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Global Approaches to Supporting Mental Health and Resettlement for Veterans With Embodied Trauma: A Comprehensive Scoping Review

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ABSTRACT

Objectives: Military veterans face significant holistic challenges when leaving military services and resettling back into the community. Recent research has shown that veterans experience higher rates of mental health difficulties than the general population and experience poorer treatment outcomes. The aim of this comprehensive scoping review was to map out the current therapeutic interventions used to support mental health care and resettlement for veterans across the globe, proposing key themes, noting any gaps and limitations.

Method: We followed a five-staged scoping review protocol to map the existing landscape of the veteran mental health research literature regarding therapeutic and resettlement interventions, identifying key themes by: (1) identifying the research question, (2) identifying the relevant literature, (3) selecting the studies, (4) charting the data and (5) collating, summarising, and reporting the results.

Results: Results show a decline in publications regarding veteran mental health and resettlement interventions since 2018, the Americentric, 'WEIRD' nature of the research base, and preference for individualised, technology-based psychological interventions, with a lack of culturally-informed, community-focused, relational research.

Conclusion: This work highlights an urgent need for further non-Westernised research into holistic psychological interventions which relationally support the culturally diverse needs of veterans resettling back into their communities across the globe. It also advocates for a holistic bio-psycho-social-sexual-spiritual-existential approach to the needs of each veteran, using a culturally-informed, relational and community-based assessment, formulation, and treatment plan for embodied trauma, moving beyond the pathologisation of *dis-ease*, and mobilising the traumatised self back into the body, relationship and community.

1 | Introduction

The ease by which veterans transition back into everyday life in their community following active service can be significantly impacted by a range of challenges in their psychological, physical and social well-being (Boros and Erolin 2021; Kintzle et al. 2016). Despite enlisting the help of well-established best practices which aim to welcome veterans home using health and educational programmes, many veterans report a sustained sense of loneliness, alienation and difficulties reintegrating with and relating to others outside of the military community (Buechner 2020; Williamson et al. 2023). One key factor impacting the success of veteran

Summary

- Implications for practice and policy
  - The findings of this study expand our clinical understanding of the therapeutic interventions that support veteran mental health and resettlement into the community. This study advocates for a holistic bio-psycho-social-sexual-spiritual-existential formulation of each veteran's needs, and for mental health support from culturally- and trauma-informed, gender inclusive mental health care services, which extend beyond the treatment of post-traumatic stress and addiction disorders.
  - These findings have policy implications for the creation of a veteran specific mental health pathway, which includes a culturally-informed, relational and community-based assessment, formulation and treatment plan for each veteran resettling into their community.

resettlement is poor mental health, which has a significantly higher prevalence for veterans compared to that of the general population, resulting in poor treatment outcomes (Williamson et al. 2023).

Recent studies suggest that only a minority of armed forces personnel seek mental health support due to the perceived stigma surrounding psychological ill health and beliefs that exist concerning barriers to care (Jones et al. 2018). Suicide mortality rates among U.S. veterans are 51% higher than that of the general population (Wang et al. 2022), with multiple variables and contributing factors postulated, including race, ethnicity, rurality and access to firearms, domestic violence, substance abuse and isolation (Franklin et al. 2017; Reno et al. 2018). High levels of mental health complexity and co-morbidities also pose significant challenges to veteran mental health care, with a recent systematic review concluding that veterans respond less well to the treatments offered than the general public (Williamson et al. 2023).

Military culture and research literature also historically orient themselves in favour of a strong gender bias towards men retiring from active service, with limited literature focusing on the experiences of individuals identifying with other genders, sexual orientations, or military areas, such as military reserve personnel (Boros and Erolin 2021). The research literature is also heavily focused upon the codification of substance use disorders and post-traumatic stress disorder (PTSD), or, more recently, the diagnosis of complex PTSD (cPTSD) in veterans (Gromatsky et al. 2020), which has become somewhat of a cultural icon of veteran distress in the mind of society, despite PTSD having a much broader application across the general population (Buechner 2020; Walker 2016). Whilst this awareness of psychotraumatology is important, some findings illustrate the need to examine effective pathways for prevention and intervention for veterans who have also experienced a morally injurious events (Williamson et al. 2023).

Furthermore, it is also suggested that much more research is needed into the efficacy and accessibility of therapeutic treatments which specifically support the veteran population (Niehmeyer et al. 2022). Few studies look holistically across the bio-psycho-social-sexual-spiritual-existential aspects of trauma on the individual as they have done for other non-veteran groups (O'Brien and Charura 2023), or consider the wider implications of veteran experiences, such as the nature of moral injury, identity re-formation, lack of community and belonging, emotional fluency, or access to non-military focused channels of communication (Buechner 2020), which all have the potential to impact resettlement experiences. Williamson et al. (2023) note that there is an urgent requirement to better understand veteran needs in order to improve veteran mental health services and improve treatment outcomes.

Other factors which are commonly overlooked when considering global veteran resettlement are non-Westernised approaches to mental health and well-being which originate from non-Westernised authors. For example, Asare-Doku et al. (2021) note that the majority of mental health studies of veterans are from Westernised countries, with scant published literature on military personnel in the West African region. They assert that it is imperative that we *contextually* understand veterans who may be faced with similar vulnerabilities to their Western counterparts, yet may differ in their ways of being and coping from those situated in Western cultures (Asare-Doku et al. 2021). For example, findings by Ijomanta and Lasebikan (2016) noted that lifetime cannabis *use* by veterans in the West African regions was 13.5%, but that lifetime cannabis *abuse* was 4.9%. Similarly, alcohol use was high, representing 76% of veterans in the region, but binge drinking among lifetime alcohol users was 6.7%. This may show that, in these particular regions, veterans are using drugs or alcohol as coping mechanisms to alleviate combat-related trauma, but that this use is not maladaptive. Yet, Asare-Doku et al. (2021) note that there is a dearth of research on non-Western veterans which urgently needs to be addressed. We also acknowledge that whilst this research is within a specific cultural context, these coping strategies do not necessarily relate to all veterans in these regions. It is therefore imperative that, as part of decoloniality, we continue to research veteran populations outside of the global West.

The question therefore remains as to how veterans can be therapeutically supported within mental health services as they settle back into the community. There is a need to explore which psychological interventions are being used across the globe and by whom. There is also a requirement to explore which psychological or holistic resettlement interventions have a positive impact on veterans using a non-pathologising, bottom-up approach to care, focusing on the concept of embodied trauma, rather than on the codification of dis-ease (Gordon et al. 2018; O'Brien and Charura 2023).

2 | Aims and Objectives of the Comprehensive Scoping Review

This comprehensive scoping review aims to map out the landscape of the existing literature regarding veteran mental health care over the past decade (2013–2023), highlighting those psychological interventions which support the resettlement experiences of veterans presenting with embodied trauma and psychological distress. This study will explore the volume and coverage of the veteran mental health resettlement literature, giving a broad overview of its focus (Munn et al. 2018). It also

aims to select and extract the relevant aspects of the current research literature in the field to broadly identify and summarise its key themes. This paper will describe the scope of the research in the field of veteran psychological intervention, synthesising, summarising, and disseminating the results without critical appraisal, in order to provide an overarching map of the evidence.

Following the guidelines of Munn et al. (2018), this comprehensive scoping review will:

- Identify the types of psychological interventions used with veterans in psychological distress
- Clarify key concepts and definitions
- Examine how the research is conducted
- Act as a precursor to a systematic review
- Identify and analyse knowledge gaps

3 | Method

A methodological framework was applied using a five-stage scoping review protocol (Arksey and O'Malley 2005; Taylor and Pagliari 2018). A comprehensive scoping review is now a commonly recognised approach used to explore and explicate emerging concepts where research is poorly indexed and dispersed across multi-disciplinary fields (Arksey and O'Malley 2005; Armostaris and Munn 2020; Levac et al. 2010; O'Brien and Charura 2023; Taylor and Pagliari 2018). This comprehensive scoping review will map the current research landscape, including an overview of the amount, focus and nature of literature, aligned with the research question, identifying gaps in the knowledge and making recommendations for future research and practice (Seidler et al. 2018).

4 | Structure of the Methodology

A five-stage scoping review protocol was followed (Arksey and O'Malley 2005; Taylor and Pagliari 2018), with the following steps:

1. Identifying the research question
2. Identifying the relevant literature
3. Selecting the studies
4. Charting the data
5. Collating, summarising, and reporting the results

The authors note the reflective and reflexive nature of this iterative process, which was applied circularly to ensure coverage of all the literature in this field.

4.1 | Stage 1: Identifying the Research Question

The research question identified for this comprehensive scoping review is:

What therapeutic intervention(s) support veteran mental health and resettlement?

To answer the research question, a subset of research questions were defined (Taylor and Pagliari 2018).

4.2 | Stage 2: Identifying the Relevant Literature

Working with a specialist librarian, the following electronic databases were identified for the comprehensive scoping review to ensure broad coverage of the literature:

APA Psych Articles, APA PSYCHINFO, CINAHL, MEDLINE.

5 | Selection Criteria

The following selection criteria were applied to the results by characteristics (see Table 2).

6 | Search Parameters

Four main lists were created by the research team to inform the final search parameters.

6.1 | Lists

Lists to Inform Final Search Parameters:

1. A List of Titles: military veterans, ex-armed forces, former armed forces, ex-military.
2. A List of Terminology: mental health or mental illness or mental disorder, or mental wellbeing.
3. A List of Practitioner Types: including counsellor counselling, therapist, psychologist, psychiatrist, doctor, psychotherapist, practitioner, therapy, intervention, treatment, health service.
4. A List of Therapies and Modalities: including humanistic, person-centred, art, dance, movement, body, breath, mindfulness, cognitive behavioural therapy, acceptance and commitment therapy, eye movement desensitisation therapy, compassion-focused therapy, dialectical behavioural therapy, systemic, narrative, cultural, transpersonal, holistic, trauma, existential, stabilisation, grounding, psychoanalytic, psychodynamic, nature, exercise, yoga, LGBTQ+, gender, trauma.

See Table S1 for the final search strategy used for the databases.

The comprehensive scoping review used Moher et al.'s (2009) Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (PRISMA) for its paper search and selection (see Figure S1):

6.2 | Stage 3: Selecting the Studies

All database hits ($N = 2732$) were downloaded to a .csv file and merged into an excel spreadsheet where duplications were removed using Cochrane Collaboration guidelines (Deeks

et al. 2008). All paper titles and abstracts in the spreadsheet were scanned by three researchers (COB, AA, GM) independently, classifying them for inclusion ('*Y*') or exclusion ('*N*'). When cases were not able to be assessed from the title alone, the full article was retrieved by the reviewer. Inclusion and exclusion criteria were followed as listed (see Table 2) and results tabulated (see Table 3).

6.3 | Stage 4: Charting the Data

The purpose of charting the data was to produce a descriptive summary of the results, to identify any gaps in the literature, and to highlight key concepts for analysis. Columns were included in the excel spreadsheet to record the extracted data from each article to describe:

- Amount—of papers defined by year of publication
- Focus—therapy or modality, topic and theme
- Nature—location of study, practitioner type, type of article, type of research organisation.

The extracted dataset also included columns for the article title, author, journal title (volume, issue, pages, DOI), keywords, article link and primary research organisation.

6.4 | Stage 5: Collating, Summarising and Reporting the Results

The abstract of each paper in scope was read by one researcher (COB), annotated and broadly categorised by topic using free line-by-line coding of their findings (Seidler et al. 2018). The results were summarised using a qualitative descriptive approach, grouping key concepts with topical similarity. The data were then checked for accuracy by one other reviewer using an independent inter-rater qualitative method to ensure rigour and to avoid subjective interpretation by a single researcher. A descriptive summary was produced using pivot tables of the extracted data in the excel spreadsheet, and an overall summary of the results was produced (see Table 3). The aim of the comprehensive scoping review was to reflect an overall summary of the main results without any further synthesis or distillation in order to answer the research question.

7 | Results

7.1 | Search Strategy, Study Selection and Data Extraction

An executive summary of the results was produced within the excel spreadsheet, showing that 2732 articles were identified by the electronic database searches, 2732 papers were screened, of which 738 were selected based on their use of inclusion criteria and terminology (see Table 3). Full extraction data is available here (https://doi.org/10.25421/yorksj.28376150). Inter-rater reliability of the descriptive data extraction process was 100% in agreement.

7.2 | Descriptive Summary of the Research on Interventions that Support Veteran Mental Health and Resettlement

Frequency analysis via pivot tables helped to answer the research questions (see Table 1).

7.3 | Amount of Research

The number of papers published regarding veteran mental health and resettlement interventions peaked in 2018 and has since steadily declined (up to 21.01.23, the date this review was run on). Please note that only full search years were included (i.e., not 2023; Figure 1).

7.4 | Focus of the Research

The key therapeutic themes found in the literature included Mental Health (74%/548 papers), Physical Health (8%/60 papers), Sexual Health (5%/36 papers), Social Care (6%/46 papers), Cultural Care (3%/20 papers) and Spiritual Care (4%/28 papers), with the theme of Mental Health being the clear focal theme (Figure 2).

The key therapies, interventions and modalities identified for working with veterans show a clear preference in the literature for working with mental health via technology-based interventions. These include, for example, mobile apps, web-based interventions, tele-mental health interventions, virtual reality and video medicine. Cognitive Processing Therapy (CPT) is the clear standalone therapeutic intervention for veterans in the literature, followed by an integrated Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) approach. Figure S2 (see Figure S2 in Supporting Information). Further details can be found at (https://doi.org/10.25421/yorksj.28376150).

TABLE 1 | Research questions.

Aspect	List of questions
General	What is the total number of studies published by year? What terms describe the nature of this research? Which academic communities are most active in this field? What veteran communities are studied?
Topic	What topics are being explored in this research?
Therapies	What types of psychological interventions are being researched in this field?
Extract and Analysis	What type of analyses are being applied?

TABLE 2 | Inclusion and exclusion selection criteria.

Characteristic	Inclusion criteria	Exclusion criteria
Type of outcome	Outcomes related to veteran mental health, quality of life or resettlement experiences.	Absence of veteran mental health, quality of life or resettlement experiences.
Population of studies	Military veterans aged 18 or older No restrictions on gender, ethnicities, or demographic characteristics	Studies that focus on individuals younger than 18, or non-military veteran related groups
Type of studies	Quantitative, qualitative, pilot, randomised control studies, systematic and literature reviews, clinical case studies, meta-analyses, meta-syntheses, and mixed method	Review articles or primary research that do not consider military veterans (e.g. exclusively addiction studies with non-military veteran groups)
Type of publication	Published peer-reviewed journal articles	Publications where no full text is available, conference abstracts, corrected papers, dissertations or theses
Publication date	2013–2023	Articles before 2013
Language	English language only	Non-English language
Location	No limits	None

TABLE 3 | Executive summary of papers included and excluded from study.

Total number of papers identified	2732
Total number of papers excluded (all reasons)	1994
Total number of papers screened	2732
Total number of papers used in study	738

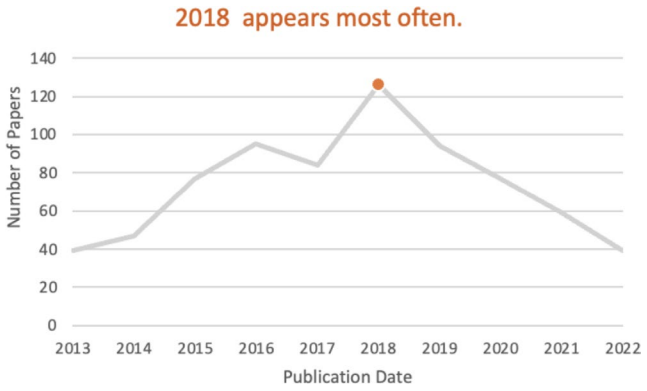

FIGURE 1 | Total number of studies published by year.

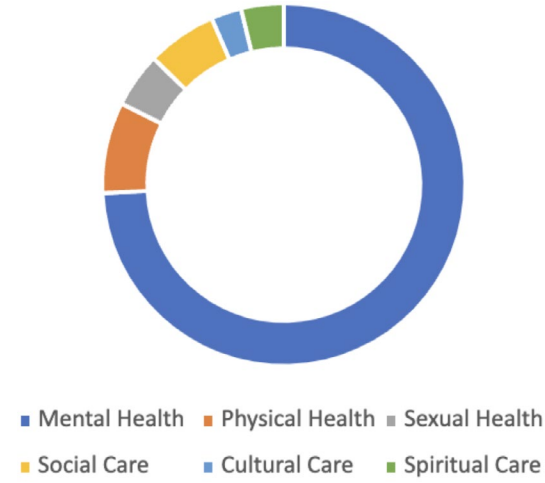

FIGURE 2 | Key therapeutic themes.

7.5 | Nature of Research

The most frequent (Figure 3) facilitators of therapies and active researchers in the field of veteran mental health and resettlement interventions are Psychologist(s) (340 papers), Psychiatrist(s) (186 papers), and Research Scientist(s) (76 papers), followed by Social Workers(s) (27 papers), Combined Practitioner(s) (27 papers), Nurse Scientist(s) (25 papers) and Medical Doctor(s) (24).

Figure S3 (in Supporting Information): *Organisation type*.

The most active research organisations in the field of veteran mental health and resettlement interventions are organisations based in the United States of America (USA; see Figure S3). They include the USA Government Veteran Affairs (343 papers) and universities based in the USA (205 papers), followed by other universities based in Canada (15 papers), the United Kingdom (14 papers), Australia (10 papers), Germany (2 papers), Iran (2 papers), the Netherlands (2 papers) and Israel, Pakistan, Russia, Switzerland, and Bosnia Herzegovina (all with one paper). Further details can be found at (https://doi.org/10.25421/yorksj.28376150).

The map in Figure 4 shows that veteran mental health and resettlement research stems mainly from the global west, situated in the United States of America, with further research in the field taking place in Australia, Canada, the UK, Europe and Russia.

Figure S4 (in Supporting Information): *Key Research Areas*.

Figure S4 shows that veteran mental health and resettlement research predominantly takes place in the state of California, followed by Massachusetts and Texas. The research hubs in California are the Government's Veteran Affairs [VA], state universities and mental health organisations. There are also notable research hubs in King's College London and Leatherhead in the UK and in Australian universities and organisations in Melbourne, Brisbane and Adelaide.

Figure 5 shows that the majority of research articles in the field of veteran mental health interventions and resettlement are quantitative studies (400 papers), followed by mixed methods

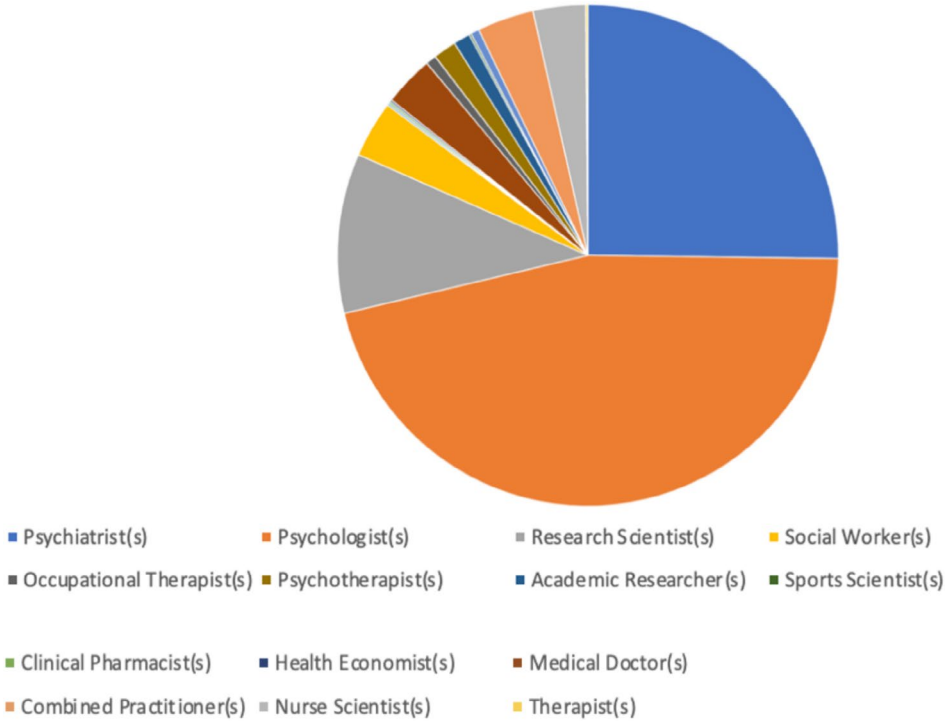

FIGURE 3 | Practitioner type.

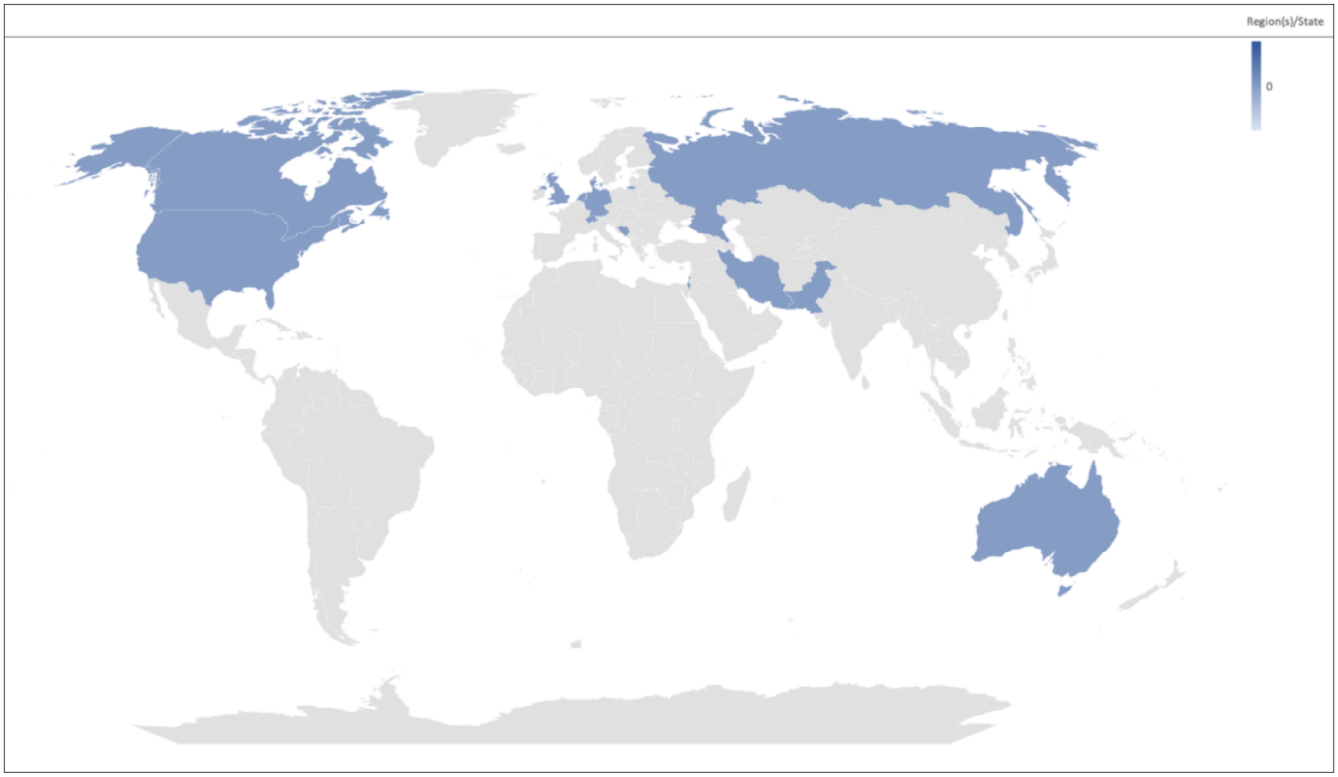

FIGURE 4 | Research origin.

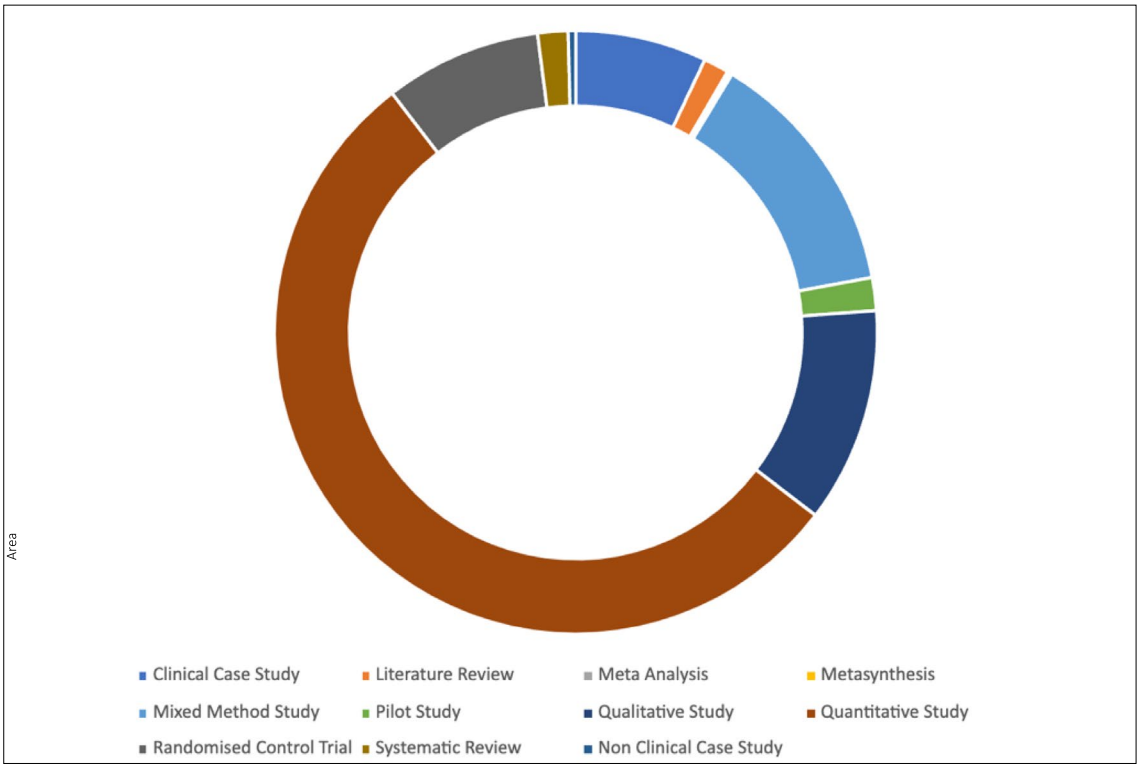

FIGURE 5 | Article type.

studies (99 papers), qualitative studies (85 papers), randomised controlled trials (62 papers) and clinical case studies (52 papers).

The aim of this comprehensive scoping review was to map out the current therapeutic interventions used to support mental health care and resettlement for veterans across the globe, proposing key themes, noting any gaps and limitations. The results of this comprehensive scoping review have highlighted three key themes.

Firstly, the urgent need for *culturally-informed veteran mental health care*. Culturally-informed veteran mental health care can be defined as that which includes the uniqueness of the individual's lived experience, incorporating the variability of ethnicity, culture, heritage, and socio-economic status, as seen *through* and *within* the cultural frame that each individual uses to construct their realities, meanings, and identities (Ranjbar et al. 2020). Furthermore, Ranjbar et al. (2020) state that the lived experiences of traumatic events, such as war, are always embedded in a cultural context and identity that can result in serious physical and mental health consequences. The healing of such experiences must, therefore, address the intersection of trauma and culture, being approached by practitioners with cultural humility shown towards each individual's biology, personality, psychology, context of origin, and preferred communal or individual way of being (Ranjbar et al. 2020).

Yet, for many veterans, culturally-informed care also extends beyond these individualised concepts to the military system itself. Treichler et al. (2023) highlighted the need for military cultural mental health care, which considers how military culture, that is rooted in hierarchy and obedience to authority, clashes with clinical values, where patient and practitioner are equal contributors in mental health decision making. They also note how military culture reduces comfort with help seeking, mismatches with civilian therapeutic contexts, and offers few treatment options for mental health care (Treichler et al. 2023). Therefore, clinicians working with veterans should not only increase their understanding of each individual's cultural values, morals, beliefs, needs, strengths, and identity as essential components in their treatment plans, but should also increase their understanding of military culture and it's intersectional impact on veteran mental health (Treichler et al. 2023) in order to deliver appropriate, compassionate, culturally-informed mental health care.

This scoping review has also clearly mapped the 'Americentric' nature of the body of this research; that is, the bias to judge other cultures and nations by American standards or to centre around American research. However, this bias is likely a function of most veteran mental health research being pioneered, funded, and conducted from the USA by Veteran Affairs, as we have seen (see Figure S3).

While this American-based research is pioneering in nature, it has also revealed a concerning gap in our knowledge regarding the lived mental health and resettlement experiences of veterans from diverse cultural contexts of origin, including those with individual differences and intersectional identities (Crenshaw 1991; Moodley 2007). There is, for example, a lack of research concerning women, who make up a growing 9% share of U.S. veterans today (Vespa 2020), and a lack of research regarding those veterans with minority sexual, gender, or spiritual beliefs (Kopacz et al. 2019). In alignment with the World Health Organisation (WHO; 2022b) which advocates for showcasing examples of good mental health practices from around the world, the findings of this comprehensive scoping review strongly highlight the need for the voices of non-Western veterans. It also advocates for a holistic, bio-psycho-social-sexual-spiritual-existential

approach to veteran mental health research and interventions, which is inclusive of each individual veteran's culture, intersectionality, aspects of difference, diversity, and preferred way of being (O'Brien and Charura 2023; Rogers 1980). There was also a notable absence of papers studying veterans from South Asian or African countries, which is surprising considering the importance, for example, of the Ghurkhas to the UK military (Pariyar 2019).

The second theme from this comprehensive scoping review highlights the *psychopathology of veteran mental health care*, recognising a gap in the conceptualisation of veteran trauma and mental distress outside of a medicalised, top-down diagnostic approach (Pilgrim 2016), which is predominantly supported by a quantitatively measured evidence base of literature, focused upon the codification of disease (O'Brien and Charura 2023). This notable tendency to pathologise the trauma experiences of veterans has often resulted in a technologically-based treatment of clinical diagnoses, such as (c)PTSD or substance abuse according to the DSM-5 (APA 2013) or ICD-11 (WHO 2022a), without applying a wider trauma-informed lens to the holistic, relational and embodied trauma experiences of military veterans attempting to resettle into the community (O'Brien and Charura 2023). The consequences of this could result in a depersonalised 'cookie-cutter' approach (Schleider et al. 2021) to veteran mental health care that continues to cyclically oppress each individual's intersectional lived experiences (Crenshaw 1991), subjugating their emic voice (Rose and Kalathil 2019), discriminating against their personal meaning and cultural values, and disempowering veterans within health care systems, as highlighted by research with other vulnerable and traumatised groups of individuals (O'Brien and Charura 2024).

The third and final theme of this comprehensive scoping review focuses on the need for *relational and community-based approaches to veteran mental health care*. There is a distinct preference in the literature for research into psychological interventions which favour a Westernised, one-to-one, clinical, therapeutic approach. This includes, for example, a preference for Prolonged Exposure Therapy and Cognitive Processing Therapy in the USA, which are recommended first-line treatments (Hamblen et al. 2019; Schnurr et al. 2022) within this Western, Educated, Industrialised, Rich and Democratic [WEIRD] country. This comprehensive scoping review has highlighted the emerging qualitative research which has begun to explore the therapeutic value for veterans of community-based, relational activities and therapies (Beehler et al. 2021; Mamon et al. 2020), which help to re-immerse often traumatised, immobilised, and existentially isolated individuals back into their bodies, relationships and communities (O'Brien and Charura 2024; Porges 2018; Van Der Kolk 2014).

8 | Discussion

In the sections that follow, we will now discuss these three overarching themes which have been observed throughout this comprehensive scoping review of the literature regarding veteran mental health and resettlement.

8.1 | Culturally-Informed Veteran Mental Health Care

As Henrich et al. (2010) aptly assert, most people are not WEIRD. That is to say that in order to understand human psychology, and indeed the idiosyncratic requirements of each veteran's mental health and resettlement needs, we must stop assuming that everyone shares the same cognitive and affective processes that apply to one population alone. A growing body of evidence suggests that this is simply not the case, and that experimental findings from several disciplines indicate considerable human variations in domains such as analytic reasoning, visual perception, cooperation, memory, fairness and heritability of IQ (Henrich et al. 2010). This assertion is also aligned to the findings of this comprehensive scoping review, where a subset of 20 papers concluded with an emerging need for culturally-informed veteran mental health care dating from 2013 to 2021 (see Figure 2). However, this veteran mental health and resettlement research, whilst notably more frequent in 2017, has begun to dwindle (see Figure 1).

Yet, Hashmi et al. (2017) take care to note that this clear message to move towards culturally-informed care has not entirely fallen on deaf ears, with the DSM-5 responding to these challenges by including a 'Cultural Formulation' (APA 2013). The findings of this comprehensive scoping review also highlight that of the sample of papers focused on the theme of 'cultural care' (see Figure 2 https://doi.org/10.25421/yorksj.28376150), there are notable attempts to further research culturally-informed approaches to the mental health and resettlement care of rural Pacific Island veterans (Whealin et al. 2017), African American and European American veterans (Castro et al. 2015), American Indian and Alaskan Native veterans (Goss et al. 2017), Asian American veterans (Tsai et al. 2014), and Israeli Bedouin and Jewish combat veterans (Shorer et al. 2021). However, Goss et al. (2017) note that more can still be done to begin to weave together Westernised, evidence-based treatments, traditional healing, and rural Native communities by addressing mental health care, technology, care coordination and cultural facilitation, whilst addressing barriers to care, such as system transference, videoconferencing and provider-patient trust.

Sasson-Levy (2017) noted that militaries are always designed by the intersection of race/ethnicity and gender, and stated that this simultaneously creates ethno-gendered groups and identities. For example, the intersection for men with their ethnicity often marks their location within the military hierarchy and determines the jobs they will be assigned and their proximity to the military core of combat. Conversely, for women, the intersection with ethnicity determines whether they will be inside or outside the boundaries of the military (Sasson-Levy 2017). In line with this, it has been asserted that women in the military are in double jeopardy, based on the argument that whilst male soldiers face the danger of being killed or wounded in combat, women also face sexual violence from their own side (Jeffreys 2007). Jeffreys (2007) argued that the cause of this danger is the masculinity of the military, and the fact that militaries are founded upon an aggressive masculinity that is vital to enable warfare to continue. In

addition to this, there have been numerous papers which have illuminated the impact of racism and ignoring the cultural needs of veterans.

For example, research by Armstrong (2024) focusing on integration in the U.S. military, due to it often being upheld by scholars and policymakers as an effective model, questioned whether racial justice is a feasible normative aim of integration for institutions of war. His critique highlights how racial militarism tolerates diversity superficially, while militarization processes effectively erase social difference and enforce a practical culture of 'colour-blindness' (Cole 2018, 189). Furthermore, he argues that the tolerance of racial militarism (and indeed multi-culturalism) in a system which has violence and hierarchy defining its institution's practical logic, consequently blocks the potential for the kind of radical (cultural) transformation that would be required for racially (and we add socially) just integration in the military (Armstrong 2024). Although we acknowledge that different military services are beginning to take rape and sexual assault of servicewomen seriously (Gray et al. 2023), if the military is to authentically have equal opportunities for women, and minoritised groups, discrimination in all its forms needs to be challenged in all areas of the military, including the frontline. Sasson-Levy (2017) made a call to add class, nationality and religiosity as crucial factors that intersect with gender and ethnicity in shaping militaries' social structure.

Fundamentally, this comprehensive scoping review notes the profound absence of emic and etic voices of those veterans with previously subjugated ways of knowing and being across the globe (Rose and Kalathil 2019). Recent research has evidenced that there is considerable variation in the presentation of mental health problems across cultural contexts, with screening and assessment measures failing to capture local idioms and culturally specific presentations of distress (Greene et al. 2023; O'Brien and Charura 2024). We will now consider the essential requirement to look outside of a purely Westernised, medicalised model of distress to enable equitable access to culturally-informed care for veterans.

8.2 | Psychopathology of Veteran Mental Health Care

In alignment with the findings of this comprehensive scoping review, a focal topic of veteran mental health research is PTSD diagnosis and treatment. Yet, when we drill down further, we have noted that there are much wider focal themes that impact veteran mental health distress than purely this medical diagnosis. For example, Figure 2 in the Results section has shown us that five hundred and forty-eight papers consider the impact of *mental health* for veterans outside of a PTSD diagnosis; for example, phobias (Landowska et al. 2018), schizophrenia and suicidal ideation (Kasckow et al. 2016), depression and anxiety (Mott et al. 2014), bipolar disorder (McLay et al. 2014), anger management (Dillon et al. 2021), sleep difficulties (Brown et al. 2017), and obsessive-compulsive disorder (Fletcher et al. 2022). Sixty papers consider the impact of *physical health*, including, for example, traumatic brain injury (O'Neil et al. 2021), pain and stress (Millegan et al. 2021), substance abuse, such as alcohol, opioid, and smoking addictions (Cleland et al. 2020; Herrold et al. 2017; Nieh et al. 2021), diabetes (Collins et al. 2014) and weight-related disorders (Rosenbaum et al. 2016). Thirty-six papers consider the impact of *sexual health*, including, for example, sexual trauma (Foynes et al. 2018), intimate partner violence (Iverson et al. 2016), and LGBTQ+ and gender minority care (Kauth and Shipherd 2016). Twenty-eight papers consider the impact of *spiritual care*, including religious impacts (Currier et al. 2017), moral injury (Smigelsky et al. 2022), yoga (Cushing et al. 2018) or mindfulness-based interventions (Wheeler et al. 2018). Forty-six papers consider the impact of *social care*, including homelessness (Corey Williams et al. 2018), barriers to treatment (Washington et al. 2015), and quality of life (Stock et al. 2014), and 20 papers consider *cultural care*, as we have previously seen.

Other literature, including, for example, a meta-regression analysis on the efficacy of recommended treatments for veterans with PTSD by Haagen et al. (2015), argued that there is an opportunity to engage with current advances in magnetic resonance imaging (MRI), combined with longitudinal study designs, which will allow researchers to connect psycho-neurobiological information to treatment outcomes. However, they also concurred that there is a need to examine the neurobiological pathways of veterans presenting with high symptomatology against patients presenting with moderate and low symptomatology for a better understanding of the neural underpinnings of treatment-resistant presentations (Haagen et al. 2015).

Furthermore, their findings also highlight the need to develop interventions for veterans with PTSD as they state they are a poor outcome group (Haagen et al. 2015). Although trauma-focused psychotherapies and prolonged exposure have been shown to result in substantial reductions in PTSD symptoms, there are persistent difficulties with treatment retention and residual symptoms at the end of a course of treatment (Schnurr and Lunney 2019). It has also been noted that approximately 30%–60% of veterans drop out of trauma-focused treatments prematurely (Schnurr and Lunney 2019; Thompson et al. 2021). It has also been evidenced that significant others, such as family members, can strongly influence mental health treatment initiation and motivation for veterans, and their involvement may increase treatment retention (Thompson et al. 2021). It is clear, therefore, that by focusing predominantly on a diagnosis of PTSD and its treatment in veteran mental health and resettlement care, we are missing a wealth of bio-psycho-social-sexual-spiritual-existential and relational factors which impact veteran mental health (O'Brien and Charura 2023).

Instead of taking this limiting top-down approach to veteran mental health and resettlement care, the findings of this comprehensive scoping review indicate that a bottom-up approach to the assessment, formulation and treatment planning for veterans should be adopted (Gazzillo et al. 2021; O'Brien and Charura 2023, 2024). This includes assessment of the concept of embodied trauma (O'Brien and Charura 2023, 2024) across the bio-psycho-sexual-spiritual-existential realms of distress, using a non-pathologising model explicated by O'Brien and Charura (2024). Body mapping may also be a highly effective assessment tool for collaborative use with veterans who may struggle to verbalise their interwoven

bio-psycho-social-sexual-spiritual-existential distress experienced as embodied trauma (O'Brien and Charura 2024; Van Der Kolk 2014).

8.3 | Relational and Community-Based Approaches to Veteran Mental Health Care

Finally, in alignment with the themes of culturally-informed and trauma-informed care when returning from active military service, this paper notes the need for relational and community-based approaches to veteran mental health and resettlement care. Bogdanov et al. (2021) note that there is a limited amount of research on community-based mental health interventions, possibly due to the poor uptake of existing psychiatric services for anxiety, depression and PTSD. It is unfortunately a common fact within most veteran mental health services that veterans often do not take up mental health care services due to a lack of trust, a lack of awareness, stigma and logistical barriers to health care systems (Weissbecker et al. 2017). The Royal British Legion (2016) noted that out of 888 military personnel who reported an emotional or stress-related problem as a result of deployment, only 42% sought any help and only 29% sought professional help from formal mental health services (Hines et al. 2014). Other research has highlighted that aspects of social connectedness, such as thwarted belongingness (feeling a lack of belonging) and perceived burdensomeness (feeling one is a burden upon others) are significantly associated with suicidal ideation (Chu et al. 2017).

Drawing on this, a study by Chen et al. (2022) on veteran community engagement and social connection needs highlighted that despite barriers to social connectedness, veterans voiced valuing social connection as an important component of their health and well-being. They did, however, also highlight that they needed additional support, including peer support, for learning about opportunities and strategies for engaging in the community (Chu et al. 2017). Similarly, in a different study with older male veterans by Sullivan et al. (2021), findings suggested that social connectedness is one part of the larger milieu of healthy aging, transitioning to a different community context, and includes the importance of engagement with social opportunities and having a purpose. It also should incorporate the continual development of screening tools and other interventions focused on learning more about the impact of social isolation in veterans (Sullivan et al. 2021).

This comprehensive scoping review, however, highlighted a body of research which takes mental health and resettlement back to its radical roots in relationship and attachment theory (Bowlby 1988). DeYoung (2015) noted that most problems in life are relational and born out of experiences in relationships with others. Veteran experiences are perhaps even more closely associated with relationships, with individuals developing close bonds in the military through prolonged and meaningful contact (Guthrie-Gower and Wilson-Menzfeld 2022). Loneliness and social isolation have become increasingly acknowledged to be veteran health concerns and are widely recognised risk factors for mental and physical health outcomes, even being linked to premature death (Cacioppo et al. 2006; Guthrie-Gower and Wilson-Menzfeld 2022). With the well-known barriers to accessing mental health, care such as stigma, poor help-seeking behaviour, and military stoicism, innovative approaches to veteran mental health care and resettlement are urgently needed (Randles and Finnegan 2022).

The findings of this comprehensive scoping review point towards the healing practice involving interpersonal relationships and social healing. Many mental health disorders are characterised by emotional dysregulation and emotional distress (Wampold 2021). Physiological equilibrium is therefore needed for psychological, social and physical well-being, with the physical presence of someone with whom we are close resulting in reduced arousal and distress, a phenomenon called co-regulation, social regulation or interpersonal emotion regulation (Wampold 2021).

Based on this premise of healing and recovery in community and relationship, a number of papers have emerged which detail the relational importance of peer support (Simons et al. 2019), service dog relationship (Galsgaard and Eskelund 2020), community-based interventions, such as community theatre (O'Connor 2017), warrior camps (Steele et al. 2018), exercise (Harrold et al. 2018) and outdoor therapy programmes (Scheinfeld et al. 2017) which focus on fostering relationships, a sense of belonging, combating loneliness and isolation, and reuniting with peers with shared lived experiences.

We concur that it is therefore important to develop approaches that are culturally informed (O'Brien and Charura 2024), relational encounters which require an approach that facilitates a *power with* rather than *power over* attitude (Natiello 1987; Proctor 2017; Smith and Charura 2024). As noted by Charura and Smith (2024), such an approach to working with relational trauma, which in this context can be seen as experiences of severing and fragmenting significant relationship(s) in military veterans, gives space for exploring within therapeutic and community contexts the question of *what has happened to you* rather than *what is wrong with you* (Charura and Smith 2024; Sweeney et al. 2018).

9 | Limitations

Here, we recognise some limitations of this scoping review. For example, the papers we have reviewed excluded veterans aged under 18. However, our justification for this is that although this paper is a global review, children and young people display different symptoms of PTSD than adults, and while evidence for the effectiveness of psychological interventions has been synthesised for adults, this is not directly applicable to younger people, who require specific adaptation (John-Baptiste Bastien et al. 2020). Impacts of trauma on children also require a developmental stage approach specific to their age (US Department of Veteran Affairs 2024) which is more nuanced than the approach to trauma-informed mental health care and intervention in adults (i.e., specifically for preschool age 1–5 years, school age 5–12 years or teenage 12–18 years). We do, however, acknowledge that in some contexts there are child soldier veterans, and therefore more research needs to be done specifically with this child veteran population.

Our results are also only drawn from literature that is publicly available in English, and we have excluded research published

in other languages. Furthermore, this scoping review was, for pragmatic reasons, a sample of papers from a 10-year period. Although this limits a broader temporal understanding of trends, a sample of a decade is recommended for scoping reviews which focus on the most current research trends and developments within a field (Proctor et al. 2023). The argument is that this allows us to identify recent gaps in knowledge, emerging themes, and the latest methodologies used in that area, whilst still capturing a substantial body of relevant information (Proctor et al. 2023).

10 | Conclusion

By highlighting trends and biases in mental health interventions with veterans, we hope to bring to light new directions in this area to meet the ongoing multi-factorial needs of ex-military individuals. We conclude that international research has continued to explore the efficacy and development of therapeutic interventions for veterans, which focus on technologically-based, medicalised approaches in order to reach more veterans resettling in local and rural communities. However, this scoping review has highlighted the need to improve trauma-informed and culturally-informed, inclusive community-based veteran mental health care, which incorporates a holistic treatment plan for each veteran. This includes consideration of each veteran's cultural preferences and intersectional lived experiences, alongside their habitual and systemic 'military' ways of being, to improve engagement with and benefit from mental health care, trauma and community services. Such an approach could address the current need to *prevent* rather than *react to* the mental ill health of veterans, as highlighted in the UK Ministry of Defence strategy (e.g., Ministry of Defence 2022).

In line with the findings of this comprehensive scoping review, we make the following recommendations for future research.

i. Importance of a personalised veteran bio-psycho-social-sexual-spiritual-existential assessment, formulation and treatment plan which includes community-based and relational activities.

ii. The need for a culturally-informed, trauma-informed and gender-informed approach to veteran mental health care and resettlement provision.

iii. The commitment to anti-oppressive practice at all levels within different military structures. This should be cemented by an understanding of intersectionality and the impact of oppression, racism, cultural omission, and misogyny.

iv. Further research is necessary to explore the efficacy of an individualised care pathway. This should include the use of non-pathologising terms and an understanding of embodied trauma, body mapping assessment tools, evidence-based and practice-based outcome measures, person-centred, community-based and relational interventions to aid resettlement.

v. The importance of veterans' input into future research outside purely Americentric research literature. This should include diverse voices from global contexts.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.