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MENTAL HEALTH NURSING FOR MILITARY PERSONNEL AND VETERANS: MANAGING PTSD, ANXIETY DISORDERS, AND SUBSTANCE WITHDRAWAL IN ACUTE BEHAVIORAL HEALTH UNIT

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ABSTRACT

This review critically examined the responsibilities of mental health nurses caring for military personnel and veterans experiencing post-traumatic stress disorder, anxiety disorders, behavioural escalation, substance intoxication, and withdrawal within acute behavioural health units. Its purpose was to clarify the clinical, ethical, cultural, and organisational requirements of safe, recovery-oriented care for a population shaped by combat exposure, moral injury, military identity, traumatic brain injury, chronic pain, stigma, and difficult transitions to civilian life. A structured narrative review approach was adopted, drawing on recent international evidence from military, veteran, psychiatric, nursing, addiction, and health-services literature, with attention to findings from Africa and other global regions. The review found that presentations are frequently complex and comorbid, requiring repeated assessment rather than reliance on a single diagnostic label. Effective nursing practice depends on early recognition of trauma-related symptoms, suicide and violence risk assessment, skilled de-escalation, structured observation, sleep support, medication surveillance, and medically informed withdrawal monitoring. Trauma-informed, veteran-centred, and recovery-oriented approaches were shown to reduce retraumatisation by promoting dignity, trust, collaboration, cultural responsiveness, and the least restrictive intervention. Ethical practice further requires careful capacity assessment, transparent confidentiality boundaries, proportionate risk management, and meaningful patient participation. Continuity after stabilisation emerged as equally important, particularly through family engagement, relapse-prevention planning, medication reconciliation, peer support, and coordinated transfer across military, veteran, civilian, addiction, and primary-care services. The review concludes that high-quality care requires clinically competent, ethically grounded, and culturally informed nursing systems. It recommends specialist workforce education, standardised trauma and withdrawal protocols, adequate staffing, integrated follow-up pathways, and future evaluation of nurse-led transition models, family interventions, digital support, and patient-reported recovery outcomes across settings.

Keywords: *military mental health; veteran-centred nursing; post-traumatic stress disorder; anxiety disorders; substance withdrawal; acute behavioural health.*

1. INTRODUCTION

1.1 Mental health burden among active-duty personnel and veterans

Military service exposes personnel to a distinctive accumulation of occupational, interpersonal and traumatic stressors that can persist across deployment, hospitalization, discharge and civilian reintegration. The mental health burden is therefore not confined to combat-related post-traumatic stress disorder (PTSD); it also encompasses anxiety, depression, sleep disturbance, moral injury, hazardous alcohol use, opioid-related problems and psychiatric comorbidity. Among Nigerian war veterans, trauma exposure significantly predicted PTSD, while hopelessness amplified psychological vulnerability, indicating that distress may be sustained not only by battlefield events but also by diminished expectations for recovery, social participation and future security (Nwoye & Nweke, 2024). For nurses in acute behavioral health units, this breadth of morbidity requires assessment models that move beyond a single diagnosis and examine symptom severity, functional impairment, substance use, physical injury, family disruption and immediate safety needs.

International evidence demonstrates substantial variation in measured prevalence. Differences in sampling frame, deployment history, cultural disclosure, screening thresholds and whether participants are community-dwelling, hospitalized or treatment-seeking can produce markedly different estimates. Such heterogeneity should not be interpreted as evidence that the burden is negligible in lower-prevalence settings. Instead, it highlights the need to distinguish between diagnosed disorders, positive screening results and subthreshold symptoms that may still compromise readiness, relationships and recovery. The comparative findings below illustrate the range of clinically relevant outcomes reported in 2024 studies.

Table 1: Selected 2024 estimates of mental health and substance-related burden among military personnel and veterans

Population and setting	Reported indicator	Prevalence
Ethiopian military personnel admitted to a command-level hospital	Positive PTSD screening result	21.9% (Tedla <i>et al.</i> , 2024)
Ugandan soldiers returning from deployment	Positive PTSD screening result; moderate substance-use-disorder screening result	16.0%; 21.0% (Baguma, Vivalya, Ocen & Kasujja, 2024)
Chinese military personnel across 30 provinces	Depression; anxiety; PTSD	2.69%; 0.99%; 1.61% (Jing <i>et al.</i> , 2024)
United States active-duty service members	Serious psychological distress; current smoking or substance use; heavy alcohol use	16.4%; 18.6%; 9.8% (Olafeju, Hendrickson, Shanahan, Mushtaq & Ahmed, 2024)
United States veterans	Probable generalized anxiety disorder; mild anxiety symptoms	7.9%; 22.1% (Macdonald-Gagnon, Stefanovics, Potenza & Pietrzak, 2024)

Table data are drawn from population-specific screening studies and should not be treated as directly standardized national comparisons.

The table should be interpreted comparatively rather than as a league table of national vulnerability. Estimates describe different instruments, timeframes and populations, including

hospitalized personnel, returning soldiers, broad active-duty samples and community veterans. Their value lies in showing that distress appears across military systems, although its measured expression varies with context, exposure and access to assessment.

PTSD remains a central component of the burden, yet conventional diagnostic categories may underrepresent the complexity of prolonged military trauma. A systematic review of serving and veteran populations found wide variation in both PTSD and complex PTSD estimates, with complex PTSD frequently exceeding standard PTSD in several samples, particularly where repeated or prolonged trauma had occurred (Grinsill, Kolandaisamy, Kerr, Varker & Khoo, 2024). Complex PTSD adds disturbances in emotional regulation, self-concept and relationships to the core PTSD domains of re-experiencing, avoidance and persistent threat. In an acute unit, these features may present as agitation, emotional numbing, dissociation, interpersonal mistrust or difficulty tolerating ward routines, making trauma-informed nursing engagement essential.

Anxiety disorders contribute an equally consequential, though sometimes less visible, burden. Generalized worry, hypervigilance, panic symptoms and somatic arousal may be misattributed to personality, poor discipline or uncomplicated stress, particularly when personnel are reluctant to disclose vulnerability. Subthreshold anxiety is clinically important because it can impair sleep, concentration, decision-making and treatment participation even when full diagnostic criteria are not met. Among treatment-seeking United Kingdom Armed Forces veterans, complex PTSD symptom clusters were associated with executive-function difficulties, reinforcing the need for nurses to assess attention, planning, impulse control and cognitive flexibility rather than focusing exclusively on emotional symptoms (Biscoe, New & Murphy, 2024).

Substance-related morbidity further intensifies acute-care complexity. Alcohol, opioids, sedatives and other substances may be used to suppress intrusive memories, manage pain, induce sleep or reduce physiological arousal. This can obscure underlying PTSD and anxiety while increasing the risk of intoxication, withdrawal, medication interactions and behavioral destabilization. In a nationally representative United States veteran sample, problem opioid use affected a clinically significant minority and was strongly associated with psychiatric and physical-health morbidity, demonstrating that substance assessment should be integrated with trauma and pain evaluation rather than treated as a separate pathway (Na, Petrakis, Krystal & Pietrzak, 2024). Acute behavioral health nurses must therefore anticipate overlapping withdrawal symptoms, anxiety, autonomic activation and trauma triggers.

The burden also differs across sex, rank, deployment intensity and stage of military transition. Female personnel may experience combat exposure alongside military sexual trauma and gender-based stress, while junior ranks may have reduced autonomy and fewer resources for confidential help-seeking. Repeated deployments, handling human remains, injury, bereavement and weak social support can cumulatively intensify symptoms. Israeli female combat veterans displayed distinct profiles combining post-traumatic stress symptoms and post-traumatic growth, showing that apparent resilience can coexist with substantial distress rather than replacing it (Zerach, 2024). Nursing assessment should consequently avoid assuming that operational competence, pride or positive meaning-making excludes clinically important symptoms.

For acute behavioral health services, the principal implication is that military and veteran presentations are often layered rather than diagnostically discrete. PTSD may coexist with anxiety, depressive symptoms, chronic pain, insomnia, traumatic brain injury and substance dependence,

producing fluctuating risk and rapid changes in behavior. Stigma, concerns about career consequences and unfamiliarity with civilian services may delay care until symptoms become severe. Nurses are therefore positioned to identify hidden morbidity through culturally responsive questioning, validated screening, repeated observation and attention to sleep, pain, withdrawal, avoidance and functional decline. The prevalence patterns support a nursing model that is trauma-informed, military-culturally competent and capable of integrating psychiatric stabilization with substance-withdrawal surveillance.

1.2 Military Service, Combat Exposure, and the Development of Psychiatric Disorders

Military service generates a distinctive ecology of psychiatric risk in which operational danger, rigid hierarchy, prolonged vigilance, separation from family, disrupted sleep and repeated exposure to death may interact over time. Combat does not operate as a single traumatic event; rather, cumulative deployments can repeatedly activate physiological threat systems while limiting opportunities for emotional processing and recovery. Among Nigerian Army veterans deployed in the North-East, combat experiences and morally injurious exposures were associated with important post-deployment difficulties, illustrating how conflict against insurgency may affect functioning beyond the battlefield (Mary, Sonter, Terkumbur & Inuwa, 2024).

The development of psychiatric disorders is shaped not only by exposure intensity but also by the meaning assigned to military events. Killing, failing to prevent harm, witnessing civilian suffering or perceiving betrayal by commanders may violate deeply held moral expectations, producing guilt, shame, anger and loss of trust. Prospective evidence among Israeli combatants indicates that potentially morally injurious events can contribute to later psychiatric symptomatology, while pre-deployment personality characteristics may modify vulnerability (Levi-Belz, Ben-Yehuda, Levinstein & Zerach, 2024).

Physical forces encountered during service may further complicate psychological injury. Repeated blast exposure can involve concussive effects, sensory disruption and persistent neurobehavioral symptoms that overlap with PTSD, including irritability, concentration problems, hyperarousal and disturbed sleep. This overlap can obscure diagnosis and intensify distress among active-duty personnel, especially when service members are expected to maintain operational performance despite emerging symptoms (Sekely, Malik, Miller, Wang & Puente, 2024).

Deployment-related psychopathology nevertheless follows heterogeneous trajectories. Some personnel remain psychologically stable, whereas others display delayed, persistent or escalating symptoms after apparently similar exposures. Research involving high-risk military personnel suggests that resilience is not simply the absence of distress but a dynamic outcome influenced by prior vulnerability, deployment experiences and adaptive resources (Bennett, Lawrence-Wood & McFarlane, 2024). Acute-care assessment should therefore avoid assuming that decorated, experienced or highly trained personnel are protected from deterioration.

Peacekeeping operations also carry substantial psychiatric risk because personnel may face armed attacks, civilian atrocities, ambiguous rules of engagement and chronic uncertainty without the psychological preparation associated with conventional warfare. A longitudinal study of Japanese peacekeepers deployed to South Sudan showed that pre-deployment sleep disturbance, anxiety and poorer general health predicted adverse PTSD trajectories, demonstrating that vulnerabilities may precede mission exposure (Kitano *et al.*, 2024).

Across peacekeeping studies, combat exposure, deployment duration, adverse social interactions and negative perceptions of deployment consistently emerge as resource-depleting conditions, whereas social support, effective coping and organisational protection may buffer risk. These findings reinforce a cumulative model in which psychiatric disorders develop through interactions between traumatic events and insufficient restoration during or after deployment (Carmona, Camilo, Carvalho & Chambel, 2024).

The consequences may continue within family life after service. South African evidence describes persistent combat-related complex PTSD as involving defensive emotional withdrawal, relational disruption and repeated reactivation of unresolved trauma within military families (Sibanda, 2024). In acute behavioral health units, nurses must therefore assess combat history, moral injury, blast exposure, sleep, substance use, relational functioning and deployment chronology as clinically interconnected determinants of presentation.

1.3 Acute Behavioral Health Units as Critical Care Environments

Acute behavioral health units function as critical-care environments because they receive patients whose psychiatric symptoms can deteriorate as rapidly as physiological instability in medical intensive care. Military personnel and veterans may arrive with severe PTSD, panic, dissociation, intoxication, withdrawal, psychosis, traumatic brain injury, chronic pain, or suicidal crisis, often in overlapping combinations. The unit must therefore provide continuous assessment, immediate containment of risk, medication surveillance, and therapeutic engagement while preserving dignity and trust. Evidence that brief trauma-focused treatment can be delivered feasibly to veterans during acute psychiatric admission also challenges the assumption that inpatient care should be restricted to custodial stabilization alone in practice (Ennis *et al.*, 2024).

The critical nature of these settings is intensified by environmental unpredictability. Noise, locked doors, unfamiliar routines, interpersonal conflict, observation procedures, and perceived loss of control may reactivate combat-related hypervigilance or institutional mistrust. Nigerian evidence from an acute admission ward showed that patients' experiences of restricted freedom and staff concerns about inadequate physical facilities materially shaped perceptions of care quality, demonstrating that ward design and organisational conditions are clinically consequential rather than merely administrative (Olusina, Ohaeri & Olatawura, 2002).

Safety must consequently be understood as multidimensional. It includes prevention of suicide, assault, absconding, medication error, sexual victimisation, withdrawal complications, and retraumatisation. Australian mental health nurses have described sexual safety as a persistent concern within acute inpatient units, requiring vigilant observation, responsive reporting systems, environmental safeguards, and gender-sensitive care planning (Olasoji *et al.*, 2024). For veterans with histories of military sexual trauma, such safeguards are especially important because unsafe interactions may intensify avoidance, dissociation, and distrust of treatment.

Aggression is another defining clinical hazard. South African nurses working in acute psychiatric wards reported exposure to verbal and physical aggression, underscoring the need for early-warning assessment, adequate staffing, team communication, and skilled de-escalation (Thandavhathu *et al.*, 2024). These measures are particularly relevant when combat conditioning, withdrawal, paranoia, or traumatic triggers amplify perceived threat. Restrictive interventions may occasionally be unavoidable, but they carry physical and psychological risks. Video-observation research found that nursing contact during seclusion and mechanical restraint was limited and often

centred on basic needs, indicating the importance of sustained relational monitoring and post-event review (Varpula *et al.*, 2023).

Workforce capacity is therefore a patient-safety determinant. Acute inpatient services require nurses able to integrate mental-status examination, withdrawal scoring, physical-health surveillance, suicide assessment, pharmacological monitoring, and trauma-informed communication. Persistent shortages of psychiatric–mental health nurses can weaken observation, continuity, therapeutic interaction, and timely escalation, thereby converting manageable distress into preventable crisis (Frawley & Culhane, 2023).

Technological and participatory approaches can strengthen situational awareness without replacing clinical judgement. Patient-focused safety technology implemented on acute mental health wards has shown the value of incorporating service users' perceptions of ward tension and emerging risk into safety systems (Kendal *et al.*, 2024). Such approaches are pertinent to military populations, whose disciplined presentation may conceal escalating distress.

Finally, critical care in these units must remain person-centred. Spiritual and existential concerns may be prominent when veterans struggle with guilt, bereavement, moral injury, or loss of identity. Integration of spiritual care within a Veterans Affairs inpatient psychiatric service illustrates how multidisciplinary models can address dimensions of suffering that medication and observation alone may not resolve (Ford, Van Denend, DeViva, Cooke & Klee, 2024). Acute behavioral health nursing therefore requires simultaneous crisis containment, physiological vigilance, trauma sensitivity, and recovery-oriented engagement.

1.4 Aim, Scope, and Organization of the Review

This review aims to critically examine the role of mental health nursing in the assessment, stabilization, and continuing care of military personnel and veterans experiencing post-traumatic stress disorder, anxiety disorders, substance intoxication, and withdrawal within acute behavioral health units. It seeks to clarify how combat exposure, repeated deployment, moral injury, military sexual trauma, traumatic brain injury, chronic pain, disrupted sleep, and difficult transitions to civilian life shape psychiatric presentation and influence nursing priorities. The scope extends beyond symptom recognition to include trauma-informed communication, suicide and violence risk assessment, withdrawal monitoring, medication safety, de-escalation, culturally responsive practice, family involvement, and interdisciplinary coordination. Particular attention is given to the clinical complexity created by comorbidity, fluctuating capacity, stigma, mistrust of services, and the possibility that military discipline may conceal severe psychological distress. The review also considers the ethical and organizational conditions that affect care quality, including restrictive interventions, staffing pressures, ward safety, continuity of care, and discharge planning. Structurally, the discussion progresses from the epidemiological and service-related foundations of military mental health to the conceptual principles of veteran-centred nursing, followed by focused examination of PTSD, anxiety, substance withdrawal, acute stabilization, and recovery-oriented practice. Within this sequence, validated assessment and monitoring tools are summarised in tabular form at the point where nurses would use them, and section 4.3 sets out an integrated protocol for the common situation in which PTSD or anxiety and substance withdrawal present together. The review then concludes by setting out, in a dedicated recommendations section, priorities for clinical practice, policy development, service integration, and future research intended to strengthen safe, evidence-informed, and humane care across military and civilian health systems internationally.

2. CLINICAL AND CONCEPTUAL FOUNDATIONS OF MILITARY MENTAL HEALTH NURSING

2.1 Military Culture, Identity, and Help-Seeking Behaviour

Military culture is not merely an occupational setting; it is a social system that shapes identity, language, emotional expression, loyalty and conduct. Through training, hierarchy, ritual and collective mission, personnel learn to prioritise endurance, self-control and group reliability. These qualities support operational effectiveness, yet they can narrow the emotions considered legitimate. Distress may be concealed when disclosure appears incompatible with the warrior identity or threatens unit belonging (Heward, Li, Chun Tie & Waterworth, 2024).

Within Nigeria, military identity is conditioned by rank, deployment intensity and exposure to asymmetric conflict. Non-commissioned personnel deployed to Boko Haram-affected zones may experience high psychological demands while possessing limited authority over operational conditions. Rank-based power differentials can influence whether symptoms are acknowledged, how superiors interpret vulnerability and whether personnel believe that requesting assistance will attract ridicule, disadvantage or reputational damage. Help-seeking must therefore be understood as an organisationally situated decision rather than an exclusively individual choice (Umeh, Olawa & Abel, 2023).

Evidence from the South African National Defence Force demonstrates that military identity is constructed through institutional expectations, recognition and military ethos. Although research on instructor identity does not directly measure treatment utilisation, it clarifies how conformity, role legitimacy and standing shape behaviour within military organisations. When identity is tied to discipline and authority, admitting psychological difficulty may threaten credibility, especially where personnel believe leaders should model invulnerability (Wagner, van Putten & Rauscher, 2021).

Cultural expectations are mediated by leadership and unit climate. Among Japan Ground Self-Defense Force members, stigma toward psychiatric illness and mental health services was associated with rank, leadership and cohesion. Strong cohesion may provide peer support, but it can also intensify pressure to avoid conduct perceived as burdening the group. Confidential, command-sensitive referral processes are therefore essential if personnel are to seek care without fearing compromised trust or occupational consequences (Yamazaki *et al.*, 2023).

In the Philippine Army, mental health stigma has been examined in relation to intentions to obtain professional assistance. The findings reinforce the distinction between recognising distress and acting upon that recognition. A soldier may understand that symptoms warrant care yet remain reluctant to approach services because anticipated judgement, shame or concerns about professional identity outweigh perceived benefits. Mental health literacy must therefore challenge the belief that treatment contradicts courage, discipline or commitment to service (Gammad, 2024).

Stigma may persist even after personnel enter treatment. Active-duty service members receiving specialist mental health care have reported public, self and structural forms of stigma, illustrating that service contact does not automatically resolve fears about weakness, deployability or career progression. For acute behavioral health nurses, apparent cooperation should not be equated with psychological safety. Therapeutic engagement requires reassurance about confidentiality,

respectful explanation of documentation and avoidance of language framing symptoms as personal failure (Zumwalde, Hawkins & Young, 2023).

Leadership can reinforce silence or legitimise care. Supportive commanders may reduce self-stigma by presenting treatment as responsible readiness maintenance, whereas destructive leadership can strengthen internalised shame and discourage disclosure. Nurses should recognise commanders and senior non-commissioned personnel as influential gatekeepers while preserving clinical independence. Collaborative education can help leaders identify deterioration, initiate timely referral and communicate that early intervention protects both the individual and the unit (McGuffin, Riggs, Raiche & Romero, 2021).

For veterans, help-seeking is shaped by transition, service accessibility, alcohol-related stigma, perceived treatment need and confidence that providers understand military experience. Evidence indicates that barriers and facilitators operate across personal, social and service levels rather than through stigma alone. Acute units should integrate military-cultural assessment, peer support, family engagement and clear post-discharge navigation, ensuring that care pathways acknowledge identity loss, mistrust of civilian systems and difficulties continuing treatment after crisis stabilisation (Hitch, Toner & Armour, 2023).

2.2 Trauma-Informed, Recovery-Oriented, and Veteran-Centred Nursing Care

Trauma-informed, recovery-oriented, and veteran-centred nursing care provides an integrated framework for responding to military personnel and veterans presenting with PTSD, anxiety, dissociation, substance withdrawal, chronic pain, suicidal crisis, or functional disruption. Trauma-informed practice assumes that behaviour may represent adaptation to overwhelming experience rather than deliberate non-compliance. In acute units, nurses must recognise how noise, surveillance, locked doors, abrupt commands and unfamiliar routines can reproduce perceptions of threat. Australian nurses have described trauma-informed care as dependent on embodied awareness, relational sensitivity, and continuous negotiation of safety, rather than a checklist applied after admission (Wilson, Hurley, Hutchinson & Lakeman, 2024).

Operationalising this philosophy requires deliberate modification of everyday nursing conduct. Clear explanations before assessment, permission-seeking, predictable routines, collaborative safety planning, and meaningful choices can reduce powerlessness without compromising clinical responsibility. For veterans conditioned to respond rapidly to danger, sudden touch, confrontational questioning, or unexplained observation may trigger hyperarousal, defensive aggression, or withdrawal. A practice-development initiative in an acute inpatient service demonstrated that trauma-informed nursing is strengthened when staff examine ward language, routines, coercive responses, and assumptions about risk (Isobel & Edwards, 2017).

The ethical importance of these measures is reinforced by Nigerian service-user accounts of involuntary admission, restraint, forced medication, and exclusion from decision-making. Participants described coercive experiences as frightening and damaging to trust, indicating that justified interventions can still produce psychological harm when communication, dignity, and procedural fairness are absent. For military patients affected by captivity, betrayal, or loss of control, nurses should use the least restrictive response, explain necessity, maintain observation as therapeutic contact, and conduct post-incident review (Aluh *et al.*, 2022).

Recovery orientation extends care beyond symptom suppression toward hope, agency, identity, connection, and personally meaningful functioning. Evidence from Botswana and South Africa shows that nurses view individualised care, participation, family support, and multidisciplinary collaboration as essential, while limited staffing, inadequate training, and biomedical dominance impede implementation. In veteran care, recovery goals may include restoring family roles, rebuilding civilian identity, managing trauma reminders, sustaining abstinence, or returning to education and employment (Kealeboga, Manyedi & Moloko-Phiri, 2023).

Nevertheless, recovery language does not automatically translate into recovery-oriented behaviour. Observation of acute psychiatric nursing practice found tensions between positive professional attitudes and routines prioritising control, task completion, and risk management. Veteran-centred nursing therefore requires reflective supervision that examines whether institutional convenience is being privileged over collaboration, especially during agitation, medication refusal, or withdrawal monitoring (Sreeram, Cross & Townsin, 2023).

Veteran-centred care adds military-cultural competence to these principles. Nurses should sensitively establish service history, deployment experiences, combat and blast exposure, military sexual trauma, traumatic brain injury, pain, substance use, homelessness, and transition difficulties. Inquiry should avoid stereotyping: military service is clinically relevant, but it does not define the whole person. Civilian nurses may otherwise overlook service-related exposures or misinterpret disciplined communication, emotional restraint, and reluctance to disclose distress (Johnson *et al.*, 2013).

Cultural responsiveness is important because recovery is shaped by language, family expectations, spirituality, community relationships, and culturally specific understandings of illness. A Japanese recovery-oriented nursing model emphasises recognising personal values, building collaborative relationships, mobilising strengths, and adapting support to the individual's social context. Applied to diverse veteran populations, this approach discourages imposing a single Western narrative of independence or psychological disclosure (Matsuoka, 2023).

Within inpatient veteran services, recovery orientation must be expressed through concrete therapeutic programming, not aspirational policy alone. Evidence from Veterans Health Administration units found that overall recovery orientation was not independently associated with thirty-day readmission, although stronger therapeutic programming showed a potentially protective relationship. Nursing contribution is therefore most credible when hope, choice, education, coping practice, peer connection, and discharge preparation are embedded consistently in daily ward activity (McGuire *et al.*, 2022).

2.3 Psychiatric Comorbidity and Diagnostic Complexity

Psychiatric presentations among veterans rarely conform to a single diagnosis. Combat exposure, deployment, moral injury, disrupted sleep, chronic pain and substance misuse may generate overlapping symptom clusters. In acute behavioral health units, hyperarousal, irritability, poor concentration, emotional numbing and autonomic instability can reflect PTSD, anxiety, depression, withdrawal, traumatic brain injury or several conditions simultaneously. Diagnostic formulation must therefore be iterative, integrating service history, collateral information, physical assessment and mental-status examination rather than relying on the admitting label.

Population evidence demonstrates that comorbidity is embedded in military mental health. Among Canadian Armed Forces personnel, psychiatric conditions clustered into highly comorbid, depression-dominant and alcohol-use-dominant groups, with greater trauma exposure associated with complex profiles. A positive PTSD screen is not a complete explanation of distress, because depression, anxiety and alcohol problems may independently influence risk and treatment response (Richardson *et al.*, 2019).

Substance-related symptoms add complexity in African military settings. Nigerian soldiers residing in a military community showed alcohol exposure, with combat involvement and junior rank associated with problematic patterns. Alcohol may be used to manage intrusive memories, yet intoxication and withdrawal can reproduce anxiety, agitation, tremor and impaired judgement. Nurses must distinguish trauma-driven arousal from withdrawal progression while assessing whether both occur concurrently (Ijomanta & Lasebikan, 2016).

Evidence from the South African National Defence Force illustrates how PTSD and depression may coexist after traumatic exposures. Depressive withdrawal, hopelessness and cognitive slowing can obscure trauma-specific avoidance, while irritability may be misread as disciplinary or personality problems. One disorder may remain unrecognised unless assessment includes mood, trauma exposure, functioning and help-seeking behaviour within the same formulation (Seedat, Le Roux & Stein, 2003).

Diagnostic systems also introduce complexity. Research with treatment-seeking United Kingdom veterans found that ICD-11 complex PTSD was distinguishable from conventional PTSD and associated with difficulties in affect regulation, self-concept and relationships. These disturbances may resemble personality pathology, chronic depression or hostility if trauma history is insufficiently explored. Nurses should document patterns across time and context, avoiding premature characterological interpretations (Murphy, Karatzias, Busuttil, Greenberg & Shevlin, 2021).

Australian veteran data show that comorbidity is heterogeneous. Distinct profiles involving depression, anger, guilt, dissociation and alcohol problems were associated with different levels of PTSD severity and quality-of-life impairment. A veteran with prominent dissociation requires different observation and grounding strategies from one whose risk is driven by alcohol withdrawal or severe depressive collapse, even when both carry the PTSD diagnosis (Terhaag *et al.*, 2022).

Physical and psychiatric disorders amplify one another. United States veteran data indicate extensive co-occurrence of chronic pain and PTSD, accompanied by additional psychiatric diagnoses. Pain may intensify sleep disruption, irritability and medication reliance, while trauma-related hypervigilance can magnify pain perception and functional avoidance. Nursing assessment should examine analgesic use, mobility, pain triggers and trauma symptoms together rather than dividing them into unrelated pathways (Hadlandsmayth, Zhuang, Driscoll & Lund, 2024).

Sleep disturbance is both a PTSD feature and a potentially independent disorder. Veterans with concurrent clinical insomnia display a different PTSD symptom pattern from those with PTSD alone, complicating interpretation of fatigue, concentration deficits and emotional reactivity. Persistent insomnia may remain after trauma symptoms improve and worsen depression, anxiety and daytime functioning. Sleep history, nightmares and medication effects require separate

assessment rather than automatic attribution to PTSD (DeViva, McCarthy, Fischer & Pietrzak, 2024).

Traumatic brain injury creates a differential challenge because headaches, slowed processing, memory difficulty, irritability and impaired concentration overlap with post-traumatic symptoms. Evidence suggests that altered emotional responding in some veterans is better explained by PTSD severity than by mild traumatic brain injury alone. Accurate formulation requires neurological history, injury chronology, cognitive observation and avoidance of attributing complaints exclusively to psychological or neurological causes (Marquardt, Goldman, Cuthbert, Lissek & Sponheim, 2018).

2.4 Ethical, Legal, and Professional Responsibilities in Acute Care

Acute behavioral health nursing is governed by the simultaneous demands of autonomy, safety, dignity, justice, and professional accountability. Military personnel and veterans may enter care during suicidal crisis, severe post-traumatic stress, intoxication, withdrawal, psychosis, or impaired judgement, yet diagnostic severity alone does not remove legal rights. Nigeria's National Mental Health Act strengthens protections relating to non-discrimination, access to care, informed participation, confidentiality, and review of involuntary treatment, although implementation depends on institutional capacity, professional education, and effective oversight (Ozota, Sabastine, Uduji & Okonkwo, 2024).

Decision-making capacity must be assessed for the specific decision and at the relevant time, rather than inferred automatically from diagnosis, admission status, agitation, or military background. Capacity may fluctuate as withdrawal, medication effects, sleep deprivation, dissociation, or acute anxiety changes. Nurses should support understanding through clear explanations, repetition, interpreters where necessary, and opportunities to ask questions, while documenting the patient's ability to understand, retain, weigh, and communicate treatment choices (Curley, Watson & Kelly, 2022).

When immediate danger necessitates involuntary care, seclusion, restraint, or emergency medication, the least restrictive effective intervention should be selected and discontinued promptly. A global meta-analysis demonstrates substantial variation in restrictive practices across adult inpatient settings, suggesting that organisational culture and service design influence use alongside clinical acuity. For trauma-exposed veterans, coercion may reproduce helplessness, confinement, or threat; continuous observation, explanation, proportionality, physical monitoring, and post-event debriefing are therefore essential safeguards (Belayneh, Chavulak, Lee, Petrakis & Haines, 2024).

Ethical reasoning during coercive interventions requires more than technical compliance with policy. Psychiatric nurses must balance respect for autonomy against beneficence and non-maleficence while recognising that fear, staffing pressures, and ward norms can distort judgement. Reflective consultation, team-based risk formulation, and accurate recording of alternatives attempted can reduce arbitrary decision-making and preserve accountability when restrictions are unavoidable (Manderius, Clintstahl, Sjöström & Örmon, 2023).

Shared decision-making remains relevant even during acute illness. Patients can often participate meaningfully in selected aspects of care, including preferred calming strategies, medication discussions, family contact, spiritual support, and discharge priorities. Structured collaboration can

counter institutional passivity and strengthen treatment engagement, provided nurses adapt information to cognitive and emotional capacity rather than presenting choice as an all-or-nothing entitlement (Thomas *et al.*, 2021).

Professional responsibility also includes ensuring that care planning reflects the patient's own account. Workplace cultures centred on surveillance, task completion, or risk avoidance may marginalise service-user participation. Nurses are accountable for documenting preferences, strengths, advance statements, trauma triggers, and disputed decisions, while escalating unsafe practices through clinical governance channels and maintaining competence in law, ethics, withdrawal assessment, and trauma-informed care (Rio, Fuller, Taylor & Muir-Cochrane, 2021).

Confidentiality presents particular complexity for active-duty personnel because operational responsibilities may justify narrowly defined disclosures to command authorities. Nurses should explain confidentiality limits early, disclose only information necessary for safety or duty-related purposes, and record the legal basis, recipients, and content of any disclosure. Such transparency protects therapeutic trust while recognising legitimate obligations concerning imminent harm, fitness for duty, safeguarding, and mission safety (Hoyt, 2013). Professional practice requires timely escalation, multidisciplinary consultation, incident review, and advocacy whenever institutional routines undermine lawful and humane care.

Because command notification and clinical confidentiality can pull in opposite directions, nurses require a working framework rather than a single rule. In practice this means distinguishing routine clinical information, which remains confidential to the treating team, from the narrow categories that may legitimately be shared with command, such as imminent risk to self or others, fitness for specific duties, and safeguarding concerns; applying a "minimum necessary" standard so that only the fact and operational implication of a disclosure are shared rather than diagnostic detail; and explaining this boundary to the patient at admission, before trust has been tested by an unexpected disclosure. Every disclosure should be documented with its legal basis, the information shared, the recipient, and the clinical reasoning, so that the patient, the treating team, and any subsequent review can verify that the narrowest necessary breach of privacy was made (Hoyt, 2013). For veterans and reservists moving between military, veteran and civilian systems, nurses should also clarify which confidentiality regime currently applies, since assumptions carried over from active service can otherwise lead patients to under-disclose in civilian care or over-estimate the privacy protections available on a military base.

Involuntary treatment requires safeguards that go beyond the initial decision to detain, seclude, restrain, or medicate. Nurses should ensure that patients and, where appropriate, their families are told in accessible language why a restrictive measure was used, what legal provision authorised it, how long it is expected to last, and how it can be reviewed or challenged, including any right to independent review, tribunal hearing, or patient advocacy support (Ozota, Sabastine, Uduji & Okonkwo, 2024; Belayneh, Chavulak, Lee, Petrakis & Haines, 2024). The clinical record should state explicitly why less restrictive options were judged insufficient at that moment, since a reasoned, contemporaneous account is what allows both clinical governance and external review to distinguish necessary safety intervention from default practice. Because military patients may already associate confinement or loss of control with captivity, betrayal, or combat trauma, a structured post-event debrief that revisits the incident with the patient, acknowledges its impact, and reviews the care plan is an ethical requirement rather than an optional courtesy; it is also where

nurses are best placed to repair therapeutic trust and to identify triggers that should inform future de-escalation.

Stigma reduction is itself an ethical obligation of acute care, not only a help-seeking issue addressed before admission. Within the unit, this translates into concrete nursing practice: using non-pathologising language in handover, documentation, and family conversations; avoiding notes that frame military identity, stoicism, or reluctance to disclose as personality deficits; limiting information shared with a patient's unit or command to what is legally required rather than what is administratively convenient; and involving peer support workers or veteran liaisons, where available, as a bridge between clinical care and military culture. Because active-duty patients have described stigma persisting even after they enter treatment, in the form of public, self, and structural judgement (Zumwalde, Hawkins & Young, 2023), the acute admission itself can either compound that stigma or begin to counter it, depending on the language and transparency nurses model during the most vulnerable point of a patient's care.

3. NURSING MANAGEMENT OF PTSD AND ANXIETY DISORDERS

3.1 Comprehensive Assessment and Early Recognition of Trauma-Related Symptoms

Comprehensive assessment in acute behavioral health units requires more than confirmation that a military patient has experienced trauma. Nurses must establish the nature, timing, frequency and perceived meaning of exposure while evaluating current intrusion, avoidance, negative alterations in mood and cognition, hyperarousal, dissociation, sleep disturbance, substance use and functional decline. Screening should occur within a psychologically safe interaction because shame, military conditioning and fear of occupational consequences may suppress disclosure. The PC-PTSD-5 offers a brief, acceptable method for identifying veterans who require fuller evaluation, but a positive result indicates probable risk rather than a definitive diagnosis (Prins *et al.*, 2016). Repeated assessment is essential because delayed disclosure and symptom fluctuation are common during stabilization and the early establishment of therapeutic trust.

When symptoms are endorsed, severity and impairment should be examined with validated instruments such as the PCL-5. Veteran research supports its reliability and diagnostic utility, yet score interpretation must remain clinically contextual. Acute distress, intoxication, withdrawal, pain, traumatic brain injury and severe insomnia can elevate overlapping symptoms. Nurses should therefore document examples of re-experiencing, avoidance, guilt, detachment, irritability and exaggerated threat perception, linking each symptom to duration, triggers and consequences rather than treating the total score as self-explanatory (Bovin *et al.*, 2016).

Diagnostic clarification may require a structured clinician-administered interview. The CAPS-5 systematically evaluates symptom frequency, intensity, trauma linkage and functional significance, enabling differentiation between transient stress reactions and sustained PTSD. Although specialist administration may fall outside routine nursing scope, nurses contribute essential longitudinal evidence through repeated mental-status examinations, behavioural observations, sleep records and collateral accounts. Inconsistency across interviews should prompt exploration of fluctuating arousal, memory fragmentation, avoidance or environmental mistrust rather than immediate assumptions of unreliability (Weathers *et al.*, 2018).

Cultural and linguistic validity is equally important. Work with Somali ex-combatants demonstrated that trauma screening instruments require adaptation to local idioms, conflict

histories and culturally meaningful expressions of distress. Literal translation alone may miss symptoms communicated through bodily complaints, spiritual explanations, social withdrawal or aggression. Nurses assessing African military populations should clarify terminology, use interpreters appropriately and distinguish culturally normative expressions from psychopathology, while preserving the core diagnostic domains needed for referral and treatment planning (Odenwald *et al.*, 2007).

Early recognition must also include presentations that are not initially described as psychological. Australian military research found that physical symptoms can contribute useful information when screening for PTSD, particularly because trauma-related distress may appear as headache, gastrointestinal discomfort, palpitations, musculoskeletal pain or persistent fatigue. Somatic complaints should neither be dismissed as "stress" nor investigated solely through a biomedical lens. Integrated assessment should examine physical causes, medication effects, blast exposure, sleep and symptom relationships to reminders or heightened arousal (Graham, Searle, Van Hooff, Lawrence-Wood & McFarlane, 2020).

Nigerian military experience further illustrates the need to assess moral injury alongside fear-based trauma symptoms. Combat-related guilt, shame, perceived betrayal and spiritual conflict may be concealed beneath anger, substance use, emotional withdrawal or disciplinary difficulty. These experiences are not interchangeable with PTSD, but they may intensify depression, anxiety and impaired functioning. Nurses should sensitively inquire about actions witnessed, undertaken or not prevented, without forcing disclosure or imposing judgement. Immediate assessment must also address suicidal risk, aggression, withdrawal complications, psychosis, access to support and capacity to participate in care, ensuring that early recognition leads to proportionate observation, specialist review and an individualized safety plan (Okulate, Akinsanmi, Oguntuase & Majebi, 2021).

Because acute units rely on repeated, nurse-administered assessment rather than a single specialist interview, the choice of instrument directly shapes what is detected. Table 2 summarises the validated trauma and anxiety tools discussed above alongside their nursing application, so that screening, severity-scoring, and diagnostic clarification are used at the correct point in the admission rather than interchangeably.

Table 2: Validated trauma and anxiety assessment tools relevant to military and veteran nursing care

Tool	Purpose	Nursing application
PC-PTSD-5 (Primary Care PTSD Screen for DSM-5)	Brief 5-item screen to identify patients who may need fuller trauma evaluation	Appropriate at admission and triage for rapid, repeatable screening; a positive result indicates probable risk rather than a definitive diagnosis (Prins <i>et al.</i> , 2016)
PCL-5 (PTSD Checklist for DSM-5)	20-item self-report measure of PTSD symptom severity across the four DSM-5 symptom clusters	Used once trauma symptoms are endorsed, to quantify severity and track change; scores should be interpreted alongside intoxication, withdrawal, pain, traumatic brain

CAPS-5 (Clinician- Administered PTSD Scale for DSM-5)	Structured clinician interview providing definitive diagnostic clarification	injury and insomnia, which can inflate results (Bovin <i>et al.</i> , 2016) Typically specialist-administered; nurses contribute longitudinal mental-status observations, sleep records and collateral history that inform its use (Weathers <i>et al.</i> , 2018)
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PC-PTSD-5, PCL-5 and CAPS-5 are discussed in section 3.1; interpretation should always account for acute intoxication, withdrawal, pain, traumatic brain injury and severe insomnia, which can elevate overlapping symptoms.

3.2 Stabilization and Symptom Management in Acute Behavioral Health Units

Stabilization in acute behavioral health units begins with rapid prioritisation of threats to life and physiological integrity. Military personnel and veterans may present with suicidal intent, severe anxiety, dissociation, intoxication, withdrawal, psychosis, aggression or medication interruption, often alongside pain and traumatic brain injury. Nigerian psychiatric emergency data demonstrate that suicidality, substance misuse and prior restraint are important markers of urgency, supporting structured triage that distinguishes immediate danger from needs suitable for planned review. Nursing assessment should establish vital signs, consciousness, recent substance use, access to lethal means, medication history, trauma triggers and capacity to engage in safety planning (Adeosun, Adegbohun, Jeje, Oyekunle & Omoniyi, 2014).

Once immediate danger is addressed, the ward environment should be regulated. Calm introductions, simple explanations, reduced noise, predictable routines and access to a quieter space can reduce hyperarousal and perceived threat. Nurses should avoid crowding, sudden touch and authoritative confrontation, particularly when combat memories or institutional mistrust are prominent. South African nurses' accounts of violence in acute psychiatric wards show that complex presentations, inadequate support and workforce pressures can undermine safe care. Effective stabilization therefore depends on experienced staffing, coordinated responses, post-incident support and clear escalation pathways (Bekelepi & Martin, 2022).

De-escalation should remain the first-line response to mounting agitation whenever circumstances permit. Staff and patient perspectives indicate that successful de-escalation depends on timely recognition, emotional self-regulation by staff, respectful communication, adequate space and organisational conditions that permit sustained engagement. Nurses should use a non-threatening posture, acknowledge distress, offer realistic choices, set concise boundaries and identify what would restore control. The intervention must be adapted continuously because repeated commands or formulaic reassurance may intensify perceived coercion (Price *et al.*, 2024).

Evidence linking greater use of verbal de-escalation with reduced mechanical restraint reinforces relational skill as a safety intervention. Medication, seclusion or restraint may become necessary when risk remains imminent, but they should not substitute for attempted communication. Where restrictive measures are used, nurses must monitor airway, circulation, consciousness, hydration, distress and adverse medication effects, while explaining the intervention and ending it at the earliest safe opportunity (Pérez-Toribio *et al.*, 2022).

Structured observation is essential for patients at risk of self-harm, violence, absconding or rapid deterioration. Observation should involve purposeful therapeutic contact rather than passive

surveillance. Reviews of constant observation suggest that team communication, staff education, documentation and patient involvement can improve quality and reduce unnecessary restriction. Observation levels should be reassessed after changes in behaviour, medication, withdrawal severity or environmental stress, with the rationale communicated clearly whenever possible (Reen, Bailey, Maughan & Vincent, 2020).

Sleep restoration is another core stabilization target because sleep loss worsens irritability, concentration, anxiety and trauma reactivity. Evidence from psychiatric inpatient settings supports multicomponent approaches, including environmental modification, daytime activity, reduced nocturnal disruption, sleep education and carefully selected behavioural interventions. Nurses should also assess nightmares, pain, caffeine, withdrawal and medication-related sedation before requesting additional hypnotic treatment (Aboaja *et al.*, 2024).

For PTSD and acute stress symptoms, management should combine supportive stabilization with evidence-based planning rather than compulsory trauma processing. Current veteran and military guidance emphasises shared decision-making, functional assessment and trauma-focused psychotherapy when the patient is clinically ready. Pharmacological treatment requires reconciliation, adherence assessment and monitoring for interactions, orthostatic effects, oversedation and behavioural change. Discharge preparation should begin early, linking symptom improvement to coping strategies, follow-up, substance-use care and a personalised crisis plan (Schnurr *et al.*, 2024).

3.3 Preventing Retraumatization and Managing Behavioral Escalation

Preventing retraumatization requires nurses to interpret agitation as a response to perceived danger, loss of control, shame, or traumatic recall rather than defiance. For military personnel and veterans, locked doors, abrupt commands, unexpected touch, invasive searches, crowding, authoritative postures may reproduce elements of combat, captivity, or institutional betrayal. Nigerian evidence shows that dismissive attitudes toward verbal de-escalation can weaken early relational intervention (Oyelade, Smith & Jarvis, 2017).

Early management should begin with individualized identification of triggers, warning signs, preferred calming strategies, and communication needs. Nurses should approach slowly, introduce themselves, explain procedures, maintain appropriate distance, and offer choices. Trauma-informed implementation is strongest when safety, trustworthiness, collaboration, empowerment, and cultural responsiveness are embedded across the organisation rather than left to individual goodwill (Goldstein *et al.*, 2024).

Behavioral escalation must be assessed dynamically. Changes in speech, pacing, vigilance, withdrawal, facial tension, or responsiveness may indicate rising arousal before aggression. South African ward evidence demonstrates that assaults and seclusion vary across clinical circumstances, reinforcing the need for repeated risk formulation, coordinated staffing, and attention to environmental stressors rather than reliance on diagnosis alone (Luckhoff *et al.*, 2013).

Relational ward models can reduce conflict without abandoning safety. The Safewards trial showed that structured interventions addressing staff–patient communication, mutual expectations, reassurance, and post-incident support reduced conflict and containment events. For veterans, such practices replace adversarial interactions with predictable, respectful engagement and may reduce escalation arising from hypervigilance or mistrust (Bowers *et al.*, 2015).

When verbal de-escalation is required, nurses should validate distress, use short statements, avoid argument, provide space, and frame boundaries positively. Education in structured verbal de-escalation can strengthen documentation and reduce reliance on seclusion, particularly when staff rehearse responses and coordinate their approach before crises occur (Haefner, Dunn & McFarland, 2021).

Restrictive interventions should remain last-resort measures for imminent danger. A multidisciplinary strategy combining violence-risk assessment, personalised behavioural planning, staff coaching, medication review, comfort spaces, sensory supports, and spiritual resources achieved substantial reductions in seclusion and restraint. Any restriction should be proportionate, continuously monitored, ended promptly, and followed by collaborative debriefing to identify triggers, repair trust, and revise the care plan (Mahgoub, Chang & Joseph-Rochea, 2024).

The nursing priorities described above for PTSD, anxiety, and behavioural escalation rarely operate in isolation from substance use in military and veteran populations, and this is where diagnostic categories, interventions, and interdisciplinary coordination must be considered together rather than as separate clinical tracks. Hyperarousal, sleep loss, agitation, and dissociation are core features of trauma presentations, but they are also cardinal signs of alcohol, benzodiazepine, and stimulant withdrawal, and self-medication with alcohol or sedatives is one of the most common pathways by which combat-related distress first presents to an acute unit. A patient admitted with apparent psychiatric agitation may therefore be simultaneously withdrawing, and a patient admitted for withdrawal may be concealing unresolved trauma that only becomes visible once detoxification is under way. The next section turns to substance intoxication and withdrawal on that basis: it addresses withdrawal assessment and medical stabilisation as a distinct diagnostic category with its own monitoring priorities, while returning explicitly, in section 4.3, to the interventions and coordination required when PTSD or anxiety and withdrawal are present at the same time.

4. Nursing Management of Substance Intoxication and Withdrawal

4.1 Assessment, Monitoring, and Medical Stabilization During Withdrawal

Assessment and stabilization during withdrawal in acute behavioral health units require simultaneous psychiatric, neurological, and medical surveillance. For military personnel and veterans, substance withdrawal may coexist with post-traumatic stress, panic, chronic pain, traumatic brain injury, prescribed sedative exposure, or suicidal crisis, making apparently routine symptoms diagnostically ambiguous. A complete admission history should establish the substances used, route, frequency, duration, last exposure, previous complicated withdrawal, seizure history, concurrent medications, medical comorbidity, and recent changes in sleep, nutrition, or hydration. It should also identify deployment-related pain treatment, self-medication after trauma, leave or discharge, and any interruption in prescribed therapy. West African evidence demonstrates substantial heterogeneity in alcohol, cannabis, opioid, and other drug use, supporting broad rather than substance-specific screening when histories are incomplete or disclosure is constrained by stigma (Emmanuel, Akinsolu, Abodunrin & Ezechi, 2024).

Polysubstance exposure is particularly important because withdrawal syndromes may overlap, mask one another, or emerge sequentially. Hospital data from Sierra Leone showed high levels of multiple-substance use among patients treated for substance-use disorders, with alcohol, cannabis, tramadol, and locally circulating synthetic mixtures frequently represented. This complexity

makes the timing of symptoms clinically significant, since one syndrome may intensify after another has begun to settle. In military or veteran admissions, nurses should therefore avoid assuming that the most visible substance is the only clinically relevant agent and should seek collateral information, prescription records, toxicology results, and evidence of non-prescribed medication use where appropriate (Eze *et al.*, 2024).

Table 3: Comparative clinical priorities during common withdrawal presentations

Withdrawal presentation	Early manifestations requiring recognition	Major deterioration risks	Core nursing-monitoring priorities
Alcohol	Tremor, anxiety, sweating, nausea, insomnia and agitation	Seizures, delirium and autonomic instability	Mental status, vital signs, hydration, orientation and seizure precautions
Opioids	Restlessness, pain, gastrointestinal distress, lacrimation and anxiety	Dehydration, interrupted treatment and overdose risk following reduced tolerance	Withdrawal severity, fluid balance, pain, respiratory status and engagement
Benzodiazepines	Rebound anxiety, insomnia, tremor and perceptual disturbance	Seizures, delirium, falls and severe agitation	Medication history, neurological status, cognition and seizure risk
Stimulants	Fatigue, dysphoria, sleep disruption and irritability	Severe depression, suicidality and psychosis	Mood, suicide risk, sleep, nutrition and psychotic symptoms
Polysubstance exposure	Mixed, atypical or fluctuating manifestations	Unpredictable progression and medication interactions	Repeated whole-person assessment and multidisciplinary escalation

Source: synthesised from the studies cited in section 4.1.

Alcohol withdrawal demands structured severity assessment, but numerical scores must be interpreted alongside clinical observation. Network analysis indicates that tremor, anxiety, agitation, sweating, and related symptoms occupy differing positions within the withdrawal syndrome, reinforcing the need to track symptom patterns rather than relying on one isolated complaint. Orientation, attention, perceptual disturbance, gait, and the quality of sleep should be documented alongside autonomic findings. Nurses should repeat assessments after environmental changes, medication administration, sleep, or worsening confusion, while recognising that PTSD hyperarousal can inflate apparent withdrawal severity (Shen *et al.*, 2024).

Medical stabilization includes correction of dehydration, nutritional deficits, electrolyte disturbance, hypoglycaemia, fever, injury, and other conditions that may mimic or aggravate withdrawal. Contemporary emergency guidance emphasises early identification of patients at risk of complicated alcohol withdrawal, close reassessment, and escalation when consciousness, autonomic function, hallucinations, or seizure risk deteriorate. Continuous observation may be required when confusion, falls risk, severe agitation, or unreliable self-report prevents safe

intermittent review. In acute psychiatric settings, physical monitoring must not be reduced simply because behavioural symptoms dominate the presentation (Gottlieb, Chien & Long, 2024).

Opioid withdrawal is rarely fatal in isolation, but undertreatment can produce severe distress, premature discharge, disrupted psychiatric care, and rapid return to use. Hospital guideline development in the United Kingdom highlights the importance of timely assessment, patient-centred communication, continuity of opioid-dependence treatment, and avoidance of punitive responses. Monitoring should include hydration, gastrointestinal loss, pain, sleep, respiratory status, and willingness to remain in care. For veterans, concurrent pain and distrust of services may complicate engagement; therefore, nurses should document pain objectively, distinguish withdrawal distress from medication-seeking stereotypes, and coordinate addiction and psychiatric review (Wickremsinhe *et al.*, 2024).

Initiating opioid treatment also requires vigilance for precipitated withdrawal, particularly where potent synthetic opioids may be involved. A 2024 hospital cohort found that a minority of patients developed precipitated withdrawal after buprenorphine initiation, demonstrating that observable worsening must be differentiated from expected symptom fluctuation. Abrupt escalation in distress, autonomic symptoms, pain, or agitation should prompt medical reassessment rather than blame or coercion. Nursing responsibilities include baseline assessment, repeated severity measurement, observation for abrupt deterioration, and immediate medical escalation rather than independently altering treatment (Thakrar *et al.*, 2024).

Benzodiazepine withdrawal requires especially cautious history-taking because prescribed use may be minimised or omitted. Abrupt reduction can produce severe anxiety, perceptual disturbance, delirium, or seizures, and individualized tapering frequently requires specialist oversight. Evidence from a bridge-clinic model underscores the value of structured assessment, staged follow-up, toxicology where clinically indicated, and linkage to continuing care. Particular attention is required when alcohol, opioids, anticonvulsants, or other sedating medicines are also involved. In acute units, nurses should maintain seizure and falls precautions, monitor cognition and sleep, reconcile all sedative prescriptions, and ensure that stabilization transitions into a documented, supervised treatment plan (Laks *et al.*, 2024).

As with trauma and anxiety, withdrawal monitoring in acute units depends on repeated, structured observation rather than a single assessment. Table 4 summarises the validated withdrawal-monitoring tools referenced above, so that severity scoring can be matched to the substance involved and repeated at a clinically meaningful interval rather than left to unstructured impression.

Table 4: Validated withdrawal-monitoring tools relevant to military and veteran nursing care

Tool	Substance focus	Nursing application
CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol, revised)	Alcohol	Structured severity scoring of tremor, sweating, anxiety, agitation and perceptual disturbance; scores should be read alongside orientation, gait and sleep quality rather than in isolation (Shen <i>et al.</i> , 2024; Gottlieb, Chien & Long, 2024)

COWS (Clinical Opiate Withdrawal Scale)	Opioids	Severity scoring of restlessness, gastrointestinal symptoms, pain and autonomic signs; supports differentiation of expected withdrawal from precipitated withdrawal after buprenorphine induction (Wickremsinhe <i>et al.</i> , 2024; Thakrar <i>et al.</i> , 2024)
CIWA-B (Clinical Institute Withdrawal Assessment for Benzodiazepines)	Benzodiazepines	Structured monitoring of rebound anxiety, tremor, perceptual disturbance and seizure risk during individualized tapering (Laks <i>et al.</i> , 2024)

These tools complement, but do not replace, continuous medical surveillance for autonomic instability, seizure risk and dehydration.

4.2 Pharmacological Support, Safety, and Relapse Prevention

Pharmacological support in acute behavioral health units should begin only after withdrawal severity, recent substance exposure, medical comorbidity, concurrent medicines, and overdose risk have been established. Medication administration must be accompanied by repeated assessment of consciousness, respiratory status, autonomic instability, hydration, falls risk, and behavioural change. For alcohol dependence, evidence supports individualized use of relapse-prevention medicines while emphasizing treatment duration, adverse-effect surveillance, and alignment with the patient's goals rather than automatic prescribing (Kotake *et al.*, 2024).

Among veterans with alcohol use disorder, extended-release naltrexone may strengthen continuity where adherence is difficult, but nurses must verify opioid abstinence, review hepatic risk, explain expected effects, and monitor engagement after discharge. Real-world Veterans Affairs data further indicate that medication initiation should be integrated with ongoing follow-up rather than treated as a self-contained intervention (Grebala *et al.*, 2024).

For opioid use disorder, buprenorphine and extended-release naltrexone require individualized selection because prior opioid exposure, withdrawal status, treatment preference, and relapse vulnerability influence effectiveness. Nursing responsibilities include observing induction, identifying precipitated withdrawal, supporting adherence, and communicating deterioration promptly to prescribers (Afshar *et al.*, 2024).

Overdose prevention is inseparable from relapse prevention. Veterans leaving structured care may have reduced tolerance and elevated risk; therefore, naloxone education, documented access, recognition of respiratory depression, and involvement of supports should form part of discharge preparation (Alexander, Hooker, Stratton, Huh & Houck, 2024).

Relapse prevention must also address psychological readiness. An Egyptian randomized trial showed that a nurse-led mindfulness-based programme improved readiness for change and self-efficacy, supporting structured coping practice alongside medication and follow-up planning (Abdelaal & El-Ashry, 2024).

Cultural context remains essential. Nigerian accounts of negotiated abstinence and moderation demonstrate that social expectations can either reinforce or undermine behaviour change. Nurses

should therefore identify drinking cues, peer pressures, family resources, and realistic recovery goals before finalizing the relapse-prevention plan (Dumbili & Uwa-Robinson, 2024).

4.3 An Integrated Protocol for Co-Occurring PTSD/Anxiety and Substance Withdrawal

Sections 3 and 4 have so far presented trauma-related and withdrawal-related nursing care as distinct clinical categories, each with its own assessment tools and monitoring priorities. In practice, acute behavioral health units cannot rely on that separation, because a single military or veteran admission frequently requires both sets of observations to run in parallel from the point of triage. Building directly on the evidence synthesised above, Table 5 sets out a staged nursing protocol for the co-occurring presentation, intended as a practical bridge between the diagnostic categories discussed separately in this review rather than as a replacement for local clinical guidelines or medical direction.

The protocol rests on four principles drawn from the preceding sections. First, dual scoring from admission: because hyperarousal, insomnia, and autonomic symptoms are common to both trauma and withdrawal states, nurses should apply a trauma screen (PC-PTSD-5) and a substance-specific withdrawal scale (for example CIWA-Ar or COWS) at the same assessment rather than sequentially, so that neither presentation is attributed entirely to the other by default. Second, medical safety takes precedence over diagnostic clarification: seizure risk, autonomic instability, and dehydration must be stabilised before nurses attempt to distinguish trauma-driven arousal from withdrawal progression, consistent with guidance that physical monitoring should not be reduced simply because behavioural symptoms dominate the presentation (Gottlieb, Chien & Long, 2024). Third, reassessment is triggered by change rather than by a fixed schedule alone, since a new spike in agitation, autonomic signs, or dissociation after environmental change, medication, or sleep should prompt a repeat of both instruments rather than an assumption that the initial formulation still holds (Shen *et al.*, 2024). Fourth, the care plan documents both diagnostic possibilities explicitly until one is excluded, so that handover, family communication, and discharge planning do not default to a single label prematurely.

Table 5: A staged nursing protocol for co-occurring PTSD/anxiety and substance withdrawal in acute care

Stage	Nursing actions	Key safety checks
1. Admission and triage	Apply a trauma or anxiety screen (e.g., PC-PTSD-5) and a substance-specific withdrawal scale (e.g., CIWA-Ar or COWS) together; take a full substance history including last use, prior complicated withdrawal and seizure history	Vital signs, level of consciousness, seizure risk, access to lethal means
2. First 24 hours	Prioritise medical stabilisation (hydration, electrolytes, nutrition) alongside a calm, predictable ward environment; document both possible formulations (trauma-driven arousal and withdrawal) rather than selecting one	Autonomic instability, dehydration, falls risk, suicide and violence risk
3. Ongoing monitoring	Repeat both instruments after any environmental change, medication	Trend vital signs and withdrawal scores together; watch for

	administration, sleep disruption, or new agitation; avoid assuming a single cause for recurring symptoms	precipitated withdrawal after agonist/antagonist medication
4. Differentiation and stabilisation	As withdrawal settles, reassess trauma symptoms that may become more visible; adjust observation level and de-escalation approach accordingly	Reassess capacity and engagement as sedation or intoxication resolves
5. Step-down and discharge planning	Reconcile medications, confirm a named receiving clinician, document triggers identified during admission, and involve family or peer support with consent	Relapse-prevention plan, naloxone or overdose education where relevant, crisis contact information

This protocol synthesises the evidence discussed in sections 3 and 4; it is intended as a practical bridge between diagnostic categories, not a substitute for local clinical guidelines or medical direction.

Applied consistently, this protocol is intended to reduce two recurring risks identified elsewhere in this review: withdrawal being missed or undertreated because presentation is read only as psychiatric agitation, and trauma symptoms being dismissed as "just withdrawal" once detoxification is under way. Both errors delay appropriate care and, in a population already inclined to distrust institutional intervention, can further damage engagement and therapeutic trust.

5. Integrated Care, Recovery, and Service Improvement

5.1 Interdisciplinary Collaboration and Continuity of Care

Interdisciplinary collaboration in acute behavioral health units begins at admission and continues beyond discharge. Psychiatric nurses coordinate risk assessment, withdrawal surveillance, medication reconciliation, trauma-informed communication, and referrals across psychiatry, medicine, psychology, pharmacy, social work, addiction services, peer support, and community agencies. Nigerian evidence shows that training, task-sharing, supervision, and referral pathways can expand mental-health access where specialist capacity is limited (Iheanacho, Chu, Aguocha, Nwefoh & Dike, 2024).

Continuity depends on shared information and assigned responsibility. Ethiopian evidence indicates that integrated care is strengthened by protocols, reliable medication systems, supportive supervision, and collaboration between mental-health and general-health teams. In veteran care, these elements reduce fragmentation when PTSD, anxiety, pain, substance withdrawal, and physical comorbidities require simultaneous management (Bekele *et al.*, 2024).

South African service-user evidence shows that colocated community psychiatry can improve relational and management continuity, although gaps persist when patients encounter changing professionals or poorly coordinated referrals. Discharge summaries should communicate trauma triggers, suicide risk, medication changes, withdrawal status, safeguarding concerns, and follow-up arrangements (Abdulla, Robertson, Kramer & Goudge, 2024).

For stabilized veterans, movement from specialist mental-health services to primary care should be collaborative rather than abrupt. The Veterans Affairs FLOW programme demonstrated that structured transition processes can be implemented across sites and that shared decision-making supports confidence during transfer (Hundt *et al.*, 2024).

Workforce availability is consequential. Greater mental-health staffing capacity can accelerate initiation of care among recently separated veterans, emphasizing that continuity requires adequate nurses, prescribers, care coordinators, and administrative support rather than referral alone (Shafer *et al.*, 2024).

Australian reintegration research illustrates the value of coordinated, veteran-informed programmes delivered by psychologists, mental-health nurses, social workers, and occupational therapists. Linking inpatient stabilization with culturally responsive outpatient support can preserve therapeutic gains, rebuild purpose and social connection, and reduce disengagement after military-to-civilian transition (Romaniuk, Saunders-Dow, Brown & Batterham, 2024).

5.2 Discharge Planning and Family Engagement

Discharge planning for veterans should begin at admission and evolve with changes in risk, withdrawal status, medication response, housing, family circumstances and readiness for follow-up. A plan specifies diagnoses, medicines, warning signs, crisis contacts, appointments and responsibility for each handover. Nigerian-led evidence on psychiatric transition emphasises early outpatient linkage, medication reconciliation, communication and attention to social barriers disrupting engagement after hospitalisation (Ojo *et al.*, 2024).

Family engagement should be collaborative, consent-based and sensitive to military identity. Relatives may provide information about sleep, substance use, trauma triggers, access to lethal means, medication adherence and behavioural change, while requiring education about boundaries, relapse indicators and emergency responses. South African nursing evidence indicates that family participation is therapeutically valuable but often insufficient because of poor contact, preparation and organisational barriers (Mabunda, 2024).

For veterans, discharge must address movement between military, veteran and civilian systems. Service access is shaped by stigma, practical obstacles, trust, provider understanding and family knowledge of available pathways. A rapid review found that veterans and families encounter multilevel barriers, supporting navigation assistance, peer involvement, culturally competent services and flexible delivery after discharge (Ein *et al.*, 2024).

Continuity is strengthened when the receiving clinician or service is identified before discharge and information transfer is direct rather than assumed. Evidence from psychiatric emergency care shows that follow-up attendance improves when relational continuity is preserved, suggesting that warm handovers and early contact may outperform generic referral instructions (Wong *et al.*, 2024).

Families should not be treated only as crisis resources. Military deployment and reintegration affect couple roles, parenting, communication and psychological adjustment across the household. Evidence remains concentrated in North American settings and reactive interventions, creating a need for preventive, culturally diverse and longitudinal family programmes across deployment and post-service phases (Ohlsson, Nilsson & Larsson, 2024).

Even well-designed discharge and follow-up services depend on veterans recognising and trusting them enough to engage. Veteran perspectives on outreach indicate that resources may exist without being recognised or trusted, so navigation assistance and warm handovers are only as effective as

the credibility of the service they lead into (Rattray *et al.*, 2024). This gap between service availability and veteran uptake is taken up directly as a research priority in section 6.3.

6. RECOMMENDATIONS FOR PRACTICE, POLICY, AND FUTURE RESEARCH

The evidence synthesised in this review points to specific, actionable recommendations. They are presented here as the authors' own recommendations, arising from the review as a whole rather than from any single cited study, and are organised by audience so that clinicians, service leaders, and researchers can identify the actions most relevant to their role.

6.1 Recommendations for Clinical Practice

Acute behavioral health nurses should receive structured, recurring education in military and veteran culture, trauma-informed communication, and de-escalation, rather than a single induction session, so that competence is refreshed as staff rotate through the unit. Units should adopt a standard, dual-track assessment routine at admission that pairs a validated trauma or anxiety screen with a substance-withdrawal severity scale, of the kind set out in Tables 2, 4 and 5 of this review, so that co-occurring presentations are identified by protocol rather than by individual clinical judgement alone. Observation, medication administration, and restrictive interventions should be documented against an explicit least-restrictive-option rationale, and every restrictive intervention should be followed by a structured, collaborative debrief with the patient. Discharge planning should begin at admission, with a named receiving clinician, medication reconciliation, a written relapse-prevention and crisis plan, and confirmed family or peer-support involvement wherever the patient consents to it.

6.2 Recommendations for Policy and Service Organisation

Health services and governing bodies should fund dedicated, specialist military-mental-health education for nursing staff in both military and civilian acute settings, since veterans increasingly present outside dedicated military facilities. Services should adopt standardised, locally adapted trauma and withdrawal protocols rather than leaving assessment tool selection to individual practitioner preference, and should staff acute units to a level that allows the structured observation and repeated reassessment this review identifies as essential, rather than staffing to bed occupancy alone. Confidentiality and involuntary-treatment procedures specific to military and veteran patients, including command-notification boundaries and independent review rights, should be written into local policy and audited, not left to individual nurse discretion. Post-discharge follow-up systems, including warm handover to a named receiving service, should be resourced as a distinct service-delivery requirement, since this review found continuity of care to be one of the most consistently under-resourced elements of the care pathway.

6.3 Recommendations for Future Research

Future studies should evaluate nurse-led discharge and transition models, integrated PTSD-and-substance-use care pathways, and the staged co-occurring-presentation protocol proposed in section 4.3, using outcomes that matter to patients and services alike, including readmission, relapse, treatment retention, family wellbeing, and patient-reported recovery. Culturally adapted family interventions and digital or peer-delivered follow-up support warrant testing beyond the North American and European settings where most current evidence originates, including within African, Asian, and other under-represented military health systems. Research should also test the confidentiality, stigma-reduction, and involuntary-treatment safeguards described in section 2.4

directly, since their effectiveness is currently inferred from adjacent evidence rather than demonstrated in military and veteran acute-care populations specifically.

Conclusion

This review examined the distinctive responsibilities of mental health nurses caring for military personnel and veterans experiencing post-traumatic stress disorder, anxiety disorders, behavioral escalation, and substance withdrawal in acute behavioral health settings. Its aims were met by integrating evidence on military culture, trauma exposure, psychiatric comorbidity, ethical practice, crisis stabilization, withdrawal management, interdisciplinary coordination, and continuity of care. The findings demonstrate that effective nursing practice depends on recognizing that military-related distress is rarely confined to a single diagnosis. PTSD commonly intersects with anxiety, depression, insomnia, chronic pain, traumatic brain injury, moral injury, and substance misuse, creating complex presentations that demand repeated, multidimensional assessment, most practically supported through the dual-track assessment approach and staged protocol set out in sections 3 and 4.

The review further established that acute units must function as both safety-critical and therapeutically restorative environments. Trauma-informed, recovery-oriented, and veteran-centred care reduces the risk of retraumatization by prioritizing dignity, trust, collaboration, cultural responsiveness, and the least restrictive interventions. Skilled de-escalation, structured observation, medication monitoring, withdrawal assessment, sleep support, and individualized safety planning emerged as central nursing responsibilities. Equally, ethical and legal obligations require careful assessment of decision-making capacity, transparent, narrowly scoped confidentiality practice, procedurally safeguarded involuntary treatment, active stigma reduction, and meaningful patient participation wherever possible; section 2.4 sets out what these obligations require in concrete nursing terms rather than as general principle alone.

The analysis also showed that stabilization alone is insufficient. Sustainable recovery depends on early discharge planning, family engagement, medication reconciliation, relapse-prevention education, peer and community support, and direct coordination between military, veteran, civilian, addiction, and primary-care services. These priorities are especially important in resource-constrained systems, where fragmented services, workforce shortages, stigma, and limited veteran-specific programmes can magnify preventable deterioration and relapse after discharge. For practice, this means treating trauma and withdrawal assessment as routinely paired rather than sequential; for policy, it means funding specialist education, staffing, and follow-up systems as named service requirements rather than assuming they follow automatically from general psychiatric provision; and for research, it means testing the specific tools, protocols, and safeguards this review has proposed in the military and veteran populations they are intended to serve. Section 6 sets out these implications as concrete recommendations. Overall, high-quality care for this population requires clinically competent, ethically grounded, culturally informed, and continuously coordinated nursing practice, sustained by services and policy that treat these requirements as core to acute behavioral health provision rather than as an adjunct to it.

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