
veterans, mental health care, stigma, national hero, symbolic interactionism

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Introduction

Veterans of the armed forces have a special place in the United States’ fairly limited and decentralized welfare system. Throughout the development of welfare services in the United States, veterans and their advocates have successfully claimed the status of “most deserving citizens”\(^1\); therefore, nationwide social protection programs have consistently lagged behind the special programs for veterans.\(^2\) Today, welfare services for veterans, including health care, housing programs, education and vocational training, addiction rehabilitation services, and others, are centralized programs managed by the US Department of Veterans Affairs (VA). In contrast, most social protection programs for nonveterans are decentralized and run by state governments. Like all American citizens, veterans may be eligible for government-provided health care, health insurance, and social protection programs if they are old, poor, or disabled. However, obtaining welfare services and health care from the VA is often more desirable, both because VA health insurance does not depend on either age (as Medicare does) or poverty status (as Medicaid does) and because VA-issued disability compensation payments for armed service–related injuries and mental problems are considerably higher than compensation payments from other programs.\(^3\)

The special status of veterans as most deserving citizens is based on the definition of all veterans of the armed forces (no matter which branch of the service they belonged to, or whether or not they experienced combat) as national heroes (i.e., individuals who made sacrifices to serve the United States and the American people). The VA’s institutions actively advertise the hero status of veterans. For example, on the West Los Angeles VA campus, where this study was conducted, the US flag flies on tall flagpoles; flowerbeds bloom in red, white, and blue; symbols of military units are painted on a bridge that crosses the campus; and walls display slogans announcing that the welfare and health care center is “serving those who served.” In this manner, the VA presents its services as a moral commitment that the nation-state has made to its most deserving citizens. In its mission statement, the VA promises that its employees “offer their dedication and commitment to help veterans get the services they have earned. Our nation’s veterans deserve no less.”\(^4\)

Indeed, at a certain abstract symbolic level, all US veterans are considered “national heroes” and thus the most deserving citizens. This symbolic collective status has been repeatedly reaffirmed by sitting presidents in speeches. However, the mundane reality of the day-to-day lives of many veterans is much less glorious. At the turn of the millennium about 5.6 percent of the veteran population, almost 1.5 million individuals, lived in poverty;\(^5\) in 2006, an estimated 200,000 veterans were homeless on any given night;\(^6\) and in 2003, an estimated 1.8 million veterans suffered from severe alcoholism,\(^7\) and about 1.2 million suffered from serious mental illness.\(^8\) Therefore, while labels such as “national heroes” and “most deserving citizens” place the category of veterans at the center of the normative order, the life circumstances of many individual veterans place them at the margins of society.
Many studies (conducted primarily in the United States) have investigated the short- and long-term effects of military service on the life chances of individuals in various domains such as education, employment, housing, crime, family life, and physical and mental health. Researchers, however, have not explored the ways in which the subjective experience of veteran identity affects the daily lives of individuals who also carry other, less normative identities such as being a drug addict, ex-convict, or mental patient. This lacuna stands in contrast to the extensive literature on other subpopulations that receive special welfare and clinical services and experience stigma as a result of these services.

For several decades, social scientists have been increasingly interested in how stigmatized individuals experience their stigma. This phenomenological approach has shown that individuals are not passive carriers of stigma, but rather employ various strategies to avoid being stigmatized, to transform their stigma into a positive identity, and to retain positive self-esteem. Psychologists have highlighted the cognitive and affective coping mechanisms used to deal with stigma. Social psychologists have demonstrated that under certain conditions, identification with a stigmatized group improves individuals’ ability to cope with a stigma by enhancing their self-esteem and allowing them to blame others (outside the group) for the stigma, rather than themselves. In addition, ethnographers (sociologists and others) have highlighted the behavioral strategies that individuals employ to cope with stigma and maintain a positive self-concept. In particular, studies have shown that the threat of being stigmatized leads individuals to modify their lifestyle, selectively participate in certain social interactions and avoid others, and use impression management techniques during social interactions. These types of behavioral coping strategies have been observed in various stigmatized populations such as the elderly, people with chronic mental illness, people who suffer from bodily impairment or other genetic disorders, homeless people, and people who carry stigma associated with deviant sexual behavior.

As I illustrate in the following section, VA clients make a very interesting—albeit understudied—case, because in addition to the sense of stigma they share with many clients of other welfare and clinical institutions, serving in the armed forces is considered the highest civic virtue. Using qualitative data collected at one of the VA’s mental health institutions, this study explores how veterans navigate between two potentially contradictory statuses: “most deserving citizens” and “mental patients.” Specifically, this study investigates which situations lead to one status taking precedence over the other, and how the stigma attached to being a mental patient is transformed into a positive identity.

The Dual Status of US Veterans at the VA

Through its special welfare and health care programs, the VA offers veterans resources that many of its clients could not otherwise afford. However, individuals who receive, or even just considering receiving, services from the VA often experience a status...
dilemma. Although a salient positive veteran identity leads individuals to believe that they deserve the resources and services the government funds and allocates through the VA system, individuals are often concerned that utilizing these services will engender the stigma associated with being a welfare recipient. This status dilemma often affects individuals’ decisions about whether or not to use the VA’s services. Several studies using data from the Veteran Identity Program survey have found that the fear of the welfare stigma deters individuals who might otherwise use the VA services. These studies have also revealed the importance of the veteran identity: individuals whose veteran identity is positive and salient are more likely to apply for VA services, while individuals whose veteran identity is negative—for instance, who feel ashamed, guilty, or embarrassed about their military service—are less likely to turn to the VA for services.

However, a main reason for choosing the VA’s health and mental care services is the inability of individuals to afford services from private institutions. Therefore, status dilemmas are not resolved simply because a veteran decides to become a VA client. Rather, individuals who cannot afford private care become clients of the VA even if they lack a positive veteran identity, and despite the perceived risk of being stigmatized. For veterans who pursue mental health care, the sense of risk associated with being a VA client is multiplied, because these individuals are concerned not only with the welfare stigma but also with the mental patient stigma. Using data obtained via qualitative research at the Veterans’ Garden in West Los Angeles (a program that provides compensated work-therapy for ten to fifteen eligible veterans who work in a fifteen-acre garden on a VA campus), I trace the role of two distinct statuses—national hero and mental patient—in the daily lives of individuals who fall into both categories.

Theoretical Framework

Two complementary sociological perspectives on identity guide the investigation. First, according to the social cognition approach, the meaning individuals extract from their perceived membership in social groups is an important influence on their self-concepts and self-evaluations. Therefore, in order to understand positive identity and stigma, this study traces the meaning that individuals attach to their membership in the imagined collectivities of “veterans” or “mental patients.” The second perspective, symbolic interactionism, requires a consideration of the situated nature of identity and stigma, in other words, the ways in which identities and their evaluations are negotiated within social interaction. Therefore, this study seeks to uncover the situations in which the identities of “veteran” and “mental patient” become salient. These situations, as the data will show, are far from random. Rather, organizational settings prescribe and schedule certain interactions to take place at certain locations. Further, as Goffman noted, in every organizationally prescribed situation—which Goffman called social occasion—“a pattern of conduct tends to be recognized as [the] appropriate and (often) official or intended one.”
Therefore, a comprehensive discussion of positive identity and stigma requires a consideration of not only personal (or psychological) aspects but also interactional and organizational dimensions. Derek Layder offers a useful conceptual framework for bridging these three dimensions; using Layder’s social domains terminology, the emergence of both stigma and positive identity can be positioned at the intersection of the subjective psychology of individuals and their situated activity (face-to-face encounters). However, as Layder emphasizes, these two domains do not exist in vacuum, but are interconnected with the social organizations in which individuals operate as well as other contextual factors. I now describe the methodology I used to explore the ways in which stigma and positive identity emerge in social interactions, and to reveal how these interactions are embedded in organizational settings.

**Method**

Veterans who receive mental health care from the VA make a hidden population. Two aspects make the study of this population especially challenging. First, as with other health care and welfare institutions, the VA maintains special regulations and procedures that protect clients from potential harm. To conduct this research, I had to be hired as a nonpaid VA employee, I submitted myself to periodic training sessions, and had the study approved and monitored by the VA’s Institutional Review Board (IRB) and several subcommittees. Second, although the general atmosphere on the VA campus welcomes visitors, clients usually maintain exclusive social ties with peers with whom they share high levels of trust and codes of behavior that are not shared by outsiders. Therefore, to enter the field required not only overcoming bureaucratic obstacles but also developing close relationships and mutual trust with the patients/workers at the Veterans’ Garden.

Entering the field was a long and gradual process. Initially, being an academic—which in the patients’/workers’ jargon made me a “brain”—created a barrier between the patients/workers, who did not hold academic degrees and were predominantly poor, and me. However, as time has passed, the garden workers learned to trust me. Undoubtedly, being a man helped me enter a group that was mostly men. For example, individuals who liked to curse or make sexist remarks about women felt free to do so in my presence. In contrast, when a woman was present, even if that woman was a fellow veteran, individuals who used bad language were promptly hushed by the other men.

One event in particular signaled to me that I had achieved a good position in the field: the workers’ assembly in which I recruited my first interviewees. I had expected all kinds of questions to follow my presentation of the study. To my surprise and delight, however, as soon as I finished my short presentation, one senior patient/worker stood up and told the others: “You all know Israel. He helps us a lot here at the garden. He is a student at UCLA and he’s doing a research here at the garden and needs our help. Here, I volunteer for this research.” Almost all the participants in the assembly immediately volunteered to be interviewed.
This report is based primarily on personal interviews with veterans and observations of public events conducted over a two-year period at the Veterans’ Garden in West Los Angeles. In addition, I volunteered to work in the garden once a week for two years (2007–2008); during this period, I became familiar with the daily routine of the garden, gained firsthand experience with a variety of activities in the garden, and developed a mutual trust with both patients/workers and staff members. Because of the delicate mental state of some of the patients/workers, the VA’s IRB did not permit formal observations to be conducted in the garden, but it allowed me to use volunteer work in the garden to develop interview questions. Therefore, while my experience as a volunteer worker was not directly part of the research project, it indirectly informed the research questions and provided the background knowledge required to conduct the interviews.

I dedicated the first year to learning about the garden and its patients/workers through volunteer work, observation of public events, collection of written materials, and informal conversations with veterans and staff members. In addition, after each day I worked in the garden, I documented my experience and impressions and then used these notes to plan formal and informal interviews. During the second year of the project, I conducted personal interviews with all patients/workers who worked at the Veterans’ Garden during that period and agreed to be interviewed. At that time, the garden was undergoing a process of organizational change, and some of the patients/workers who were considered mentally capable were asked to look for a “real job” and prepare to leave the garden. Therefore, I engaged in a few dozen informal interviews to keep track of subjects’ efforts to find jobs or apply for greater disability compensation. These conversations offered important insights into the exacerbation of status dilemmas in periods of transition and uncertainty. In total, I conducted forty-five formal and informal interviews with patients/workers at the garden.

In the interviews, interviewees felt comfortable enough to share very personal and sensitive stories with me. Some interviewees were curious about the study; I told them only that the study was about the experience of individuals who work at the garden. The interviews were semistructured, and at the beginning of each one the interviewee was given the opportunity to tell his life story and describe the circumstances that brought him to the garden without being guided by more specific questions. The interviewees were never asked to focus on their military service, which allowed them to focus on parts of their biography that were not directly related to their veteran identity, but were nonetheless central to their self-concept.

Collecting interview and observational data provided insights into multiple dimensions of identity and stigma: the subjective dimension at the individual level, the interactional dimension, and the dimension of organizational settings. In turn, I found situational analysis to be a useful analytical tool for making connections between the three dimensions. Generally, in situational analysis, the investigator draws maps in order to make sense of coded qualitative data. In this study, I primarily created and used what Clarke termed social worlds maps, because these tools...
depict the “collective commitments, relations, and sites of actions” that construct and reconstruct social worlds. The data revealed several distinct “social worlds,” which provide a structure for the following empirical discussion.

The empirical discussion includes four sections, each of which represents a unique juncture of the veteran and mental patient identities and the statuses attached to them. The first three parts show how the statuses of being “crazy” and a “hero” emerge during different social occasions that are part of the routine of the Veterans’ Garden. The last part reveals the ways that a sense of stigmatization becomes more salient when individuals wish to leave the institution or are asked to do so.

In the following discussion, I use pseudonyms for all interviewees. To prevent the possible identification of the interviewees, other pieces of information were excluded or modified in ways that did not significantly change the meaning of the statements made in the interviews.

Playing Multiple Roles in the Veterans’ Garden

The Veterans’ Garden in West Los Angeles was created in 1986. Although it is publicly described as a program of horticultural therapy for disabled veterans, the garden is an economic organization as well, because while some of its expenses are subsidized by the VA, the garden’s budget includes revenues from selling plants, flowers, vegetables, and fruit. The garden is an interesting site within the VA campus because of the social occasions that are part of its routine. Patients/workers spend a lot of time in the garden with peers; interactions with peers are based on the assumption of shared experiences, mutual understanding, and common goals. Patients/workers also encounter customers and donors with whom they have less in common, however, and on these occasions, they have a short-term mission of selling flowers and plants or asking for donations. During each type of interaction, subjects play distinct roles and carry different statuses, which make the garden a useful site for learning about the interrelationship between heroism and stigma.

Interactions with Visitors

Donors and customers are one source of income for the Veterans’ Garden. Their relationships with the garden’s patients/workers are interesting because they include the exchange of both material and symbolic goods. The garden offers not only flowers and plants but also a sense of morality, in exchange for money. Contributions are framed as an act of patriotism by emphasizing, sometimes explicitly but most often implicitly, a narrative of giving national heroes something they have earned. Every Thursday, a farmers market is held in the garden. During market hours, a poster introducing the program to visitors hangs from the front gate, and in the nearby selling area a basket offers brochures that tell visitors “You can actively participate in the Garden’s success: Shop weekdays at the Vets’ Gardens, Come to the Farmers Market on Thursdays, Volunteer . . . Join the Friends of the Garden” [bold in...
original]. A film about the garden and its workers sometimes played on a nearby monitor. These symbolic expressions were aimed at making the exchange between the garden program and its customers not simply an economic transaction but also a moral and emotional act of patriotism. Every dollar spent in the Veterans’ Garden became “special money” with both quantitative market value and qualitative moral content.23

When customers visited the garden (during the farmers market or on any other day), patients/workers often helped them find the plants they wished to purchase and answered questions about how to take care of the plants. The moral aspect of seemingly simple sales exchanges often emerged in these brief interactions. For example, at one event, I was helping Morgan (a patient/worker) at the checkout point when a middle-aged woman approached and asked to buy some apricots. “This young man picked them only half an hour ago!” Morgan said, pointing at me. “Is that really so?” the woman asked. I raised my right hand in the gesture of swearing to tell the truth, and Morgan said, “Veterans don’t lie.” Morgan used the customer’s rhetorical question as an opportunity to remind her that she was not dealing with ordinary salespeople, but rather veterans of the armed forces who deserved extra respect.

Despite this type of positive characterization, any interaction between a mental patient and a stranger could have involved a sense of stigmatization. However, being part of a special program for veterans enabled individuals to transform a potential source of stigma into a positive label, because, as illustrated in the next section, VA membership facilitates an imagined connection between mental difficulties and combat heroism.

Combat Heroism and the PTSD Assumption

In the Veterans’ Garden, interactions between patients/workers and visitors were often based on an assumption of service-related difficulties, specifically combat-related posttraumatic stress disorder (PTSD). After a long history of construction as an illness,24 PTSD is currently not only a specific clinical category but also a widely available cultural trope. Thus, casual visitors at the Veterans’ Garden are likely to assume that the mental health problems suffered by the individuals working there are the outcome of exposure to traumatic events during their military service. This assumption was indeed part of the subtext in many interactions between visitors and veterans. For example, during the farmers market, Eric, a senior worker at the garden and a patient, took it upon himself to present the work-therapy program to visitors and usually used the following script: “All of us are veterans and the garden is part of our program. We have two guys from the Second World War, two from Korea, most of us were in Vietnam. This is a self-sufficient program.” Interestingly, Eric chose to introduce the patients/workers of the garden through the wars that occurred during their military service. Many of the garden’s workers never actually experienced a combat situation, and some had served only in peacetime. By
choosing to introduce fellow veterans according to times of war, regardless of their actual service period and job in the military, Eric discursively constructs a suggestive context. That context accords with the VA’s promotion of veterans as heroes generally, and further suggests that they are combat heroes.

There were other ways in which patients/workers could have presented themselves. For example, when I conducted interviews, interviewees presented themselves to me through their individual life stories and talked about the specific mental and physical problems that led them to seek help at the VA. One respondent told me, for example, that he was raised in a poor family and first suffered from depression as an adolescent and that his depression further deteriorated during his noncombat military service. Another interviewee explained that he started using drugs years after his military service and that his addiction led to the emergence of the paranoid schizophrenia from which he was currently suffering.

In contrast to combat-related mental difficulties, and in particular to PTSD, mental problems such as paranoid schizophrenia or depression are not associated with the allure of military heroism, and thus, telling strangers that they suffer from these types of “ordinary” mental health problems would involve a greater risk of stigma for veterans. Therefore, although interviewees shared intimate and nuanced information with me and with their peers, when they spoke with casual visitors in the garden, patients/workers used very general terms to depict themselves as a homogenous category: veterans of wars and mental health patients. This presentation to nonveteran visitors both permits and suggests the idea that mental health problems among the veterans emerged from the trauma of combat.

One particular event explicitly demonstrated that the assumption of combat-related PTSD mediated the interactions between veterans and visitors to a significant degree: the grand opening of Serenity Park, a spot in the garden that includes parrot cages, a water fountain surrounded by beautiful plants and flowers, and a place to sit and relax in the shade. The opening event was called Helping Parrots Helping Veterans, and the audience was asked to make a donation to the garden. The speakers pushed the PTSD narrative to the fore: seven of the eight speakers, including VA personnel, one of the patients/workers, and a famous Hollywood actor, repeated a version of the following theme: both the veterans who fought in wars and the parrots that were abused by their owners suffered trauma, and now they help each other to heal. The speakers also emphasized a slogan-like version of the same message: “Parrots that suffer from PTSD are taken care of by veterans who suffer from PTSD.” Although PTSD became an overt focus at the grand opening of Serenity Park, on most occasions it was simply implied or assumed.

Some of the veterans who occasionally served as messengers of this narrative were aware of their special role; some were also aware of the fact that the delivery of this message parallels an aspect of the praxis of the entire VA system, which depends on its capacity to frame advocacy and the provision of material support as moral acts. For example, when I asked Eric about a possible transfer of the management of the garden to a nonprofit organization he responded:
Eventually they will take over the VA. Yes, you have to be realistic, this is an expensive property. It’s all about money and sympathy! . . . Oh yeah, sympathy is very important. You know, we have a lot of soldiers now in Iraq, the VA looks for ways to make more money. When I go to sell plants I tell all the sad stories, it may be a cold sell, but that’s how it is in capitalism.

Occasionally, claiming the status of national hero took the form of a cynical performance. The following situation, which took place during a ride to a baseball game, exemplifies this type of performance. From time to time, the garden sent patients/workers to a Los Angeles Dodgers baseball game with tickets donated to the VA. I accompanied a group of veterans on one of these trips. While we were in the van waiting for the stadium gates to open, other cars were already entering the stadium through a special gate for people with reserved tickets. Norman, one of the veterans, urged the driver to go through the special gate: “Tell them that we’re veterans,” he said. Another guy, Michael, chimed in and suggested saying that they were mental patients. Norman became excited and shouted to the driver: “Yeah, do the show. Tell them that we are veterans, do the show!” Although the driver did not do “the show,” the situation revealed the patients/workers’ awareness of the symbolic resources at their disposal.

### An Alternative Self-understating

The narrative of heroism and service-related injuries that the veterans relayed—explicitly or implicitly—to donors, customers, and other strangers, traces a direct course from past military service to present mental and physical difficulties. This narrative, however was not the only one present in the garden, nor was it even the main one. Taking part in the work-therapy program at the Veterans’ Garden means spending several hours every day with other patients/workers, often without close supervision. The shared life experiences and the intimacy that these daily encounters create enabled the garden’s patients/workers to act as an informal support group. Interviewees used the terms *comradeship* and *family* to describe their relationships with coworkers at the garden; they felt that they understood one another better than their doctors understood them. Thus, participating in this peer group allowed individuals to gain emotional support and informal information about the VA’s programs and procedures.

Individuals in the work-therapy program regularly receive individual psychiatric treatment and participate in support groups, in which they learn to claim responsibility for the processes that have led them to their present situation, and to take charge of their rehabilitation. Among peers, there was no point in trying to claim the status of traumatized combat hero, both because peers were less likely to accept this narrative if it was not true and because within veterans’ circles falsely representing oneself as an ex-combat soldier is considered a sin. Whenever a newcomer tried to claim the status of combat hero, he quickly discovered that the shared framework...
among the garden’s patients/workers was not war heroism, but common difficulties in life that had created mutual empathy and similar goals. Likewise, when I asked interviewees about the circumstances that led them to the VA and the Veterans’ Garden, most spoke about mental and physical deterioration, and financial crises they had experienced. Some interviewees reported that substance abuse or alcoholism was the cause of their problems, thus blaming themselves rather than the military or the government. For example, one veteran, impoverished and struggling with drug addiction asked, “What will you write about me? Will you write about a fifty-two-year-old man that fucked up his life and now tries to make his way back up? ‘cause that will be true!” None of the interviewees mentioned PTSD (except for one whose PTSD was related to domestic abuse he suffered during adolescence, not military service). In fact, most of the interviewees emphasized that their military service made them eligible for much-needed medical care and other welfare services. Chris’ comments illustrated this idea:

[It] kind of saved my life, being in the military. Because I had my breakdown when I was in the military, and I was able to get good care from a military hospital, and then when I was discharged from the military I got really good care here also at the VA hospital. So I’ve been coming to this VA since I was 20 years old.

Chris, who attributed his mental health problems to difficulties in his childhood, considered his military service a lifesaver, even though his mental deterioration began during his service and caused his discharge. The way in which the garden and its workers were presented to strangers was, therefore, very different than the way it was understood and experienced by the veterans themselves. When playing the role of salesmen and representatives of the garden and the VA in interactions with donors and customers, subjects adopted the status of national heroes by implying that they suffered from combat-related post-traumatic disorders. In contrast, when subjects interacted with their fellow patients/workers, they stressed themes of poverty, life crises, substance abuse, mental illness, and efforts to receive better services and compensation from the VA. Which status the veterans claimed in a particular situation was thus based on whether the interaction was with “one of us” (or a frequent visitor) or with a stranger whose support and contribution was sought. My interactions with Norman, a patient/worker in his sixties, provide a good illustration of this process.

On one of my first days working at the garden, I was asked by the work manager to join a group of patients/workers who were gardening at the front of a tall hospital building that was separated from the rest of the VA campus by one of Los Angeles’s widest and busiest streets. As a newcomer, I mistakenly thought that the hospital across the street was a general hospital that had hired the Veterans Garden’s gardening services. Shortly after arriving at the site, however, I noticed that many of the people entering and leaving the hospital were wearing navy or army hats and shirts. Curious, I asked Norman, who was working near me, if all the patients in this
hospital were veterans; he answered, “Yes, all of them are veterans.” Although he had already answered my question, Norman continued, saying that he himself had served six years and that in return the country promised to give him medical care for life. “I could have been killed,” he added excitedly, “it is only fair that a country offers medical care for people who put their life on the line!” Norman, who had met me only a few minutes earlier, treated me as a complete stranger, and therefore presented himself through the combat hero framework and drew a connection to social rights. However, I did not remain a stranger for long; as Norman and the other patients/workers became accustomed to my presence in the garden, our conversations became more open and often covered personal issues. In none of my many subsequent conversations with Norman did he ever again present himself as a combat hero (which perhaps he was). Instead, he shared a difficult life story and a history of substance abuse and mental deterioration, a story similar to the stories I heard from other patients/workers. Norman’s first introduction of himself (and the entire VA clientele), which focused on the combat hero narrative, was therefore based on his assumption that my position in the field was similar to that of occasional visitors, which led him to act as a representative of the VA; in all our subsequent interactions, the mental patient/drug addict narrative prevailed.

Occasionally, the two narratives clashed; the rivalry between the two was exposed, for example, when two new and relatively young patients/workers asked Eric to share some of his experiences in the Vietnam War, a topic that was rarely discussed among the older and more senior patients/workers in the garden. Eric, who often served as the main messenger of the formal combat hero narrative in interactions with customers and donors, excitedly told the newcomers some war stories, but when one of the guys suggested that Eric’s mental health problems were a result of his experiences in Vietnam, Eric immediately denied it, announcing that “it didn’t happen because of the war but because of the drugs.” Individuals seek to maintain a coherent presentation of reality to others in social interactions, and a lack of coherence can cause confusion and embarrassment. This is exactly what happened in the situation described previously: the narrative of a combat hero experiencing combat-related problems threatened the coherence of the message Eric sought to communicate as a mentor: the narrative of a drug abuser experiencing mental deterioration. Therefore, in an effort to convince the new patients/workers that recognizing their real problems was necessary for recovery, Eric firmly rejected the PTSD narrative.

In sum, the organizational settings of the VA campus, as exemplified most notably in the Veterans’ Garden, structure the multiple roles and statuses of veterans. The main roles veterans played at the garden were patients/workers and peers for one another. Thus, when veterans were “just” doing their daily tasks at the garden, they also served as a support group for one another, and as a support group, patients/workers often shared positive and negative evaluations of the VA’s services and personnel. In contrast, when interacting with visitors, veterans were “on duty”; they exhibited their loyalty to the VA and often performed the role of combat heroes suffering from PTSDs. The transition from one role to the other involved a change in
the status carried by the subjects. Thus, in interactions with donors and customers, mental illness was framed as related to heroic participation in wars.

The VA institution thus facilitated the social occasions in which mental illness was transformed into a source of positive identity among veterans. However, in the mental health institution, mental illness sometimes also carried a perceived negative stigma. Clients often referred to the mental health care facility as the VA’s nut house, and interviewees felt that carrying the stigma of being a “nut” was the price they had to pay for the services they received from the VA. One of the patients/workers explained to me that he received a paycheck every month in order to carry the title of “nut.” Indeed, to sustain their entitlement to certain welfare benefits, veterans must submit to periodic psychiatric evaluations, which they call “crazy checks.” Thus, a sense of stigmatization accompanies the status of mental health patient. Among their peers, this sense of stigmatization, which is not shared with strangers, is often discussed openly.

The scope of the current study does not allow any conclusions about whether or how often subjects actually experienced stigma-based discrimination within or outside the VA. Overall, interviewees felt that in the garden and on the VA campus they were surrounded by people who understood and respected them. Therefore, as long as subjects were doing routine work and interacting with peers, the “mental patient” stigma was not a source of great concern and was often discussed among veterans using humorous language; for example, patients/workers occasionally teased each other about being a “nut job,” but this teasing was always conveyed empathically. Another example of using humor to control the mental patient stigma was a situation in which a group of patients/workers were picking squash and chatting, when one suddenly announced with a grin: “We are all nuts, but we are nonviolent nuts!” Indeed, on the VA campus, the mental difficulties of patients/workers are normalized and contained. In contrast, as described in the next section, when trying to leave the VA campus, subjects felt that they were carrying the status of mental health patient with them into a social environment that may not tolerate this status.

Leaving the Garden

During the research period, the Veterans’ Garden was undergoing organizational changes and several of the senior patients/workers were asked to look for a “real job” and prepare to leave the garden. These individuals feared that coming out of the “VA’s nut house” might discredit them in the labor market. Further, they had minimal expectation that their veteran status would counterbalance the mental patient stigma. Therefore, the transition from the VA occupational therapy program to the labor market was even more difficult than it already would have been for older individuals with minimal or no credentials.

The risk of stigmatization and the active management of that risk by veterans through discursive performance emerged with particular clarity during a conversation with a senior worker at the Garden. When I asked Tommy, a senior worker...
at the garden, what he said in job interviews about his work at the Garden, he answered:

I’d be honest, [I say] ‘I work in a therapy program for veterans in rehab’, but what I don’t say is that I’m myself in the program. I say that I work in the therapy rehabilitation program for veterans, which is true, I’m not really lying, I just don’t tell them that I’m enrolled in this program myself. That’s what I don’t tell . . . They might think that I am a rehab specialist. If that’s what they want to think, it’s up to them, but I don’t volunteer that information, and I don’t say that I’m not a rehab specialist, which I’m not. They might look at my resume, my resume is honest, so if they assume [that I am a rehab specialist] that’s fine.

Tommy coped with risky job interview questions through “information control.” He refrained, as much as possible without lying, from sharing biographical information that might discredit him. Individuals tend to resort to this tactic when they feel discreditable, but at the same time have the opportunity to try to manage the impressions of others and thereby avoid stigmatization. Therefore, individuals are likely to use information control techniques in situations and places outside their ordinary routines, because their impairment may be unknown to the individuals in these novel situations. The veterans in this study used information control when attempting to leave the VA welfare system and enter the “normal” labor market.

Despite his efforts, Tommy, who held a semimanagerial position in the garden, failed to find a job outside the VA, and was eventually hired for a job on the VA campus. Indeed, finding a job within the VA system was the preferable solution for interviewees who felt that their chances of finding a job in the “real” labor market were minimal. But even within the VA system, finding a job was very difficult because a limited number of jobs were available, and many of these positions were not open to individuals with a history of psychiatric problems. At least one interviewee, who for years had a central role in the garden that required taking on a great deal of responsibility and applying management skills, accepted a job at Pride Industries, an organization that offers jobs to people with disabilities. Despite being very capable, this person moved from one place for people with greater needs to another.

**Conclusion**

Previous studies have suggested that having a positive veteran identity encourages individuals to use the VA’s services even though they might suffer a stigma as a result. To improve the scholarly understanding of the relationship between veteran identity and the stigma associated with being a mental patient at the VA, this study applied a grounded, context-sensitive investigation strategy in which interview and observational data were collected at the Veterans’ Garden in Los Angeles. This study provides several important insights.
First and most importantly, the findings suggest that the stigma perceived by veterans who receive mental health care services from the VA may not be profoundly different from the stigma experienced by individuals who receive similar services from other providers. Similar to “ordinary” mental patients, VA clients often feel discredited outside the clinical institution. Concerns about stigma operate as a double barrier for many US veterans who experience mental health problems. The fear of stigma may prevent individuals from seeking mental health care in the first place; this problem is not limited to US veterans. For example, studies have found that in the United Kingdom the stigma of mental disorder prevents many ex-service personnel from seeking help.29 In addition, once veterans do seek help, concerns about stigma make it harder for them to leave the clinical setting after being clients for an extended period.

As many studies have shown, for individuals who suffer from mental health problems, having a salient positive identity is key to establishing well-being and coping with a sense of stigma. Among veterans, the “veteran identity” may seem to be the natural candidate for the source of positive identity. However, the findings of this study suggest that the heroic veteran identity might entail problematic consequences given the fact that veterans can and do have multiple identities, for example as recovered drug addict or healing mental patient. As an institution, the VA nurtures the collective national hero status of veterans. The VA definition of veterans as heroes presents a powerful incentive for VA clients to imply, or allow the public to believe, that they suffer from combat-related physical or mental problems. However, I never heard any patient/worker falsely present himself as a combat hero. Rather, the combat hero status was claimed collectively under the specific circumstances discussed above.

This situation presents a provocative moral question for the VA, for veterans, and for society at large: does the idealistic heroization of all veterans by the VA and in popular media present an impossible situation for veterans: if they were to decline being positioned as heroes—as combat heroes—would they also eliminate the moral and monetary basis for the existence of the community in which they have found a livable life and mutual understanding? If so, is the activity of skirting the bounds of truth in presenting themselves to the nonveteran public, for example during job interviews, to be understood as a moral failing or the best way to negotiate an impossible situation?

This study suggests that playing the role of national hero (especially via the “combat hero” narrative) does not necessarily reinforce a sense of positive identity, because veterans are often aware of the manipulative and instrumental nature of this act, and therefore drop the mask as soon as the show is over. Indeed, after customers and donors left the Veterans’ Garden feeling satisfied with their patriotic contribution to the garden, veterans still had to deal with what they considered their real problems, as well as the possibility that these problems would become a source of stigma.

This is not to suggest that a positive veteran identity should not be nurtured or that this identity should not be used as a symbolic tool for obtaining material resources. Rather, this study raises the possibility that the veteran identity may be a more effective source of positive self-concept when this identity is not used to frame problems
such as psychiatric disorders or addiction. Indeed, this is precisely what makes the VA campus a safe environment for veterans who suffer from mental health problems: at the VA, an individual can receive emotional support from others, whether or not the individual identifies as a national hero.

Finally, the case of US veterans is somewhat peculiar. Because the United States has a very large population of veterans, but a very limited welfare system, veteran identity is frequently related to claiming special rights and seeking material resources. Furthermore, to be eligible for the VA’s welfare and health care services, a person needs to have a record of serving the country with sufficient honor, and disability compensation is granted by the VA only if a physical or psychiatric problem “was incurred or aggravated during active military service.”30 Acquiring certain medical services and financial benefits thus depends on an individual’s success in claiming the status of national hero—that is, someone who served with honor and got injured while doing so. Therefore, ironically, the institutional settings that embody the special collective status of US veterans also make it difficult for many individual veterans whose mental health and other problems are not directly related to military combat, to develop positive identities that they can share with others outside the institution, because this identity development requires that the veterans remove the national hero mask. Future research should explore the ways in which veteran identity affects the experiences of individuals with mental health problems in countries with more expansive welfare systems—that is, in countries in which veterans do not need to claim the national hero status in order to gain access to welfare and clinical resources, because these resources are available to all citizens.

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Notes


3. For example, according to the most recent data, in California, where participants in this research live, the maximum monthly Supplemental Security Income (SSI) benefit is US$866.40 (US$1,462.20 for a couple; World Institute on Disability, “Disability benefits 101 working with disability in California,” accessed June 26, 2013, www.disabilitybenefits101.org/ca/programs/income_support/ss_disability/ssi/program.htm. Compared to that, disability compensation that is funded by the Veterans Affairs (VA) is much more generous and can reach a maximum of US$2,816 for single veteran with 100% disability, and even exceed that if the veteran has a spouse, children, or parents to support (Military.com, “VA disability compensation rates,” accessed June 26, 2013, www.military.com/benefits/veterans-health-care/va-disability-compensation-rates.html#BM03). In addition, SSI is a means-tested benefit, which means that the recipient must not only be physically or mentally disabled but also poor. In contrast, the eligibility for disability compensation from the VA does not depend on the other resources the applicant might have.


18. JoAnn Damron-Rodriguez et al., “Accessibility and Acceptability of the Department of Veteran Affairs Health Care: Diverse Veterans’ Perspectives,” Military Medicine 169, 3


25. Future research may investigate whether veterans are helped more through their communal ties or through therapeutic relationships with clinicians.


27. The only exception was the sense of stigmatization that a few interviewees expressed feeling as a result of a decision not to allow patients/workers to drive the garden’s van or handle money in transactions with customers and suppliers. This feeling was expressed mainly by senior patients/workers who had previously driven the van and been trusted with money. My investigation could not reveal when exactly this decision was made and whether it was due to the garden’s management initiative or the enforcement of VA regulations. In either scenario, however, the decision not to allow patients/workers to drive vans and handle public money was probably meant to protect them, because their mental conditions made driving vans unsafe and asking individuals who struggle with poverty and addictions to handle money could create undue temptation.


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