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Finding Your Voice: A Novel Intervention for Female Veterans at Risk for Self-Directed Violence

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Introduction

In the United States in 2022, approximately 49,000 people died by suicide [1]. The suicide rate among active and former members of the US military has increased significantly over the last several years and has remained high, making self-directed violence (SDV) a critical military health concern [2-5]. To gain a better understanding of military suicide, researchers in a seminal study reviewed coroner/medical examiner and law enforcement suicide narratives from the Centers for Disease Control and Prevention's (CDC) National Violent Death Reporting System (NVDRS) and mental health provider narrative data collected across multiple sectors from the Department of Defense Suicide Event Report (DoDSER) [6]. They identified common precipitating circumstances: intimate partner relationship problems, mental health challenges, substance misuse, financial issues, and criminal/illegal activity. They also found that decedents were experiencing multiple high-stress problems and having difficulty coping and regulating their emotions [6].

Females make up about 14% of the military population, and of the 14%, over 38% report military sexual trauma (MST) [7]. Data from the Department of Veterans' Affairs' (VA) national screening program reveal that about 1 in 3 women reported "yes" that they experienced MST when screened by their VA provider [8]. MST has been found to be a predictor of serious SDV in women [7]. Women veterans with post-traumatic stress disorder (PTSD), MST, and exposure to combat are more prone to alcohol and other substance misuse, depression, emotional dysregulation, mental illnesses, internalized anger, shame, self-blame, helplessness, hopelessness, powerlessness, and physical health issues such as cardiovascular disease and chronic pain [5,6,9]. In addition, MST survivors face social functional impairments, including difficulties in family relationships, occupational performance, and educational achievements. The military environment, characterized by close living quarters and hierarchical power dynamics, exacerbates the risk and consequences of MST. Survivors often experience institutional betrayal and fear of retaliation, hindering reporting and access to support [10].

Intimate Partner Violence (IPV) is also prevalent among female veterans. According to the CDC, about one in four women has experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact. IPV has broad consequences, including chronic conditions, mental health problems, and PTSD. Those currently living with IPV and those who have survived IPV have more potential to engage in high-risk and unhealthy behaviors [11]. The comorbidities of MST and IPV can compound negative coping behaviors, creating challenges in navigating the best course of treatment for practitioners [11]. Treatment programs should be heterogeneous enough to allow for non-judgmental trauma processing from many different perspectives, and they must be recovery-promoting.

Additionally, Skopp NA, Holland KM, Logan JE, et. al. found in their study that large-scale quantitative analyses can be overly generalized and may not detect critical contextual information, necessitating a more nuanced approach to addressing SDV, MST, and IPV. Identifying and acknowledging subtleties enables more informed decisions and the development of more effective solutions to SDV, MST, and IPV [6].

New interventions to address SDV, MST, IPV are important. Survivors of MST and IPV may benefit from trauma-informed storytelling methodologies. Storytelling refers to an individual telling their individual or community story to another person or a group of people [12]. Storytelling is an innovative and practical approach to processing trauma, in which the community of support embraces the narrative, fostering a spirit of collaboration. Professionals are using this novel approach to better recognize and appreciate inherent subjectivity and expression [13-15]. Storytelling methodology has already impacted public health research and practice. It has long been used in the clinical setting between physicians and patients; nurses have used storytelling as a tool to provide more holistic care for women [16,17]. In one study, storytelling was used to gather pertinent client information, strengthen client-nurse communication, provide client education, and enhance staff and clinician development [18]. Storytelling has also proven to be an effective teaching tool where students learn to listen in a nonjudgmental and contextual way, hearing the values and beliefs of the storyteller and bringing learning to a more in-depth personal level [19,20]. As storytelling becomes a more valued and utilized method in addressing patients' health-related concerns, it becomes more adaptive to other purposes such as promoting self-efficacy and self-esteem in female veterans with unique health and mental health concerns. A major barrier to preventing MST, SDV, and IPV is the limited avenues for direct intervention and the potential to cause more harm [9]. Training professionals who engage in formal services with victims of MST and IPV using storytelling techniques may be able to elucidate what trauma(s) happened to female veterans and how at risk they are for SDV more effectively than traditional therapeutic methods.

Our intervention *Life Stories: Finding Your Voice (LSFYV)*, is novel in that survivors of MST, PTSD, and Traumatic Brain Injury (TBI) literally had center stage to say the words they might never have spoken; the community of listeners supported and incorporated these new stories, had conversations about them, explored what could have been done differently, all in open the dialogue with each other. This intervention along with our pilot study go beyond traditional and fixed methodologies to capture more genuine responses, cultural determinants, nuances of human experiences, and to better systematically understand underrepresented populations.

Background

The CDC's NVDRS is a data set that includes deaths by suicide, homicide, legal intervention, unintentional firearm injury, and deaths of undetermined intent that occurred in the 50 states, the District of Columbia, and Puerto Rico in 2022. Results are reported by sex, age group, race and ethnicity, method of injury, type of location where the injury occurred, veteran status, precipitating circumstances of injury, and other selected characteristics [21]. Findings from studies using these data drove hypotheses that led to this pilot study.

Non-Profit Collaboration

Lady Veterans Connect (LVC) was incorporated as a non-profit as Sheppard's Hands, Inc. in August 2012 and revised their name to LVC in October 2016 to align more closely with the mission to provide "Hope – Homes – Healing" for women veterans. LVC works primarily with the female veteran homeless population who struggle with co-morbidity challenges. LVC provides one-on-one support and group work. LVC has an infrastructure in place, including Meet and Connect activities (one avenue used to recruit LVC candidates), workshops, conferences, retreats and resiliency training, Question Persuade Refer (qPR) training for support people, and other services. LVC provides a 12-month transitional housing program for people experiencing homelessness to promote sustainable independent living, healing, reducing risks of suicidal behaviors and suicide, and building self-efficacy and self-worth.

The Theatre Lab's Life Stories® Program (The Theatre Lab is a 501(c)(3) non-profit organization located in Washington, D.C.) teaches hundreds of youths and adults each year from vulnerable populations to create original dramatic works using their own life experiences. Life Stories is a pioneering, tuition-free outreach program that provides life-changing opportunities for dramatic self-expression, empowering individuals to think creatively, communicate effectively, and envision new futures. This process has been proven to increase self-esteem, reduce feelings of isolation, and improve communication and critical-thinking skills.

LSFYV Intervention Blueprint

The Theatre Lab's Life Stories® Program is offered free to schools and social service partners in the Washington D.C. area. Instructors typically go to schools and community partners once a week for 8-10 weeks to teach a theatre workshop. The program culminates in a performance or professionally edited video featuring works devised and performed by the students themselves. Staff work with as few as eight students or as many as 28, depending on the class structure. The Theatre Lab's Life Stories® Program is the recipient of the Mayor's Arts Award for Innovation in the Arts. Since 2000, The Theatre Lab has provided Life Stories® Programs to more than 4,000 individuals, including District of Columbia public and charter school students, Latinx teens, incarcerated and at-risk youth, returning veterans, and families impacted by homelessness, among others.

The *LSFYV* intervention/workshop is based on the Theatre Lab's Life Stories® Program workshop framework with *LSFYV* leadership involved directly with the Life Stories® Program. The added element to our workshop is the inclusion of interviews with participants using validated psychological survey instruments and analyses using quantitative and qualitative statistical methodology. The surveys were conducted on day two of the workshop and post-program intervention, and the results were written for peer-reviewed publication. By publishing in this way, the study can be replicated elsewhere. The study has been approved by the Institutional Review Board (Human Subjects Protection) at the University of Kentucky (UK-IRB) and was funded by the Veterans United Foundation.

The *LSFYV* intervention/workshop employed a mixed, multi-

week approach, where participants engaged with a coach remotely prior to in-person instruction and guidance. The workshop on storytelling and acting culminated in a public performance by the participants in a theatre on the Kentucky State University (KSU) Campus. KSU provided accommodations for the participants, allowing them to be together while maintaining separate sleeping quarters. The instruction/coaching was led by the senior author of this study (A Harris), who is a faculty member at the Theatre Lab. She, herself a veteran, coaches, and teaches veterans with PTSD. The therapeutic outcomes of the Theatre Lab program, designed to give participants control of their own narratives, include an increased sense of belonging, stress reduction, and a heightened sense of well-being. Although there is a profound impact from the Lab and participants, these have been anecdotal in nature.

Methods

Intervention/Workshop Coaching Methodology

The in-person workshop followed this schedule: on the first day, participants settled into their lodgings and transitioned into preparing for trauma work. Crisis hotline numbers and resources were provided to the participants during group integration. Participants engaged only in those activities as permitted by self-assessment of their capabilities. To help facilitate participant safety in a non-clinical setting, Emotional Freedom Techniques (EFT or "tapping") breathing techniques were introduced, along with meditation skills. Participants were advised on physical and emotional safety plans and how to deal with triggering incidents. The head coach/instructor (senior author) introduced the curriculum she had developed—the *Individual Road Map to Success and Individual Intentions.* All participants were notified that participation would include a presentation at the conclusion of the workshop. The presentation format (e.g., painting, writing, storytelling, song, or dance) was decided by the participant and supported by the facilitator.

The second-day curriculum, also developed by the senior author, included *Bridge Activities and Examine Trust, Focus and Communication* and, on day three, *Activating Material*—participants become actively involved with improvisational scene work by working with the group, who ask questions, help examine topic choices, and provide support. At this point, participants began to embody their own stories and connect with the others in the group. The next day, they created individual material. On day five, they rehearsed for the performance, and on the last day, they took center stage to tell their story.

The director from the Theatre Lab was also a leader during the in-person workshop, with his focus on the performance. The performance was recorded and shared live on social media. Post interviews were conducted by phone one month after the workshop. The goals and objectives of this study, for participants, were to 1) create an active space but also a safe space; 2) create an environment conducive for dialogue; 3) understand how self-esteem affects moments of decision; 4) critically and viscerally analyze life situations and one's own responses; 5) safely take risks in a fictional world with the potential to learn rather than fail; 6) take action and to be the protagonist in one's own life; 7) utilize the multiple perspectives different individuals bring to every interaction as a positive tool for problem solving; 8) explore choices and the consequences they can bring; 9) and practice for real life situations and reactions to triggers.

Participants found their voices through interactive work in storytelling and improvisation. Participants played characters in stories that developed from true stories and fictionalized ideas (e.g., how a life story could have played out better) that stemmed from discussions. The development of an individual's life story was critical because the "theme" of the final production was specific to the individuals in the group.

Mindfulness practices were incorporated throughout the week to help still and clear participants' minds. Gentle yoga, designed for the writing body, allowed the body to speak. Guided creative writing prompted stories to surface. Participants had opportunities to share any or all artistic work with the community, not only their final presentation. The interactive coaching work, as part of participants' life story development, included helping participants improve breathing and use breath for emotional de-escalation; enhance skills in communication and decision making; learn to select a platform and articulate truth; empower participants; increase self-esteem; reduce feelings of isolation; and improve communication and critical-thinking skills.

Study Methodology

The survey instruments for this study were selected to systematically determine if this type of intervention is effective in combating risk factors for SDV in female veterans experiencing MST, PTSD, TBI, and/or IPV.

Participants were interviewed individually. They were first read a statement approved by the UK-IRB as required for human subject protection. Participants were given contact information for the Office of Research Integrity if they had any complaints, suggestions, or questions about their rights as a research volunteer. Participants were not required to answer all questions.

The interviews were not audio or video recorded; the interviewer explained the surveys, what information the surveys were collecting, and explained that the questions would be read aloud. He described the purpose (hypotheses) of the study, which was that the workshop outcomes were intended to improve their ability to communicate MST, PTSD, TBI, and/or IPV traumatic events, the consequences of these events, and to improve self-esteem and self-efficacy, among other health and well-being improvements. It was explained that by taking part in the research study, their responses may help in understanding more about the impacts of MST, PTSD, TBI and/or IPV. Participants could skip survey questions that were triggering, and the interview would take approximately 30 minutes. There were no known risks to participating in the study. Responses would be kept confidential to the extent allowed by law. After surveys were scored, all personal identifying information

from the interviews would be removed and paper copies would be destroyed. All publications, by researchers, arising from the study would not contain information that could be used to identify participants. The surveys would be retained for six years following the conclusion of the study. The de-identified data would be used for future research or shared with other researchers without any additional informed consent.

Following the administration of the surveys, participants were asked if they would sign a waiver to allow the recording of their performance at the end of the workshop, where they would be able to be identified. All participants signed the waiver allowing for the recordings of their performances to be shared on social media.

Survey Instruments

Five validated survey instruments were selected (see appendix for the surveys) and administered by the research assistant and second author, under the guidance of the lead author. The second author also developed the analytical methodology based on the results. This was a feasibility study with a convenience sample of four participants.

The Patient Health Questionnaire-9 (PHQ-9) is a widely used self-report screening tool for assessing the severity of depression, comprising a nine-item questionnaire. This survey assesses the frequency of depressive symptoms experienced within the past two weeks. The PHQ-9 is primarily based on the diagnostic criteria for major depressive disorder outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), used in both clinical and research settings. The PHQ-9 items directly correspond to the nine symptoms of major depressive disorder as specified in the DSM-5 [22].

The second instrument used is the Interpersonal Support Evaluation List (12-item shortened version). This survey instrument measures perceptions of social support. We used this to measure how isolated

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

female veterans felt. The survey has three subscales: Appraisal support, Belonging support, and Tangible support. Participants respond to statements that may or may not be true about them. For example, "I feel that there is no one I can share my most private worries and fears with," "If I was stranded 10 miles from home, there is someone I could call who could come and get me" [23].

We included the Pemberton Happiness Index (PHI), an integrative measure of overall well-being. The scale includes eleven items related to remembered well-being with subcategories of general well-being (e.g., "I am very satisfied with my life"); eudaimonic (centered around the meaning and purpose of life and living a virtuous life, e.g., "I think my life is useful and worthwhile"); hedonic (pursuit of pleasure and enjoyment and immediate gratification, e.g., "I have a lot of bad moments in my daily life"); and social well-being (e.g., "I think that I live in a society that lets me fully realize my potential"). The scores for each item are added for a combined well-being index [24].

The fourth survey instrument was the General Self-Efficacy (GSE) and is based on Albert Bandura's theory of human behavior and is embedded in social learning theory. This was included to measure how much these women persevere in the face of obstacles or adverse experiences, and to determine if GSE improved with the intervention [25]. The GSE theory postulates that the more an individual believes they can make a change, the greater the probability that the change will come to fruition [26].

The fifth survey was the Positive and Negative Affect Schedule (PANAS). The instrument consists of 20 questions designed to measure positive (pleasurable engagement with the environment) and negative affect (general distress, or negative states such as anger, guilt, or anxiety) [27]. Participants were asked if they generally feel this way or how they feel on average.

Each female veteran participant took five surveys, each survey item had four possible answers, as shown on the x-axis in Figures 1-4. The y-axis represents the total number of responses for each test. A higher number indicates a healthier or positive response. Positive responses are defined as answers equivalent to four on each test. For purposes of harmonization, some of the original survey instruments were modified. All survey responses were scored on a 1 (negative behavioral characteristic, NBC) to 4 (positive behavioral characteristic, PBC) scale; in some cases, survey items were reworded to maintain a consistent scoring of negative to positive behavioral characteristics.

The PHQ-9 was the first test given. Questions include "1. Little interest or pleasure in doing things" to "9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way." Participants were asked to how often they were bothered by specific problems and could respond "1. Nearly every day to 4. Not at all."

The second test, the Interpersonal Support Evaluation List, is like the PHQ-9 in that it has four choices per question. However, each answer differs from the PHQ-9 for each question. For example, the question, "If I wanted to go on a trip for a day, I would have a hard time finding someone to go with me," a larger number (Response 4. Definitely True) would imply an NBC. Whereas for a question like, "If I decided one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me," a larger number (Response 4. Definitely True) would imply a PBC. To accurately reflect the data, the questions in which a larger number is an NBC their answers were reversed. For example, a 4. Definitely True becomes a 1. Definitely False, if the participant wanted to go on a trip for a day, they would have a hard time finding someone to go with them. A 4. becomes the most PBC. Reversing questions in this way has been documented elsewhere [23].

The third test is the Pemberton Happiness Index. Like the second test, some questions were reversed for purposes of harmonization with 4 being the most PBC. Participants were asked to give an answer 1-4. In the original instrument, the scoring scale ranges from 0-10 with 0 "Totally Disagree" to 10 "Totally Agree;"; however, for this study the range was changed to 0-4 with "0. Totally Disagree" to "4. Totally Agree."

For the fourth test, the General Self-Efficacy Scale (GSE), the data collection is the same as the PHQ-9.

The fifth test, or the PANAS-GEN, has five options as opposed to four, so the only answer which was never chosen, "extremely," was omitted for harmonization purposes.

Results

The results show that PBC's were more prevalent during the event while after, though still most prevalent, they decreased. During the event, the participants, in total, had 187 of the most positive responses (a response equal to four). After the event, the total number of most positive responses dropped to 128; a decrease of almost 32%. There was an almost 54% increase in the most negative response (a response equal to one).

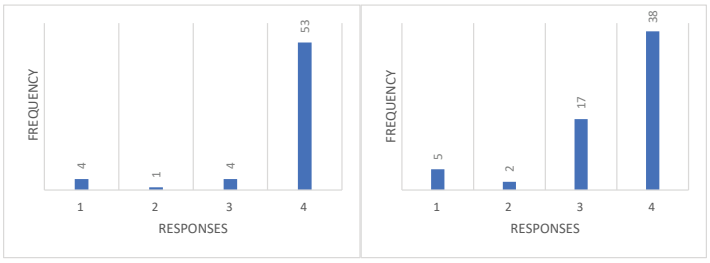

Figure 1: Participant 1 survey response frequencies.
A. Survey administered during the workshop. B. Survey administered after the workshop.

The second author conducted the post-intervention interviews and noted that the results quantitatively support what he observed, anecdotally, as a shift in overall participant perspective and demeanor, and that the intervention produced more positive responses compared to the post-test. Namely, responses were more composed, thoughtful, and clear-headed; participants reported,

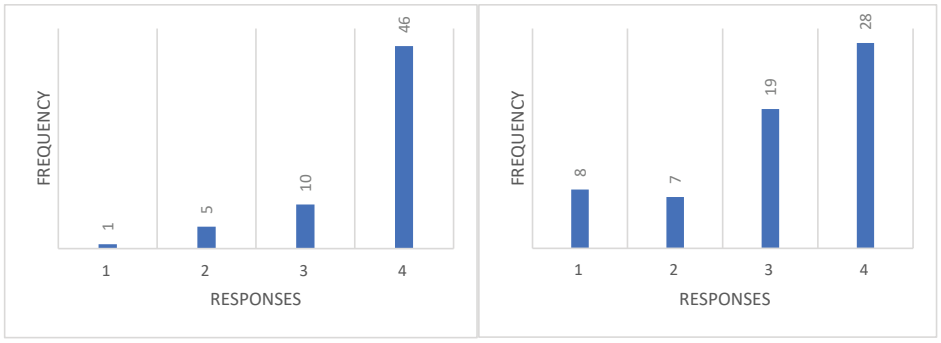

Figure 2: Participant 2 survey response frequencies.
A. Survey administered during the workshop. B. Survey administered after the workshop.

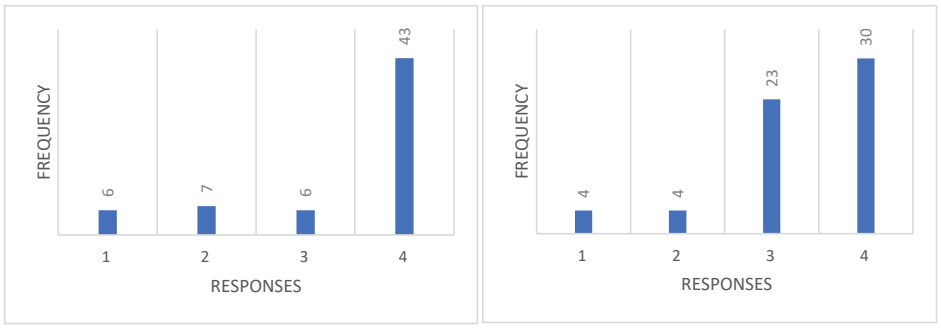

Figure 3: Participant 3 survey response frequencies.
A. Survey administered during the workshop. B. Survey administered after the workshop.

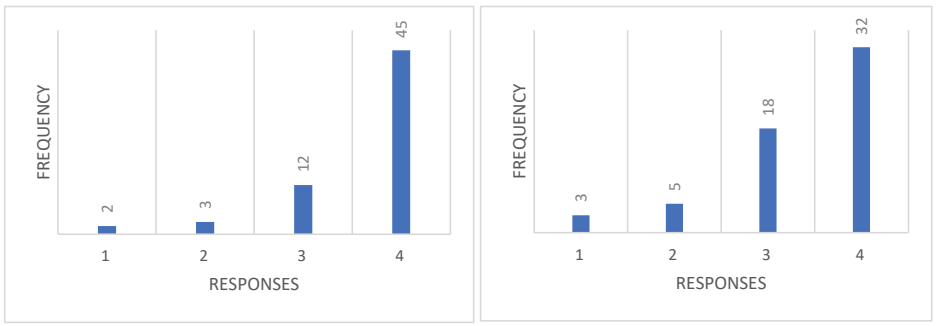

Figure 4: Participant 4 survey response frequencies.
A. Survey administered during the workshop. B. Survey administered after the workshop.

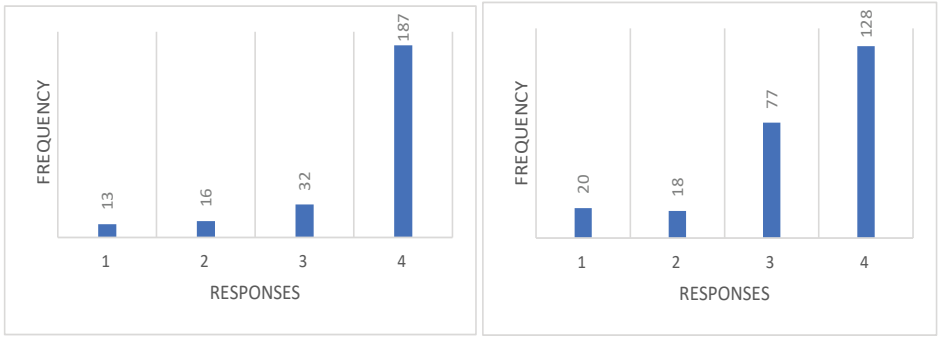

Figure 5: Combined survey response frequencies.
A. Survey administered during the workshop. B. Survey administered after the workshop.

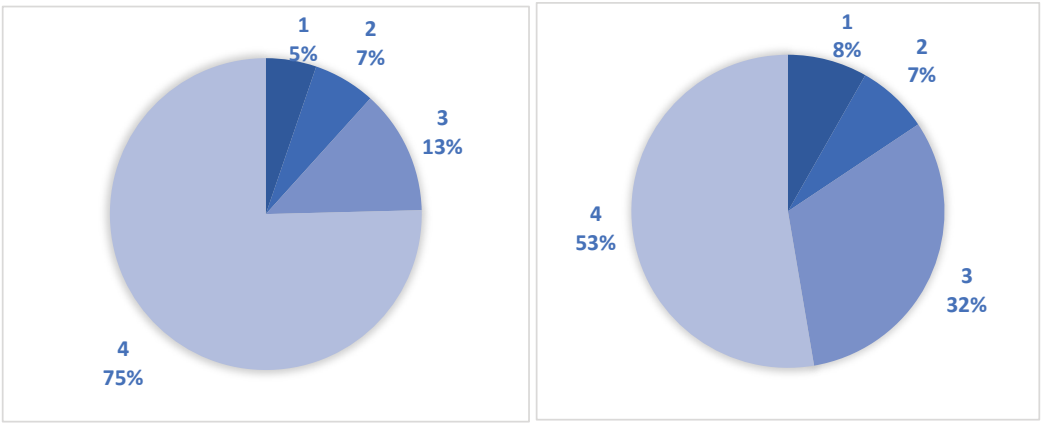

Figure 6: Combined survey response frequencies.
A. Survey administered during the workshop. B. Survey administered after the workshop.

overall, to have better mental health during the interviews during the intervention compared to after the intervention. This was likely due to the level of camaraderie, hope, and general effectiveness of the event.

Discussion

The survey instruments for this study were selected to systematically determine if this type of intervention is effective in combating risk factors for SDV in female veterans experiencing MST, PTSD, TBI, and/or IPV.

Social isolation of US veterans from their communities is commonly referred to as the military-civilian divide. This perceived or actual gap between those who have and have not served in the military could contribute to feelings of isolation and SDV [28]. Veterans may feel as if their experiences are not recognized or appreciated by the civilian population. The *LSFYV* intervention enabled participants to articulate their stories with us in the community using a powerful technique. Military-civilian segregation can serve as an alternative measure for veterans' community integration and the extent to which they interact with nonveterans. According to a study by McDaniel et al., veterans residing in counties with greater military-civilian residential segregation experienced higher psychosocial despair than those living in less segregated areas [28]. Friends, family, and members of the community who attended the performance, as well as those watching the performance live, and those who commented and liked on social media, all contributed to lessening the military-civilian divide during the workshop and performance. Returning home to the same environment post-intervention might have contributed to the percentage of changes in NBC and PBC. Our non-traditional intervention also allows us to use a qualitative approach to acknowledge individuals and their unique stories.

Several studies have identified associations among early mortality, social isolation, and loneliness [28,29]. Whereas solitude suggests a positive experience of aloneness, social isolation, objectively defined as a persistent lack of social contact or involvement in social activities, increases risks for poor physical and psychological health outcomes and contributes to suicide risk [30-32]. However, loneliness, defined as "chronic impaired belongingness" [30], may be an even more potent predictor of suicide outcomes than objective social isolation [33] because it relates to the construct of thwarted belongingness (i.e., social rejection), a necessary component for suicide according to the interpersonal-psychological theory of suicide [30]. Relationship problems, being one of the highest suicide risk factors for veterans, only compound loneliness and can lead to further isolation [34]. Using innovative approaches to explore how experiences of MST and IPV shape sociocultural factors can strengthen support systems for female veterans and foster multiple pathways to healing.

The camaraderie experienced during the in-person portion of the workshop led to a decrease in loneliness and an increase in belongingness. Perceived sense of belongingness was not only measured through the surveys but also observed anecdotally. Other researchers have observed that female veterans experience quite different risk factors for suicide, drug and alcohol misuse, and other self-destructive behaviors than their male veteran counterparts [10]. They most often talk about guilt and deep grief over leaving children and households behind to serve, and the strained and estranged relationships that result. They talk about severe discrimination and sexual harassment, which they could not escape, and brutal rapes and physical abuse. It is rampant. If these women told superiors about sexual harassment or sexual abuse or assault, they were often dismissed, blamed, or disciplined; some expressed that they gave up their military careers before they reached a beneficial status (some, sadly, very close to it) because they were too afraid of those they served with [10]. Female veterans may have lost their voices, disproportionately, and with this project, we hope to help them find it, safely and with positive support. We cannot go back and prevent these abuses, but we can reduce the impact of the violence and injustices they experienced. This study also highlighted the importance of moving from a general veteran approach to a female-centered approach.

Qualitative SDV research, as in this pilot study in part, can supplement quantitative research by providing new insights that

support a more comprehensive understanding, helping to inform prevention and identify factors that warrant further investigation [35-37]. Other benefits of qualitative SDV research include identifying overarching themes (e.g., shame, fear, avoidance, felt invisible, struggles to find and get needed resources, difficulty putting pieces of traumatic events together coherently, guilt in sacrificing time with children and other family and friends) [38,39] associated with "root causes" of SDV to develop prevention strategies. Insights gained through qualitative analysis can also help inform hypotheses and theory [40,41]. For example, a qualitative study of war veterans [38] revealed the effectiveness of Joiner's interpersonal-psychological theory of suicide [30] in recognizing SDV behaviors during deployment transition.

A limitation of the intervention was that there was no continued funding to maintain contact between the cohort and staff, as well as among the participants themselves. Losing camaraderie through daily contact after the workshop is likely a reason for the percentage of change between the positive answers given during the workshop and those provided after participants had returned home, (Figure 6). The impact of the intervention would be more valuable if support and connection could be sustained. Another limitation is regarding the fifth test, or the PANAS-GEN, which has five options, but for this study one option was eliminated to harmonize survey responses. This is a limitation for replication by eliminating an answer that has the potential to be selected in other studies.

Recommendations include creating a forum for participants to engage in a continuum of care, such as utilizing the LVC infrastructure and facilities, as well as those of other non-profits. This would also help identify those veterans not associated with the VA and assist in finding various sources of assistance. The curriculum could be further developed, using the results from this pilot study, to include continuity of care to allow for the building of sustainable peer support. Participants may also be encouraged to utilize social media platforms to share their growth and struggles, as well as encouragement and resources. Lastly, this approach is generalizable and replicable allowing it to reach a broader population in a myriad of regions.

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