

RESEARCH ARTICLE

The Vermont Research Trial Protocol: A Mixed-Methods Study of Group EMDR Integrated with Compassion-Focused Therapy for PTSD, Complex PTSD, and Moral Injury in First Responders and Law Enforcement Officers

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First responders experience disproportionately high rates of posttraumatic stress disorder, complex posttraumatic stress disorder, and moral injury. Standard trauma-focused treatments inadequately address the shame, guilt, and existential distress characteristic of moral injury, while occupational cultures of stoicism create marked barriers to help-seeking. This mixed-methods feasibility study evaluates an intensive group intervention integrating eye movement desensitization and reprocessing, delivered via the Acute Stress Adaptive Protocol, with compassion-focused therapy for first responders and law enforcement officers, including frontline healthcare workers. Three cohorts are recruited through the Vermont Centre for Responder Wellness. Acute Stress Adaptive Protocol's trauma processing sequence provides a mechanistic bridge to compassion-focused-therapy-derived compassionate mind training components targeting shame, self-criticism, and moral-emotional distress. A within-culture peer-to-peer delivery model uses trained peer supporters as active therapeutic agents alongside accredited clinicians. Validated outcome measures are administered at baseline, postintervention, and at 1-, 3-, and 6-month follow-ups, with quantitative data analyzed using linear mixed models with full information maximum likelihood estimation. The study will establish feasibility parameters, recruitment and retention rates, safety signals, fidelity data, and preliminary effect sizes to inform a future definitive randomized controlled trial and will assess the scalability and cultural fit of peer-delivered, integrated trauma care in occupational settings.

Introduction to the Research

The psychological effects of trauma exposure, including life-threatening situations, human suffering, and morally challenging situations among law enforcement officers, first responders, military veterans, and other high-risk occupational groups, remain a vital area of focus in global mental health research. As a result, these groups face higher rates of posttraumatic stress disorder (PTSD), complex PTSD (CPTSD), depression, anxiety, substance misuse, and other forms of related functional impairments. In recent years, more attention has also been given to moral injury, a form of psychological distress caused by perceived violations

of deeply held moral or ethical beliefs, often involving guilt, shame, betrayal, or existential disorientation [1–11]. Although overlapping with PTSD, moral injury is increasingly recognized as a somewhat distinct concept with marked implications for treatment development [11–14]. Linden and Arnold [15] further emphasize the need to distinguish moral injury from related constructs such as posttraumatic embitterment disorder (PTED), underscoring the importance of timely intervention before acute moral distress becomes entrenched.

International clinical guidelines recommend trauma-focused psychological therapies—principally trauma-focused cognitive behavioral therapies and eye movement desensitization and

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reprocessing (EMDR), as first-line treatments for PTSD [16–22]. Prolonged exposure, cognitive processing therapy, cognitive therapy for PTSD, and narrative exposure therapy are well supported and widely endorsed [23–29]. However, despite their effectiveness for standard fear/threat-based PTSD presentations, these interventions may not fully address the moral, relational, and existential dimensions of trauma characteristic of moral injury. Moral injury is fundamentally characterized by shame, self-condemnation, loss of moral identity, and disrupted trust and belonging—processes that may require therapeutic aims beyond fear extinction or habituation alone [30,31]. While some adaptations of cognitive processing therapy and PTSD and complex PTSD are beginning to incorporate moral emotions, a substantial gap remains in capturing the disruptions in subjective meaning-making and transgressive experiences central to moral injury [12,32]. The past decade has seen exponential growth in moral injury research [33], yet empirically evaluated, integrated treatment models capable of addressing both traumatic memory processing and the moral–emotional consequences of morally injurious events remain limited.

Trauma and moral injury are not solely private, internal struggles; they are deeply social and relational experiences, influenced by the cultures we live in and often mended through relationships. Herman [34] observed that trauma

“overwhelms the ordinary systems of care that give people a sense of control, connection, and meaning”.

When those systems collapse, the effects fracture not only the survivor's inner world but also the social fabric connecting them to community and shared moral values. Moral injury shares this relational and moral texture; it captures the anguish that arises when people witness, participate in, or are powerless to prevent actions that violate their deepest moral beliefs, experiences inseparable from the social and ethical worlds that define accountability and wrongdoing [34,35]. Both trauma and moral injury, therefore, call for responses that reach beyond the individual mind—approaches that restore connection, rebuild trust, and engage the social, cultural, and moral dimensions of suffering and healing. In high-risk occupational groups, this relational dimension is especially salient. Organizational and cultural factors in policing and emergency services—stoicism, stigma surrounding mental health, fear of professional reprisal, and the additional moral burden of postincident investigations perceived as unjust—may intensify internalization of moral distress, compound psychological isolation, and create marked barriers to help-seeking [36–38]. Moral injury in these professions is not only a personal concern but a system-level issue, with implications for burnout, compassion fatigue, workforce retention, substance misuse, suicidality, and public trust [8,39,40]. Neurobiologically, moral injury and PTSD involve overlapping yet distinct neural circuits, particularly in the medial prefrontal cortex, insula, and limbic regions associated with self-referential thinking, emotion regulation, and social cognition, reinforcing cycles of moral disconnection and psychological isolation when left unaddressed [30,32,36,41,42].

Because moral injury is fundamentally relational, interventions that leverage group and community processes are particularly well suited to its treatment. As Yalom and Leszczv [43] observed, therapeutic factors such as universality, cohesion, and mutual aid are best harnessed in groups; for first responders whose injuries often occur within tightly knit occupational communities, the group dynamic provides a powerful setting for repairing ruptures in trust, normalizing distress, and facilitating moral repair [1,12,44,45].

Meta-analytic evidence confirms that group psychotherapy for PTSD produces meaningful symptom reductions comparable to other active interventions [46], and randomized trials demonstrate that group-based trauma-focused interventions, including group cognitive processing therapy delivered to active-duty military personnel and community-delivered group cognitive processing therapy by trained paraprofessionals in conflict-affected settings, can achieve large, sustained improvements in PTSD symptoms and functioning [47–49]. A systematic review of group EMDR protocols (e.g., Integrative Group Treatment Protocol and Group Traumatic Episode Protocol) documents improvements in PTSD, depression, and anxiety across humanitarian, disaster, and occupational contexts, supporting group EMDR as a practical, scalable option within stepped care systems [50–54]. Critically, however, a randomized controlled trial examining group EMDR for front-line and emergency workers during the COVID-19 pandemic demonstrated marked reductions in PTSD and CPTSD symptoms but did not produce marked reductions in moral injury scores, highlighting that fear/threat-based trauma protocols, while effective for intrusive and arousal symptoms, may be insufficient to address the guilt, shame, betrayal, and spiritual repair dimensions of moral injury [51]. As Zeleke et al. [55] highlights:

“In general, addressing trauma and fostering healing and resilience begin with understanding idioms of distress through the community's narrative, shaped by lived experiences. Interventions and research need to focus on the community as a source of healing and resilience, promote community-based and collaborative efforts, and address psychological factors at the individual and community levels”. (page 3)

Healing begins with understanding the idioms of distress through community narratives and with interventions that promote community-based, collaborative efforts to address psychological factors at both the individual and community levels. Law enforcement, first responders, and emergency workers sustain moral wounds within operational communities; recovery is therefore optimized when it takes place in a similarly communal environment. [54,56–58].

EMDR therapy is a trauma-focused intervention grounded in the Adaptive Information Processing (AIP) model, which proposes that psychological symptoms arise when distressing experiences remain insufficiently processed and are stored in memory networks alongside their original emotional, cognitive, and somatic components [59–62]. EMDR is endorsed by the World Health Organization (WHO) [20,21], Department of Veterans Affairs and Department of Defense [18], International Society for Traumatic Stress Studies [24], United Nations High Commissioner for Refugees [63], and Deutschsprachige Gesellschaft für Psychotraumatologie [16], with research consistently demonstrating its effectiveness for PTSD, often yielding more rapid results than traditional talk therapies [22,26,64–66]. Group EMDR adapts standard EMDR principles for simultaneous delivery to multiple individuals, making it scalable for populations, such as disaster survivors or emergency service personnel, where access to individual therapy is limited [51,54,67–69]. The Acute Stress Adaptive Protocol (ASAP) is an EMDR-based early group intervention designed for high-risk occupational groups. Grounded in AIP, ASAP targets the critical early window when traumatic memories are being consolidated, aiming to prevent acute stress reactions from escalating into chronic PTSD. Operationally, it is concise, deployable within 72 h following critical incidents,

delivered in peer support or field settings without requiring full narrative disclosure, and adaptable to police, fire, and emergency medical service cultural contexts. Pilot programs, including those with the Police Service of Northern Ireland and Vermont Centre for Responder Wellness, have demonstrated substantial reductions in intrusive symptoms, hyperarousal, and emotional distress [51,70]. While group EMDR and ASAP have consistently demonstrated effectiveness in reducing PTSD-related symptomatology, evidence reviewed above suggests that these outcomes may not fully encompass the broader moral, emotional, and interpersonal sequelae associated with moral injury. Consequently, complementary therapeutic components targeting shame, self-criticism, and moral-emotional functioning may enhance treatment for individuals presenting with marked moral injury.

Compassion-focused therapy (CFT), developed by Gilbert [71,72], is a transdiagnostic psychotherapeutic approach grounded in evolutionary psychology, affective neuroscience, attachment theory, and cognitive behavioral principles. At its core is the tripartite model of emotion regulation: the threat system (fear, anxiety, and anger), the drive system (achievement and resource-seeking), and the soothing system (affiliation, safety, and contentment) [72]. Individuals with high levels of shame or self-criticism, common in trauma and moral injury, often exhibit an overactive threat system alongside an underdeveloped soothing system. CFT aims to rebalance these through compassion-focused practices, including rhythmic breathing, mindfulness, compassionate imagery, and compassionate letter writing, fostering development of what Gilbert terms the “compassionate self”, a secure, emotionally regulated self-state characterized by strength, wisdom, and warmth [73,74]. These qualities are cultivated toward both self and others, a process of particular importance when core distress stems from perceived moral transgressions, failures, or betrayals [1,75,76]. CFT psychoeducation also supports understanding of how trauma is encoded in memory, fragmented, somatic, and intrusive, helping individuals make sense of their internal experience with reduced shame and greater self-compassion [77]. In trauma-focused interventions, CFT is increasingly used to address shame-based and moral-emotional injury, with emerging evidence suggesting that compassion-based interventions may be particularly effective for populations with high levels of guilt, shame, and moral distress, including military and emergency service personnel [77–79]. Combining CFT with trauma-focused therapies has therefore been proposed as a promising mechanism-consistent approach to addressing both traumatic memory processing and moral-emotional injury [9,77].

Intensive trauma treatment, the delivery of evidence-based interventions within a condensed time frame, has gained increasing attention within trauma services and is especially suited to occupational populations for whom prolonged weekly therapy may be impractical or inaccessible [52,80–82]. Intensive formats allow deeper therapeutic immersion without prolonged gaps between sessions, enhancing emotional regulation and the desensitization of traumatic material. Research shows that intensive trauma therapies, including EMDR and prolonged exposure, conducted over a few days, are as effective, if not more so, than standard treatment methods, with notable improvements in PTSD and overall well-being [62,80,81,83–85]. Alongside clinical considerations, there is growing recognition of the need for scalable and adaptable trauma interventions capable of addressing the gap between the scale of trauma exposure in global conflict, domestic disasters, and high-risk service professions and the finite capacity of professional mental health systems [52]. Trauma task shifting,

the structured delegation of selected trauma care responsibilities to trained paraprofessionals or allied personnel, has been identified by the WHO [86] as a sustainable strategy to address workforce shortages, particularly in underresourced or overstretched systems. In high-risk occupational groups, task shifting enables the redistribution of trauma-informed practices to individuals with close occupational experience, peer support officers, chaplains, and veteran outreach workers who can provide low-intensity psychosocial support or early intervention in informal or semiformal settings [51,52]. Crucially, this “within-culture” model, in which trauma support is delivered by individuals who share occupational language, norms, and epistemologies, reduces stigma, enhances perceived legitimacy, and promotes psychological safety [9,87–90]. Trauma narratives are more openly shared, and interventions are more effectively received when delivered within a context of shared occupational experience and trust [9,91]. Strategic task shifting based on evidence-supported frameworks such as AIP-informed psychological first aid and low-intensity EMDR therefore provides a scalable, ethical, and culturally sensitive solution, not a substitution for specialist care but a rational, tiered enhancement of the trauma service ecosystem [62,92–98].

Despite advances in trauma treatment, several critical gaps remain in the literature. First, there is limited empirical evaluation of integrated interventions specifically designed to address both PTSD and moral injury within a single treatment protocol. Second, although group-delivered EMDR shows promise for reducing PTSD symptoms, its effect on moral-injury-related outcomes, shame, guilt, betrayal, and spiritual distress has not been sufficiently investigated. Third, there is a lack of research examining intensive, group-based interventions that combine trauma-focused and compassion-focused therapeutic components in high-risk occupational populations. Fourth, the potential of trauma task shifting within such integrated models has not yet been rigorously evaluated for safety, feasibility, and clinical outcomes [4,5,12,44,99].

The present study aims to address these gaps by evaluating an integrated, group-based intervention combining EMDR therapy with compassion-focused therapeutic components, delivered in an intensive format. The intervention, grounded in AIP, CFT, and within-culture task-shifting principles, is designed to target both traumatic memory processing and moral-emotional distress, while being sensitive to the cultural and organizational contexts of high-risk occupational groups. The primary objective is to examine the feasibility, safety, and preliminary clinical effectiveness of this integrated approach in reducing PTSD symptoms and moral-injury-related distress among law enforcement, first responders, and military veterans. Secondary objectives include assessing changes in depression, anxiety, shame, self-compassion, and functional impairment, as well as treatment acceptability, retention, and the role of paraprofessional delivery within the intervention model. By systematically evaluating this integrated, group-based approach, this study aims to contribute to the development of comprehensive and scalable treatment models for trauma-exposed occupational populations, informing future controlled trials and implementation research.

Methodology

Study aims and research questions

The primary aim of this study is to assess the feasibility, acceptability, and initial clinical effectiveness of an integrated, intensive, group-based intervention combining EMDR therapy with CFT for law enforcement officers and frontline first responders

experiencing PTSD, CPTSD, and/or moral injury. This proof-of-concept study will establish the parameters, including recruitment rates, retention, safety signals, and initial effect size estimates, needed to design and power a subsequent large-scale randomized controlled trial (RCT). The study is conducted in collaboration with the Vermont Centre for Responder Wellness, Colchester, VT, USA, a specialized mental health facility dedicated to supporting the psychological well-being of first responders across the state.

The primary research question is as follows: Is it feasible and acceptable to deliver an integrated intensive group EMDR–CFT intervention to law enforcement and first responders experiencing PTSD, CPTSD, and/or moral injury?

Secondary research questions are as follows:

1. What are the recruitment, retention, and intervention completion rates for an intensive group EMDR–CFT program among first responders with occupational trauma?
2. What preliminary safety signals—adverse events, symptom exacerbation, and dropout due to distress—emerge during delivery of intensive group EMDR–CFT?
3. What are participants' experiences of the acceptability, cultural appropriateness, and therapeutic benefits of the integrated intervention?
4. What preliminary effect size estimates are observed for PTSD, CPTSD, moral injury, depression, anxiety, shame, and quality of life outcomes from pre- to postintervention and at follow-up?
5. What implementation barriers and facilitators influence delivery fidelity, participant engagement, and the scalability of the task-shifting model using paraprofessionals and peer supporters?

Research study trial design

The study uses a mixed-methods research design [100] within a longitudinal framework. Quantitative measures will capture psychometric data (symptom severity, functional outcomes, and treatment adherence) over 12 months, while qualitative methods will capture participant's lived experiences and implementation processes. An action research component allows iterative adjustment of the intervention based on emerging findings and stakeholder feedback, following cycles of planning, action, observation, and reflection [101,102]. The 4 methodological elements, mixed methods, longitudinal cohort, feasibility study, and action research, are described in Table 1.

Treatment overview

The intervention comprises 3 cohorts delivered over an intensive 8-day period (see Fig. 1 for timetable). Days 1 to 3 involve assessment, psychoeducation, and preparatory stabilization work. Days 4 to 8 form the active treatment phase, during which group EMDR therapy, delivered via the ASAP, is combined with compassion-focused intervention (including compassionate mind training [CMT]) in a structured, sequential format. The protocol also incorporates selected techniques from acceptance and commitment therapy [103], specifically values clarification, psychological flexibility exercises, and committed action planning. These served to complement CFT's focus on moral repair and reconnection with purpose, supporting participants in bridging the gap between trauma-related avoidance and value-based living [104].

Group EMDR therapy—ASAP

The ASAP is an EMDR-based group early intervention grounded in the AIP model, specifically designed for high-risk occupational

Table 1. Key research design elements for the Vermont Research Protocol

Design element	Primary characteristics
Mixed methods	Integrates quantitative and qualitative approaches within a single program of inquiry to generate meta-inferences unattainable by either alone. Design integration at the conceptual level: convergence/divergence, explanatory and sequential elements, and exploratory and phenomenological capture of lived experience. Integration during data collection, analysis, and interpretation: triangulation, complementary narratives, and development and expansion of themes.
Longitudinal cohort study	Observational design following defined closed cohorts over time with repeated measures. Assessment time points: preintervention, postintervention, and 1-, 3-, and 6-month follow-ups. Enables capture of recovery trajectories and identification of risk factors, including attrition, occupational stressors, and future adverse events.
Feasibility study	Preparatory investigation determining whether and how a future definitive intervention study can be constructed and conducted [145]. Assesses process (recruitment, retention, and adherence), resources (time, staffing, and costs), acceptability, and data quality. Provides preliminary parameter estimates for sample-size planning. Not powered to test effectiveness.
Action research	Participatory and cyclical inquiry conducted with pertinent stakeholders to improve practice while generating knowledge [101,102]. Iterative cycle: plan → act → observe → reflect. Integrates mixed methods and foregrounds power sharing, reflexivity, and ethics of care, and participants as coresearchers. Validity criteria: outcome, process, democratic, catalytic, and dialogic validity.

The Vermont Protocol research treatment timetable					
Day 1					
Day 2					
Day 3					
Day 4					
Day 5					
Day 6					
Day 7					
Day 8					
		4-d intensive (In person)			
		1 d at 1-mo follow-up (virtual)			
		1 d at 2-mo follow-up (virtual)			
		1 d at 3-mo follow-up (virtual)			
		1 d at 4-mo follow-up (in person)			

Fig. 1. Example of intensive treatment timetable.

groups, including law enforcement, fire, and emergency medical services personnel. Unlike conventional psychological debriefing, which requires sequential narrative recounting and carries known risks of symptom exacerbation, ASAP targets the critical consolidation window within 72 h of a critical incident, aiming to prevent acute stress reactions from escalating into chronic PTSD. Each session follows an 8-step worksheet-based structure conducted in approximately 45 min, calibrated to minimize disruption to operational responsibilities. Participants identify the incident's most distressing moment, the present point of disturbance (PPOD), rate their distress using subjective units of distress (SUD), and undergo bilateral stimulation (eye movements, tactile pulsers, or auditory tones) to facilitate adaptive reprocessing without requiring full verbal disclosure of the trauma narrative. Postincident stabilization and adaptive template techniques are included to consolidate reprocessing gains and reduce vulnerability to future incidents. The 8 steps of the ASAP protocol are outlined in Fig. 2.

The 8-step protocol follows a clinically sequenced structure that progresses from trauma regulation through processing to closure. Step 1 establishes present-moment awareness and baseline self-regulation capacity through a mindfulness-based body scan and SUD assessment, activating the calming system before trauma engagement, a necessity grounded in both AIP window-of-tolerance principles and CFT's 3-system model. Step 2 activates positive adaptive memory networks through resource installation and brief bilateral stimulation, establishing the neurobiological foundation on which dysfunctional traumatic memories will be integrated during reprocessing, using memory reconsolidation theory within a group setting [62]. Step 3 develops an adaptive positive belief, a first-person, present- or future-oriented self-perception such as "I did the best I could" or "I am resilient", which acts as the processing anchor for the entire sequence and holds particular clinical importance for moral injury cases where self-condemnation is central. Step 4 marks a clinical decision point: SUD is reassessed after resourcing, and additional stabilization is indicated if distress remains high before trauma processing begins, serving as a safety check within the group context. Step 5 implements the 3-phase trauma processing sequence outlined above. Step 6 concludes

the processing sequence by incorporating the adaptive belief: The positive cognition from step 3 is reevaluated for ongoing relevance following processing, with a return to belief selection if perspectives have shifted sufficiently and confirmed through validity of cognition assessment and bilateral stimulation, ensuring that the belief is integrated with the trauma memory network. Step 7 offers structured containment for any incompletely processed material via a guided imagery container exercise with brief bilateral stimulation, providing temporary stabilization when session time constraints or clinical indications prevent complete processing in one session—noting that containment does not replace full processing. Step 8 involves final SUD assessment, comparing initial and final distress ratings, psychoeducation to normalize ongoing between-session processing, grounding techniques, and referral pathways for continued clinical support—forming the protocol's built-in postsession safety framework.

The core processing sequence in step 5 comprises 3 progressive phases, each particularly relevant to moral injury presentations. Direct processing (step 5a) involves engaging the memory network through image formation and bilateral stimulation, with SUD reassessment confirming network activation. Distanced processing (step 5b) introduces cognitive distance through an observational perspective; participants view the experience from a safe remove, maintaining memory engagement while reducing emotional flooding. Temporal-contextual processing (step 5c) incorporates a dual perspective, where participants imagine their current self, equipped with all present knowledge and experience, observing their past self during the event, and consider what they would want to say to that past version of themselves. This phase explicitly aims to foster self-compassion and meaning-making, facilitating the integration of present wisdom with past experiences and the contextualization of morally distressing actions within the constraints of what was known and possible at the time—a mechanism with direct clinical relevance to shame-based moral injury presentations [1,41].

This 3-phase architecture establishes a mechanistic link between ASAP and the CFT components of the intervention. Step 5c triggers the compassionate self-relating and temporal recon-textualization that CMT aims to develop and strengthen—the

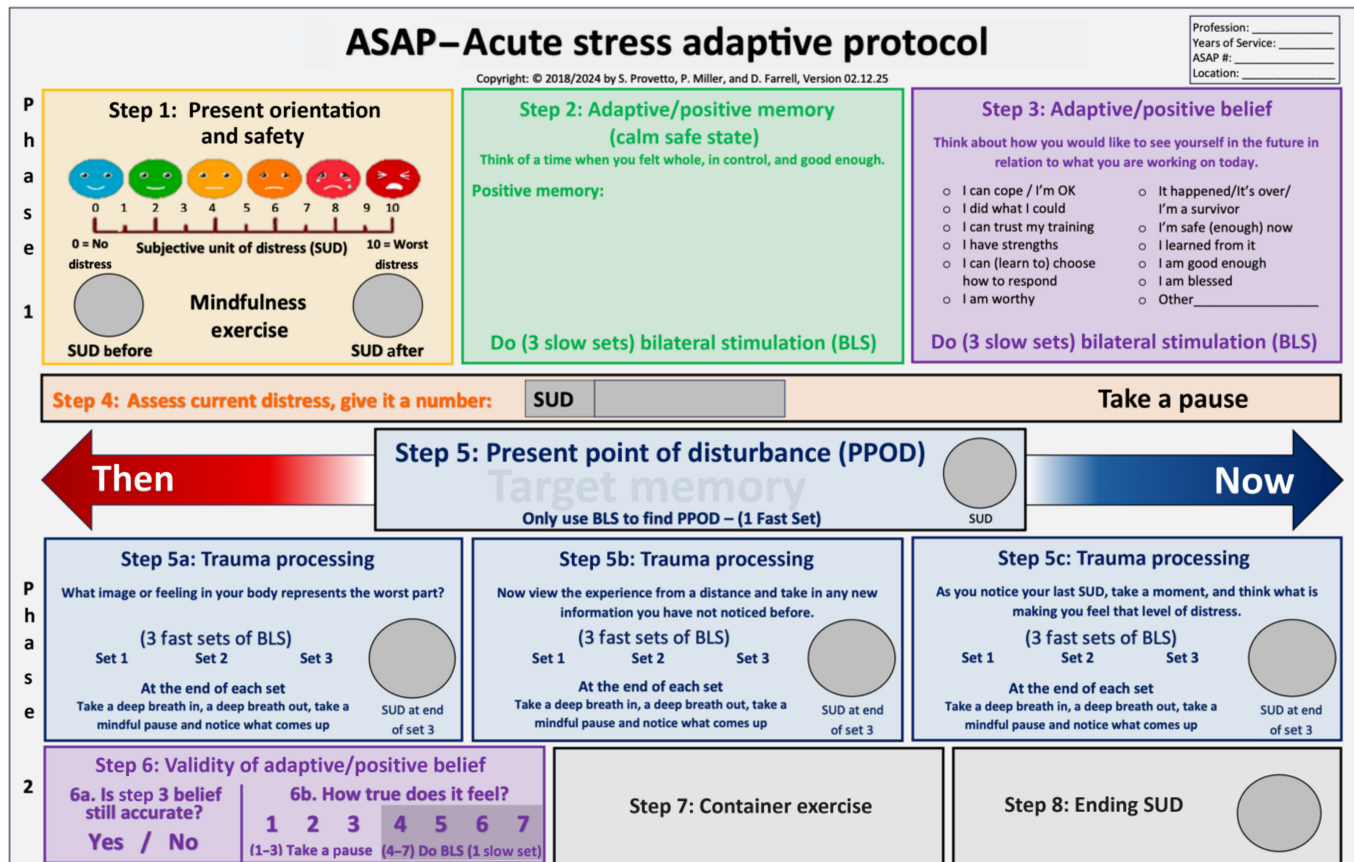


Fig. 2. The Acute Stress Adaptive Protocol (ASAP) worksheet highlighting its 8-step architecture.

2 modalities are not simply sequenced but are mechanistically connected, with ASAP's processing benefits providing the experiential foundation upon which CFT's compassion-based practices are built. ASAP is flexible in its operation; can be peer led, designed for field and station environments without needing a clinical setting; and has shown high acceptability, safety, and feasibility in pilot programs with police, fire, and emergency medical service personnel, including the Police Service of Northern Ireland and the Vermont Centre for Responder Wellness [51].

Figure 3 summarizes the 5 core objectives of ASAP, which together articulate its dual role as both a clinical intervention and a public health tool. The primary clinical goal—reducing acute posttraumatic symptoms through early bilateral stimulation-based reprocessing—is supported by a secondary prevention rationale: By intervening during the critical consolidation window, ASAP aims to interrupt the progression from acute stress reaction to chronic PTSD before dysfunctional memory encoding becomes entrenched [62]. Emotion regulation and arousal modulation represent a second, mechanistically distinct objective: The protocol's structured progression from mindfulness-based stabilization through graded trauma engagement is designed to keep participants within a functional window of tolerance, directly relevant to AIP theory and aligned with CFT's emphasis on soothing system activation as a prerequisite for therapeutic engagement [72]. Third, ASAP's risk screening and triage function—operationalized through continuous SUD monitoring across all 8 steps—produces real-time distress data that informs clinical decision-making and referral pathways, functioning simultaneously as an intervention and a structured assessment

tool. This triage capacity is particularly important in the context of intensive group delivery, where individual risk profiles must be monitored across multiple participants at once. Finally, ASAP's aim of strengthening community empowerment and capacity building is its most distinctive contribution to the intervention model outlined in this paper: By designing the protocol for peer delivery within occupational communities, ASAP creates a within-culture trauma response infrastructure that develops lasting local capacity rather than fostering dependence on externally deployed specialist clinicians—a principle central to both the task-shifting framework and the peer-to-peer delivery model, which is a key focus of this feasibility study [51,86,87].

CFT components

CFT modules are arranged throughout the treatment phase to address shame, self-condemnation, and moral-emotional distress that EMDR reprocessing alone may not fully resolve. Figure 4 outlines 9 key elements of CFT integrated into the intensive treatment delivery program. The rationale for integrating these approaches is based on a distinction between PTSD-related symptomatology traumatic stress—which EMDR aims to target through adaptive reprocessing of dysfunctional memory networks—and the deficits in the soothing system and shame-based self-relating that characterize moral injury, requiring a different therapeutic mechanism. Drawing on Gilbert's [72] tripartite model of emotion regulation, psychoeducational content introduces the threat, drive, and soothing systems as a framework for understanding trauma responses, normalizing hyperarousal, avoidance, and emotional numbing as adaptive

1. Reduce acute posttraumatic symptoms
2. Enhance emotion regulation and modulate arousal
3. Prevent symptom deterioration (secondary prevention)
4. Conduct risk screening and triage to care
5. Strengthen community empowerment and capacity building

Fig. 3. Key attributes of the Acute Stress Adaptive Protocol (ASAP).

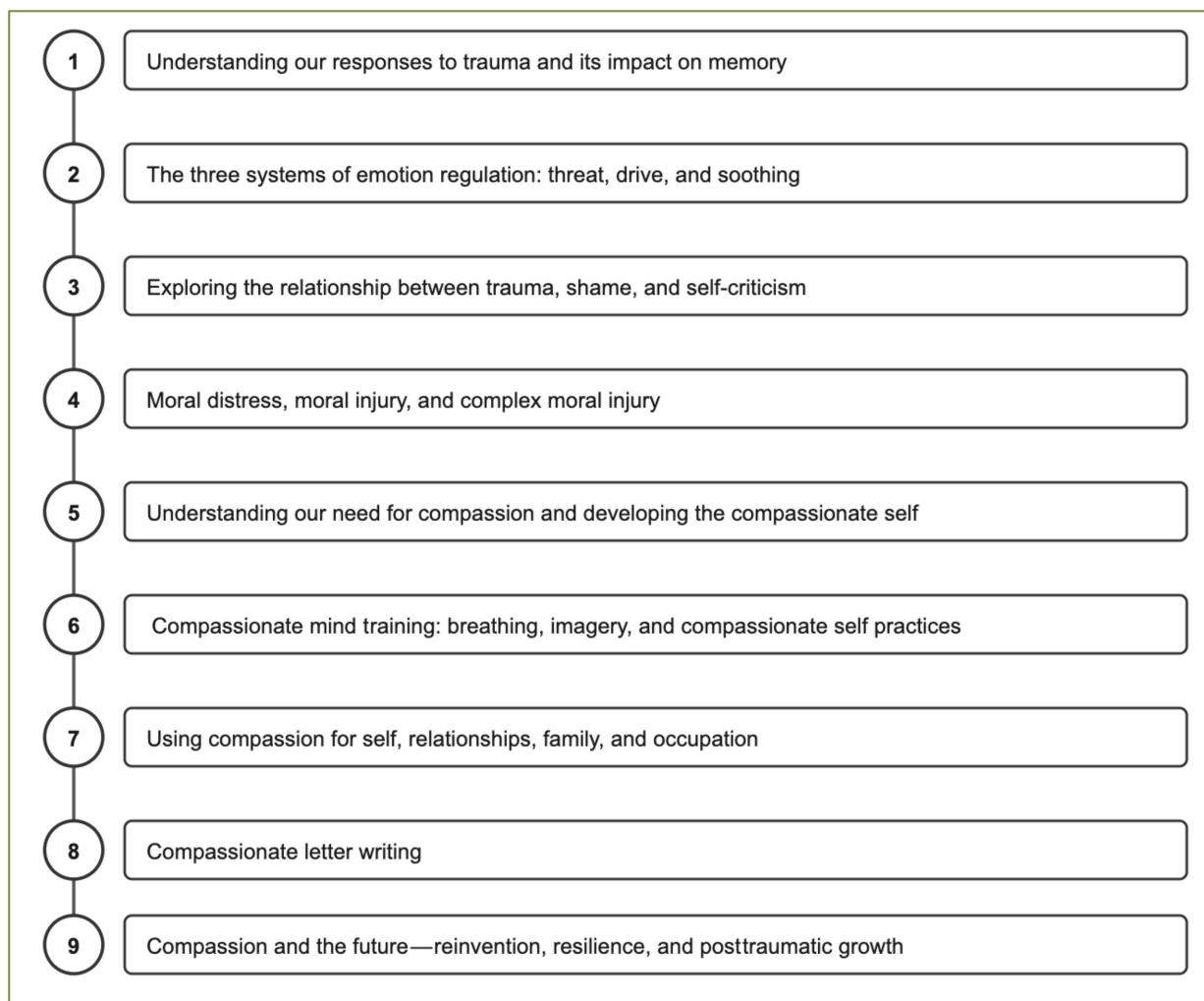


Fig. 4. Nine key aspects of compassion-focused therapy curriculum used within the intensive trauma treatment study.

rather than pathological reactions to overwhelming moral experiences. For first responders, this perspective is especially important: Occupational cultures that emphasize stoicism and mission

focus tend to produce chronically overactivated threat and drive systems, alongside severely underdeveloped soothing systems, which intensify the self-critical and shame-based processing

characteristic of moral injury [9,75]. CMT [73] constitutes the core skill-based component of the CFT modules. CMT techniques, including soothing rhythm breathing, compassionate imagery, compassionate self exercises, and compassionate letter writing, are designed to activate the affiliative soothing system and foster development of the “compassionate self”: a secure, emotionally regulated self-state characterized by warmth, strength, and wisdom, from which participants can engage with painful moral memories without being overwhelmed by shame or self-condemnation. Compassionate letter writing is used specifically as a targeted intervention for moral injury, enabling participants to relate to morally distressing experiences—including perceived failures, transgressions, or acts of omission, with acknowledgment rather than self-punishment [77,105]. These CMT components are sequenced to follow EMDR reprocessing sessions, consolidating adaptive memory integration with compassionate self-relating and supporting reconnection with core values and moral identity [75,79].

Peer-to-peer support delivery model and task shifting

A key and innovative aspect of this intervention framework is the deliberate integration of trained peer supporters as codeliverers of specific program components. These peer supporters are selected from within the same occupational communities as the participants, law enforcement officers, fire service personnel, paramedics, and frontline emergency workers, who have undergone specialized training in trauma-informed support, ASAP facilitation, and CFT psychoeducational delivery. This culturally grounded approach is supported by evidence indicating that trauma narratives are more openly shared and interventions are more effectively received when delivered within a shared occupational context, language, and a sense of trust [9,87,91]. The lived experience of the peer supporter, including its moral codes, stoicism, institutional frameworks, and specific stressors that lead to moral injury, is not incidental but forms an active therapeutic element, decreasing the psychological distance between participant and intervention and directly addressing the stigma and identity threats that hinder help-seeking behaviors in these groups [89,90]. Within the protocol, peer supporters deliver psychoeducational content, facilitate group containment activities, support completion of the ASAP worksheet, and provide between-session peer contact and check-ins. They do not conduct trauma reprocessing, clinical assessment, risk formulation, or independent therapeutic decision-making—these remain exclusively within the scope of the EMDR- and CFT-accredited clinicians who provide direct clinical oversight throughout the intervention. This scope delineation is operationalized through a tiered competency framework: Peer supporters complete a standardized training program prior to delivering the protocol, receive treatment manuals and session-specific fidelity checklists, and participate in weekly clinical supervision with the lead clinicians. Supervision serves both fidelity-monitoring and pastoral functions, ensuring that peer supporters’ psychological well-being is actively monitored and supported throughout their involvement, a critical safeguard given the risk of secondary trauma inherent in this role [51].

The peer-to-peer model also directly operationalizes the task-shifting framework outlined in Introduction to the Research. By training and embedding peer supporters within the protocol under structured clinical governance, the model extends the reach

of specialist trauma care beyond the clinical hour without compromising therapeutic integrity and creates a scalable, replicable delivery infrastructure that does not depend on the availability of EMDR- or CFT-accredited practitioners at every point of contact. Evaluating the feasibility, fidelity, and acceptability of this delivery model is one of the 5 primary objectives of this study, and secondary research question 5 specifically addresses the implementation barriers and facilitators that will inform its refinement for a future definitive RCT [51,86,87,92].

Participants

Participants will be recruited from the US law enforcement and frontline work community, including police officers, fire fighters, paramedics, and frontline health, emergency, and social care workers. Recruitment will be coordinated solely by the Vermont Centre for Responder Wellness, which maintains established referral pathways and professional networks across Vermont. Outreach strategies include clinician referrals, word of mouth from previous participants, targeted social media campaigns, and engagement through occupational health and peer support networks.

Inclusion and exclusion criteria

Inclusion criteria are as follows:

- Aged 18 years or older
- Currently used as a frontline health, emergency, or social care worker
- Occupational exposure to psychological distress, trauma, and/or moral injury
- Evidence of psychological distress and/or moral injury with measurable impact on psychological well-being and functional capacity
- A minimum score of 24 on the Impact of Event Scale—Revised (IES-R), indicating clinically marked posttraumatic symptomatology [106]

Exclusion criteria are as follows:

- Individuals not currently in active service or employment
- Individuals currently receiving psychiatric or psychological treatment
- Individuals presenting with active suicidal ideation

Note that it is assumed that participants are either actively working or have been formally assessed and deemed fit for duty by their occupational health provider.

Outcome measures

The study will gather data at preintervention, postintervention, and at 1-, 3-, and 6-month follow-ups. The following validated psychometric instruments will be used to evaluate treatment outcomes related to PTSD, CPTSD, moral injury, comorbid symptoms, and functional well-being.

- International Trauma Questionnaire (ITQ) [107]—a brief measure assessing International Classification of Diseases-11 [108] PTSD (reexperiencing, avoidance, and sense of threat) and CPTSD, including disturbances in self-organization (affect dysregulation, negative self-concept, and interpersonal difficulties). The ITQ demonstrates strong psychometric properties across trauma-exposed populations [109].

- IES-R [106]—a 22-item self-report measure assessing subjective distress caused by traumatic events across 3 core symptom clusters: intrusion, avoidance, and hyperarousal. Widely used in trauma research with established reliability and validity [110].
- Moral Injury Event Scale (MIES) [111]—a 9-item self-report scale exploring perceived transgressions, betrayals, or violations of an individual's moral code during traumatic exposure. Validated in military and first responder populations with good internal consistency ($\alpha = 0.90$) [112].
- Moral Injury Outcome Scale (MIOS) [2]—a validated 14-item measure assessing both distress and functional impairment arising from morally injurious experiences across psychological, social, behavioral, and spiritual domains. The MIOS captures both adverse outcomes and potential posttraumatic growth, offering dimensional assessment beyond event exposure.
- Generalized Anxiety Disorder Assessment (GAD-7) [113]—a 7-item measure assessing anxiety severity. Demonstrates excellent psychometric properties ($\alpha = 0.92$) and is widely used in clinical and research settings [114].
- Patient Health Questionnaire (PHQ-9) [115]—a 9-item measure assessing depression severity aligned with Diagnostic and Statistical Manual of Mental Disorders diagnostic criteria. Extensively validated across diverse populations with strong sensitivity and specificity for major depressive disorder [116].
- EuroQol 5-Dimensional 5-Level Instrument [117,118]—a standardized, preference-based measure of health-related quality of life assessing 5 dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Generates utility index values for health economic analysis (0 to 1 scale) alongside a visual analog scale (0 to 100) for self-rated health status.
- External and Internal Shame Scale (EISS) [119]—an 8-item measure assessing global shame experience, distinguishing external shame (perceptions of how others view the self) and internal shame (self-devaluation). Demonstrates good reliability ($\alpha = 0.85$ to 0.87) and validity in trauma populations.
- PTED Self-Rating Scale [120]—a 19-item self-report questionnaire assessing prolonged embitterment reactions following adverse life events, including feelings of injustice, resignation, and emotional dysregulation. The measure shows good internal consistency ($\alpha = 0.93$) and test-retest reliability, with the capacity to discriminate clinically marked embitterment from other presentations [120].
- Effort-Reward Imbalance (ERI) Questionnaire [121]—assesses occupational stress by examining the imbalance between effort expended at work and rewards received (esteem, salary, and career opportunities). The ERI model identifies a key psychosocial risk factor for health and well-being in high-demand occupations Siegrist and Li [122] and has been validated in emergency services personnel [123].

Rationale for assessment battery

This comprehensive battery was chosen to capture the phenomenological complexity of occupational trauma in first responders, addressing both fear-based or threat-related PTSD-related trauma responses (ITQ and IES-R) and moral-evaluative dimensions

(MIES, MIOS, and EISS). While the principal outcome measures used in this study (SUD, VOC, IES-R, and ITQ) are well-established indicators of PTSD-related symptom change, they predominantly reflect fear-based or threat-related systems and dimensions of traumatic stress. Consequently, they may not adequately capture changes in moral injury, shame, guilt, or disturbances in meaning, which provided the rationale for incorporating dedicated measures of moral injury into the present study. Intentional overlap in constructs—particularly dual assessment of PTSD symptoms via ITQ and IES-R—allows for triangulation and enhances construct validity, while distinguishing International Classification of Diseases-11 CPTSD features from Diagnostic and Statistical Manual of Mental Disorders-5 PTSD presentations. Similarly, both MIES (exposure to potentially morally injurious events) and MIOS (functional outcomes of moral injury) offer complementary perspectives: event-based screening and dimensional assessment of distress, impairment, and growth. The inclusion of transdiagnostic measures (PHQ-9 and GAD-7), shame assessment (EISS), embitterment (PTED), occupational stress (ERI), and quality of life (EQ-5D-5L) reflects the intervention's integrated theoretical framework, addressing CFT-relevant mechanisms (shame and self-criticism) alongside broader functional outcomes and health economics. All measures demonstrate established psychometric properties in trauma-exposed populations, with particular focus on first responder and occupational trauma contexts where available. Pilot testing with first responders ($n = 12$) indicated that the full battery takes approximately 25 to 30 min at each time point, balancing thorough assessment with participant burden—an important consideration for active-duty personnel.

Baseline-only measures

To characterize developmental risk and resilience factors that might influence intervention response, 2 retrospective measures of childhood experiences were administered at baseline only. These measures were included to examine the potential moderating influence of adverse and protective developmental experiences on clinical outcomes.

- Adverse Childhood Experiences International Questionnaire (ACE-IQ) [124]—administered solely at preintervention as a retrospective measure of childhood adversity across multiple domains, including abuse (physical, emotional, and sexual), neglect, household dysfunction, and peer/community violence. The ACE-IQ demonstrates good test-retest reliability and validity across various cultural contexts [125] and is associated with a higher risk of adult psychopathology, such as PTSD and CPTSD [126]. Childhood adversity is evaluated as a potential moderator of treatment response and to assess the developmental trauma burden within the sample.
- Benevolent Childhood Experiences Scale (BCEs) [127]—administered at preintervention only as a retrospective measure of positive childhood experiences that may confer resilience and buffer against adversity. The 10-item scale assesses protective factors including predictable caregiving, supportive relationships, beliefs in self-competence, and experiences of safety and belonging. The BCEs show good internal consistency ($\alpha = 0.73$ to 0.91) and incremental validity in predicting adult mental health outcomes beyond ACEs alone [127]. This measure allows examination of strength-based developmental

factors and potential resilience mechanisms that may influence treatment outcomes.

Together, ACE-IQ and BCEs serve 3 analytical purposes: (a) describing sample characteristics and variation in early-life adversity exposure; (b) examining whether childhood adversity influences response to the EMDR-CFT intervention; and (c) investigating whether positive childhood experiences have protective effects on treatment outcomes. The pairing of adversity and strength-based measures aligns with contemporary trauma research emphasizing both risk and resilience factors [128] and is especially relevant given evidence that childhood adversity predicts CPTSD presentations [129] and may intensify shame-based self-relating, a key focus of CFT treatment.

Demographic data

The following demographic variables will be captured at baseline: age, gender, professional job title, and years of experience in current role.

Consent procedures

Potential participants will be identified via the Vermont Centre for Responder Wellness based on their trauma history and assessed for eligibility. All participants will receive a detailed Participant Information Sheet outlining the study's aims, procedures, risks, benefits, and their right to withdraw at any time without consequence. Consent will be obtained through a structured multistage process.

- The trial is explained verbally to maximize informed understanding.
- The participant is provided with the Participant Information Sheet and given at least 3 d to consider participation and raise any questions.
- Written consent is obtained prior to formal enrollment and countersigned by the principal investigator.
- Verbal consent is recaptured on day 1 of the intensive intervention and reconfirmed at any point during the active treatment phase and at conclusion (day 8).

Participation is entirely voluntary. Participants may withdraw at any time before the end of the treatment period without obligation or adverse consequence.

Research access and participant support services

All participant access and support services will be managed by the Vermont Centre for Responder Wellness. During the intervention period, specifically days 4 to 8, the center will offer continuous on-site support, including a licensed therapist, accredited peer support professionals, and dedicated access to both in-session and follow-up psychological support. The center's wider participant care framework includes 24/7 crisis response, daily check-ins, structured breakout sessions, psychoeducational and community-building activities, and ongoing postintervention care planning. These services are provided by a coordinated team of therapists, social workers, and trained peer supporters working within a trauma-informed, compassion-focused approach.

Fidelity and adherence

Fidelity will be maintained through standardized treatment manuals, fidelity checklists, and regular clinical supervision and

consultation sessions, ensuring that all interventions are delivered consistently and according to protocol. Independent assessors will carry out periodic session audits and interrater reliability checks. Any deviations will be documented and remedied through corrective feedback and ongoing training. Weekly clinical supervision by EMDR- and CFT-accredited therapists will ensure clinical integrity across both specialist and paraprofessional delivery roles.

Data collection

The clinical trial will gather both quantitative and qualitative data. Standardized psychometric tools will be used at the specified time points. Qualitative data will be collected through semistructured focus group interviews, led by a qualified forensic and counseling psychologist who is not part of the intensive treatment team, thereby reducing dual-role concerns. The focus group approach will follow established guidelines for applied research [130]. All interviews will be audio recorded with consent, transcribed verbatim, and analyzed using framework analysis. During transcription, all identifying information (names, locations, and organizational affiliations) will be removed. Participants will be assigned anonymized ID codes (e.g., P001), which will be used consistently throughout all analyses and reporting.

Data governance, confidentiality, and storage

The study is governed by Northumbria University's ethical and research governance policies, which are fully aligned with the UK Policy Framework for Health and Social Care Research and the Concordat to Support Research Integrity [131].

Although data collection will take place in the United States, all data management, storage, and analysis will be conducted in accordance with UK General Data Protection Regulation [132], the Data Protection Act (2018) [133], Northumbria University's Data Management Policy, and relevant US federal and state data privacy and health research laws (including Health Insurance Portability and Accountability Act). All identifiable or sensitive data will be anonymized at the point of collection and securely transferred to the UK through encrypted, password-protected channels. No personally identifiable data will be stored outside the UK. Digital data will be stored on Northumbria University's secure U-Drive system, which is protected by a firewall, regularly backed up, and accessible only to the designated research team. Hard copy materials will be scanned, anonymized, and destroyed using certified shredding. Audio recordings will be transcribed, anonymized, and deleted within 3 months of the final study report; anonymized transcripts will be retained for up to 3 years for audit and secondary analysis. In the event of a data breach, this will be reported immediately to the university and affected participants in accordance with institutional policies and applicable legal requirements in both jurisdictions.

Quantitative and qualitative data analysis

Quantitative outcomes will be analyzed using linear mixed models (LMMs), implemented in jamovi with the GAMLj module. LMM is the preferred analytic strategy for longitudinal feasibility data with repeated measures across multiple time points (preintervention, postintervention, and 1-, 3-, and 6-month follow-ups) because it models individual trajectories over time while accommodating the hierarchical structure of the data (participants nested within cohorts) and the correlation between

repeated measurements within individuals. Critically, LMM handles missing data directly through full information maximum likelihood estimation, which uses all available data to estimate model parameters without requiring complete cases or imputation. Under the missing-at-random assumption, plausible in a clinical trial where dropout is more likely to be related to observed variables such as symptom severity at baseline than to unobserved future values, full information maximum likelihood produces unbiased parameter estimates and correct standard errors [134,135]. This renders separate missing data procedures, such as multiple imputation, unnecessary and avoids the methodological inconsistency of double-handling the missing data problem. Fixed effects in the model will include time (as a categorical factor to permit nonlinear trajectories), occupational group, and key baseline covariates (ACE-IQ score, baseline IES-R, and moral injury severity). Random effects will capture between-person variability in baseline scores and rates of change. Given the feasibility nature of this study, primary outputs from LMM will be effect size estimates (Cohen's *d* with 95% confidence intervals) and variance components to inform the sample size calculation for a future definitive RCT, rather than hypothesis tests of efficacy.

Qualitative data will be analyzed using framework analysis [136–138], a structured method allowing both deductive coding aligned with the *a priori* research questions and inductive identification of emerging themes from participants' accounts. The 5 stages—familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation—will be applied systematically by 2 independent analysts to enhance credibility. Themes derived from qualitative analysis will be examined alongside the quantitative LMM findings in an integrated interpretive stage, enabling triangulation, identifying convergence and divergence across data strands, and providing a nuanced account of the mechanisms through which the intervention may, or may not, produce therapeutic change. This mixed-methods integration is especially important for contextualizing preliminary effect size estimates from a single-arm feasibility study, where qualitative data on acceptability, cultural fit, and participant experience give essential explanatory depth.

Potential risks to participants

Although the study concentrates on distressing memories addressed within the intensive trauma treatment program, the Vermont Centre for Responder Wellness offers comprehensive on-site and postintervention clinical support. If the intervention becomes overwhelming or a participant needs to withdraw, one-to-one support is available through the center's expert clinical team, including access to consultant psychiatrists, clinical psychologists, mental health nurses, and registered psychotherapists. Any withdrawal will be recorded as a dropout in the research data.

Adverse event reporting

All adverse events occurring during the study period will be systematically documented, assessed for causality, and reported in accordance with institutional guidelines and regulatory requirements. Serious adverse events will be reported to the Research Ethics Committee within 24 h of the research team becoming aware of the event. Participants experiencing adverse events will receive appropriate clinical support and referrals as

needed. A designated safety officer will monitor all reported events and recommend protocol modifications if safety concerns arise. All adverse events will be included in the final study report regardless of their perceived relationship to the study intervention.

Composition of the research team

The multidisciplinary research team includes experienced trauma psychologists, a consultant psychiatrist, qualified psychotherapists, mental health social workers, mental health nurses, and trained peer-to-peer support workers, ensuring comprehensive clinical expertise and diverse professional perspectives throughout the study.

Dissemination strategy

The findings from this research will be shared through various channels to reach a broad audience within the scientific community and relevant professional networks. Results will be presented at national and international scientific conferences, including specialized meetings related to the study population and methodology. Furthermore, findings will be submitted for publication in high-impact, peer-reviewed academic journals to enhance the evidence base and guide future research and clinical practice. All dissemination activities will comply with ethical guidelines regarding participant confidentiality and will acknowledge funding sources and institutional affiliations.

Discussion

Innovation and contribution to knowledge

This research protocol proposes a novel therapeutic framework combining group EMDR, ASAP, with CFT to address the distinct and interconnected symptoms of PTSD, CPTSD, and moral injury among law enforcement and first responders. While group EMDR has increasingly gained empirical support for its effectiveness and trauma resolution capacity in high-risk populations [51], the complementary application of CFT provides a strong framework for tackling shame, self-criticism, and moral suffering—key features of moral injury [1,75]. This dual-modality intervention is innovative in its comprehensive, emotionally sensitive, and group-based approach.

The study further contributes to the expanding body of research on scalable, ethically grounded trauma interventions by integrating the principles of task shifting. By training non-specialist mental health personnel (e.g., peer supporters or trauma-informed practitioners) to deliver parts of the protocol under direct clinical supervision or consultation, effective systems of triage and risk assessment are established, supporting global efforts to enhance trauma care access in resource-limited or occupationally burdened populations [86,139].

Anticipated challenges and mitigation strategies

Several operational and ethical challenges are anticipated:

- **Recruitment and retention:** Given the occupational culture of stoicism and stigma in law enforcement and emergency services, securing voluntary participation may be difficult. To mitigate this, the study incorporates trusted community partners, occupational health liaisons, and embedded peer champions to facilitate safe entry points into care.

- Emotional safety and group dynamics: Group-based trauma interventions carry a risk of emotional triggering and secondary traumatization. The protocol incorporates clinical oversight, prescreening, structured containment strategies, and continuous risk monitoring.
- Task-shifting supervision and fidelity: While task shifting increases scalability, ensuring treatment fidelity is essential. A stepped care training model, competency frameworks, and weekly clinical supervision/consultation by EMDR- and CFT-accredited therapists will maintain clinical integrity.

To ensure treatment fidelity during task transfer, the study will adopt a structured 3-tier supervision model. Peer support facilitators will receive weekly group clinical supervision from EMDR-Europe-accredited consultants and CFT-trained supervisors throughout the intervention phase, with individual consultations available for complex or safety-related issues. Supervision will be guided by session-level fidelity checklists completed by facilitators after each group, evaluating both protocol adherence (e.g., “were the specified components delivered?”) and delivery competence (were they delivered with sufficient quality?), aligning with the adherence/competence distinction in implementation science [140]. A stepped competency framework will oversee progression: Facilitators must demonstrate threshold competence through structured observation after completing training before delivering independently, with at least 2 directly observed practice sessions before the trial begins. Clinical supervisors/consultants will review fidelity data fortnightly and record any protocol deviations. A predetermined deviation threshold will initiate an additional training session and supervisory review before the facilitator resumes delivery. Vicarious trauma and facilitator well-being will be monitored via standardized measures at each supervision contact, with a clear referral pathway to occupational health services. This model aligns with evidence-based supervision frameworks for task-shared trauma interventions [141] and fidelity monitoring methods used in similar trials [142].

A key mechanism of this protocol lies in its community aspect. Group EMDR (ASAP) plus CFT situates recovery in a relational context where shame and betrayal can be countered by mutual recognition, compassion, and belonging. Empirical reviews of group trauma therapy confirm that cohesion, peer normalization, and shared meaning-making produce marked reductions in PTSD phenomena [46,48,143,144]. In moral injury specifically, reparative processes that include acknowledgment, witnessing, accountability, and compassion, which are inherently communal [1,12]. Thus, the group is not only the delivery format but also a healing agent.

Broader implications

Scalability and systems integration

The integration of EMDR and CFT within a group-based format offers a scalable, cost-efficient solution with potential for replication across diverse law enforcement, first responder, and military populations. By leveraging task-shifting strategies, the model supports decentralized delivery in both urban and rural contexts. This is relevant to public health systems seeking trauma-responsive, evidence-based models that extend beyond the clinic.

Policy and workforce resilience

The protocol aligns with national and international policy initiatives aimed at enhancing psychological resilience and occupational health in trauma-exposed professions (e.g., NHS People Plan and APA Guidelines for Moral Injury). It provides a potential model for integrating structured, peer-supported interventions into existing occupational frameworks, thereby reducing long-term mental health issues and boosting workforce retention.

Advancing moral injury research

Notably, this study will contribute to the growing empirical understanding of moral injury among civilian first responders. By incorporating validated psychometric measures (e.g., ACEs, BCE, ITQ, IES-R, MIOS, MIES, and EQ-5D-5L) and lived-experience narratives, it paves the way for further theoretical refinement and cross-cultural adaptation of moral injury concepts.

Limitations

Given the feasibility of this study’s design, maintaining methodological proportionality is crucial to prevent overgeneralization of findings and to ensure proper interpretation of preliminary data. As a proof-of-concept investigation, this study focuses on establishing the feasibility, acceptability, and safety of the intervention while generating preliminary effect-size estimates rather than making definitive efficacy claims. The lack of a randomized control group, limited sample size, and single-site recruitment strategy are deliberate design features aligned with feasibility study guidelines [145], which emphasize that such studies should address “whether something can be done, should we proceed with it, and if so, how” rather than provide conclusive evidence of effectiveness.

The data generated will likely reveal trends, identify potential moderators of treatment response (e.g., developmental trauma burden, PTSD versus CPTSD presentations, and occupational role differences), and highlight implementation challenges that necessitate refining the protocol. Importantly, feasibility studies are specifically designed to determine whether and how to proceed to a definitive RCT, including key parameters such as recruitment strategies, retention rates, intervention dose optimization, outcome measure selection, and sample size calculations [146]. Findings from this study will therefore serve multiple purposes:

1. Establishing proof of concept for the integrated EMDR-CFT model in first responder populations
2. Refining research questions and hypotheses for definitive testing
3. Identifying barriers and facilitators to implementation within occupational trauma settings
4. Generating preliminary data to secure research funding for a fully powered efficacy trial.

As a research team, we recognize that early effectiveness signals should be interpreted with appropriate epistemic humility, considering the methodological limitations of feasibility studies. Effect sizes may be inflated due to self-selection bias, lack of blinding, placebo or expectancy effects, and regression to the mean, all common threats to internal validity in uncontrolled cohort studies [147]. Therefore, any observed symptom reductions or functional improvements will be presented

as preliminary indicators that require confirmation through replication in a controlled trial, rather than as definitive proof of intervention effectiveness. The mixed-methods approach, which includes qualitative feedback from participants and implementation data, will provide essential context for interpreting quantitative results and understanding how the intervention may (or may not) produce therapeutic change.

The primary aim of this feasibility study is, therefore, strategic: to establish the empirical foundation and research infrastructure needed to execute a definitive multisite RCT. This involves forming collaborative partnerships with first responder organizations, demonstrating the acceptability and safety of interventions, refining the treatment protocol based on participant feedback and fidelity monitoring, optimizing the assessment battery to balance comprehensiveness and participant burden, and generating credible preliminary data to support competitive grant applications. By maintaining proportionality between study design and inferential claims, we aim to provide methodologically rigorous evidence that advances the field while avoiding premature conclusions that could mislead clinical practice or policy decisions.

Conclusion

The Vermont research clinical trial addresses a critical gap in treating moral injury alongside PTSD/CPTSD in first responders through an innovative integrated intensive group EMDR–CFT intervention. The study will include feasibility metrics, such as recruitment, retention, protocol adherence, and safety profile, in connection with the intervention, primarily captured through psychometric and quantitative data. Acceptability findings will also be obtained from qualitative data, which will record participants' experiences, perceptions of occupational and cultural suitability, along with peer-support mechanisms. What makes this study innovative is the dual focus on PTSD-related trauma and moral evaluative distress, with a group intensive intervention that emphasizes peer support and reducing stigma in occupational cultures that often resist disclosure. A key aspect is also to explore the implications of compassionate leadership and community.

It is important to recognize the methodological limitations inherent to any feasibility study. These include the absence of a control group or other comparator, self-selection bias, recruitment from a single site, and reliance on self-reporting measures. That said, the findings should provide essential groundwork for a definitive multisite RCT, based on power calculations, protocol refinement, and the identification of a suitable comparison intervention, such as EMDR therapy only or treatment as usual.

Future research priorities could focus on mechanistic studies investigating mediating factors such as compassion, shame reduction, trauma targets, and others; moderator factors including developmental trauma, occupational dynamics and complexities; extended follow-up periods; health economic evaluation; and dismantling studies that explore and isolate active treatment components.

The implications of this study can directly influence clinical practice, including task-shifting models, training needs, integration into existing occupational support systems, and employee assistance programs. It also contributes to the debate on organizational policy and practice, such as improving the availability of authentic trauma-informed care, workforce retention, compassionate leadership, and community engagement. More

importantly, it helps to further recognize moral injury as a distinct treatment target in occupational trauma populations.

This feasibility study indicates that integrated group EMDR–CFT is a promising, scalable, and culturally sensitive intervention for first responders confronting the dual challenges of PTSD/CPTSD and moral injury. By addressing both trauma memory processing and shame-related self-perception through peer-supported group delivery, this approach may enhance treatment engagement, diminish stigma, and help sustain the workforce in high-risk occupations. The findings lay the groundwork for further definitive efficacy testing, while also strengthening the evidence base for moral injury interventions and contributing to community healing models that acknowledge the complex trauma experiences and occupational cultures of those serving on the frontlines.

Ethical Approval

The study has been reviewed and approved by the Northumbria University Ethics Committee (ref: Farrell2024-8250-9111)

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Data Availability

All data supporting the findings of this study are available upon reasonable request from the corresponding author, D.P.F. (derek.farrell@northumbria.ac.uk). Data will be shared in accordance with applicable data protection regulations and institutional policies.

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The Vermont Research Trial Protocol: A Mixed-Methods Study of Group EMDR Integrated with Compassion-Focused Therapy for PTSD, Complex PTSD, and Moral Injury in First Responders and Law Enforcement Officers

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First responders experience disproportionately high rates of posttraumatic stress disorder, complex posttraumatic stress disorder, and moral injury. Standard trauma-focused treatments inadequately address the shame, guilt, and existential distress characteristic of moral injury, while occupational cultures of stoicism create marked barriers to help-seeking. This mixed-methods feasibility study evaluates an intensive group intervention integrating eye movement desensitization and reprocessing, delivered via the Acute Stress Adaptive Protocol, with compassion-focused therapy for first responders and law enforcement officers, including frontline healthcare workers. Three cohorts are recruited through the Vermont Centre for Responder Wellness. Acute Stress Adaptive Protocol's trauma processing sequence provides a mechanistic bridge to compassion-focused-therapy-derived compassionate mind training components targeting shame, self-criticism, and moral-emotional distress. A within-culture peer-to-peer delivery model uses trained peer supporters as active therapeutic agents alongside accredited clinicians. Validated outcome measures are administered at baseline, postintervention, and at 1-, 3-, and 6-month follow-ups, with quantitative data analyzed using linear mixed models with full information maximum likelihood estimation. The study will establish feasibility parameters, recruitment and retention rates, safety signals, fidelity data, and preliminary effect sizes to inform a future definitive randomized controlled trial and will assess the scalability and cultural fit of peer-delivered, integrated trauma care in occupational settings.

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