The Efficacy of Acceptance and Commitment Therapy on Moral Injury in First Responders: A Narrative Review

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Abstract

Moral injury (MI) is a recent addition to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (APA, 2025). The American Psychiatric Association note that it is a problem requiring clinical attention. Moral injury clinically impairs individuals across lifespan and sectors, with first responders being at increased risk. Despite this, there is no evidence-based treatment recommendation for the first responder community that considers the unique context of their roles in society. Acceptance and Commitment Therapy has been proposed as an effective treatment for MI. However, the evidence is uncontrolled, based on descriptive studies, and contains a myriad of methodological concerns pertaining to the studies supporting the assertions. Nonetheless, there is a lack of alternative interventions with a superior evidence-base normed to first responders. This narrative review underscores the urgency in needing to establish an evidence-base for an effective intervention on MI, as it is paramount to the ongoing wellbeing of first responders.

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Moral injury, like all mental health conditions, can occur across a range of professions, with a growing evidence-base documenting moral injury among first responders (Haight et al., 2017). Moral injury (MI) is a growing and significant concern for first responders, who are frequently exposed to potentially morally injurious events (PMIE) (Knobloch & Owens, 2024; Rimon & Shelef, 2025; Smith-MacDonald et al., 2021). Despite the military being the only place MI was originally recognised, research has now accepted that the occupational environments and roles of first responders can create moral injurious events (D'Alessandro-Lowe et al., 2025; Lentz et al., 2021; Smith-MacDonald et al., 2021). First responders have greater exposure to situations that compromise their personal moral values, organisational values, professional responsibilities and associated values, and their own and societal expectations (Lentz et al., 2021). There are a myriad of scenarios where this could occur, for example, attending a structure fire and not being able to conduct a rescue; being prevented from, or ineffectually, administered live-saving care; or from cumulative exposure to tragedy, although it is a reality of life. While there is a low incidence of exposure of these types for the general population, there is a higher incidence when you are professionally required to be exposed to tragedy. Concerningly, while previous scoping reviews have found that despite the recognition of MI amongst first responders, treatment specific to them is lacking (Lentz et al., 2021). Moreover, research of MI in first responders is weighted towards qualitative studies (Lentz et al., 2021; Vaknin & Ne'eman-Haviv, 2025) and discussion around potential treatments approaches (Jones et al., 2022) rather than the development of Level 1 evidence-base of psychological therapies for MI.

Moral injury not only has its own psycho-social-spiritual sequela, it is often significantly associated with psychological comorbidities including PTSD, depression,

anxiety, and suicide (Hall et al., 2022; Rimon & Shelef, 2025). Moral injury was previously understood as a form of PTSD but has become recognised as a discrete problem despite shared symptomology with PTSD (Litz et al., 2022). Since then, challenges in researching and addressing MI existed due to the historic disparity across definitions and current lack of evidence-based treatments (Coady et al., 2021).

Currently, MI is a recognised clinical problem due to the level of impairment it leads to, coupled with a lack of possible mitigation or recovery (Litz, 2024). Despite this, historically MI was not recognised in the Diagnostic and Statistical Manual of Mental Disorders-V-Text Revised (DSM-5-TR). Recently the American Psychiatric Association (APA), in their September 2025 supplementary update, have included MI as a diagnostically relevant problem (APA, 2025). Moral injury is listed within DSM-5-TR: Z Code 65.8 “Moral, Religious, or Spiritual Problem”, and while the DSM Z coding is not a clinical diagnosis or disorder, it highlights contextual problems that require clinical attention. The broad definition being “include experiences that disrupt one’s understanding of right and wrong, or sense of goodness of oneself, others or institutions” (APA, 2025). Given the recency of entry into the DSM-5-TR far more research is warranted into to how MI impacts or leads to other mental health diagnoses (D’Alessandro-Lowe et al., 2025; Hall et al., 2022). Additionally, due to MI becoming a clinical problem requiring treatment in a therapeutic setting, it is paramount that treating clinicians can identify and provide evidence-based interventions.

This is relevant particularly when MI is comorbid to PTSD, as this can exponentially increase risk and suicidality as well as make PTSD symptomology more severe, pervasive, and enduring (Usset et al., 2021). However, current best-practice PTSD interventions, such as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), appear to have limited efficacy in addressing MI, suggesting foundational differences to PTSD (Barr et al., 2022; Bluett, 2017; Litz & Walker, 2025). Additionally, those treatments have limited efficacy at

times, lost gains at posttreatment, and dropouts ranging between 0-54%. Researchers postulate that the poor outcomes of PE and CPT in treating MI is due to those modalities treating fear-structures which is not the main mechanism of intervention needed for MI (Bluett, 2017). Cognitive therapies are effective on PTSD, as PTSD is a fear-based anxiety disorder occurring due to a trauma-event causing altered cognitions around safety (Carey & Hodgson, 2018). Therefore, CPT and PE, focus on processing fear through exposure and habituation to target hyperarousal (Barr et al., 2022) intrusions, hypervigilance, avoidance, and cognition alternations (Koenig & Al Zaben, 2021). Whereas MI interventions need to focus on violations of core moral values and the corresponding suffering occurring from trying to control the associated moral pain, as well as addressing the MI symptom clusters of guilt, betrayal, self-condemnation, loss of meaning, difficulty forgiving, and moral concerns (Koenig & Al Zaben, 2021). Therefore, it is warranted to evaluate alternative treatment approaches, that can address MI's symptom clusters by targeting experiential avoidance and focusing on values instead of PTSD symptoms.

Acceptance and Commitment Therapy (ACT) is a transdiagnostic intervention, forming part of the third-wave modalities derived from Cognitive Behaviour Therapy (CBT). ACT has sustained evidence in being an efficacious intervention for many mental health diagnoses as well as stress incurred at work (Nieuwsma et al., 2015). Moreover, ACT has also been an effective intervention for multiple populations, both clinical and non-clinical, experiencing traumatic stress as do first responders (Evans et al., 2023; Nishikawara & Maynes, 2023). ACT has over 1000 RCTs showcasing its evidence-base as a modality effective in treating a variety of mental health conditions (Evans et al., 2023). Yet, ACT's efficacy in treating PTSD, while promising, has mixed results (Evans et al., 2023), and is only considered a second-line treatment for PTSD in veterans (Bluett, 2017). The mechanisms of change in ACT is accessed through six core processes: acceptance, cognitive

diffusion, present moment contact, self-as-context, values clarification, and commitment action (Evans et al., 2023; Nishikawara & Maynes, 2023).

The genesis of ACT involved contesting the dominant medical model's approach to psychological disorder and interventions (Nieuwsma et al., 2015). ACT formulates MI as a psychological, and potentially spiritual, distress (Pernicano et al., 2022) that stems from experiential avoidance of moral emotions and lack of psychological flexibility. This forms the theoretical foundation for why ACT may be more effective interventions for MI than pre-existing trauma or stress treatments (Borges et al., 2022; Farnsworth et al., 2017). ACT has demonstrated some potential efficacy for PTSD symptoms, though efficacy decreased at follow-up (Bluett, 2017). ACT's focus on values orientation, addressing functioning over symptom reduction, and being transdiagnostic, may make it uniquely suited to MI with its distinctives, and similarities, to PTSD. This advocates the need that ACT for MI be evaluated to understand both its appropriateness and effectiveness as an intervention for MI amongst first responders.

Current Review

There is a lack of literature synthesising ACT's application as a MI intervention amongst first responders. Furthermore, there is limited research critically reviewing the validity of ACT studies in MI, particularly regarding measurement validity, which refers to if the scale accurately assesses what it is created to measure. This is relevant due to the heterogeneity caused by the differing MI definitions and diagnosis. Therefore, this review seeks to explore the state of evidence on ACT as a MI intervention for first responders.

This narrative review aims to outline MI, with specific reference for first responders. Secondly, this review seeks to appraise ACT's theoretical conceptualisation of MI, while evaluating the methodology of ACT for MI. Finally, this review synthesises the efficacy of

ACT on MI to assess suitability as an intervention for first responder's suffering from MI and directions for future research.

Method

A literature search was conducted via EBSCOhost across several academic databases, including PsycINFO and MEDLINE, to identify, select, and synthesise relevant articles published up to October 2025. Due to the recency of MI's concept and lack of complete literature reviews, a lower limit to the date of literature search was not applied. The search terms used included: (moral injury OR moral distress) AND (Acceptance and Commitment Therapy OR ACT) AND (first responder OR paramedic OR police OR firefighter). Due to limited research on ACT as a MI intervention, subsequent searches were expanded by analysing reference lists to identify additional sources. Articles were chosen based on their relevance with inclusion criteria including peer-reviewed articles and book chapters. Furthermore, sources were required to focus on ACT and/or MI, along with relevance to first responders, or analogous populations enabling probable generalisable findings. However, due to lack of studies incorporating first responders, and lack of definition around MI, this search was later broadened. Exclusion criteria initially included articles unavailable in English, interventional focuses unrelated to ACT, or populations irrelevant to first responders, or where MI was not of clinical relevance. After this a thematic synthesis was undertaken.

Key Literature Findings

There were multiple narrative reviews that discussed ACT and MI (D'Alessandro-Lowe et al., 2025; Evans et al., 2018; Jones et al., 2022; Nieuwsma et al., 2015; Nishikawara & Maynes, 2023; Walser & Wharton, 2021), which were included in this synthesis as they were relevant despite not demonstrating treatment efficacy. Furthermore, many published articles included references to moral injury amongst first responders (Coady et al., 2021; Knobloch & Owens, 2024; Lentz et al., 2021; Maguen et al., 2024; Mooren et al., 2024;

Phelps et al., 2023; Rimon & Shelef, 2025; Smith-MacDonald et al., 2021; ter Heide et al., 2022; Udovicich & McLaren, 2025), with some identifying moral injury as a concern within first responders, yet few discussed cultural nuances of moral injury. Four key studies were identified that specifically examined the efficacy of ACT, or ACT-like interventions, for MI (Bluett, 2017; Borges, 2019; Farnsworth et al., 2017; Pernicano et al., 2022). However, none had a focus on first responders, and furthermore, the methodologies of those studies were inadequate.

Bluett (2017) researched ACT as an intervention for PTSD and MI found ACT to have a 64.7% had a favourable response reducing efficacy over time. However, they had a small sample size of 33 participants and were targeting MI and PTSD simultaneously as adjunct to each other instead of discrete disorders (Bluett, 2017). The Bluett (2017) study had predominately male (87.9%), and white (84.8%), participants located in USA with military backgrounds. However, it is unknown if Bluett (2017) screened for any comorbidities, beyond PTSD, that may have been acting as confounds. Another key pilot study by Farnsworth et al. (2017), which looked at an iteration of ACT for MI, ACT-MI. The population was exclusive to veterans, with a very small sample of 11 participants, entirely male, geolocated within a USA inpatient setting, with many having comorbid diagnosis of depression, substance use and/or PTSD (Farnsworth et al., 2017). Moreover, participants had co-occurring CPT treatment which participants themselves identified as problematic as well as stating that the supplied ACT intervention at only six sessions which was too short. Borges (2019) also utilised the ACT-MI intervention under review. However, this was a single case study of one American veteran delivered via telehealth. The Pernicano et al. (2022) study developed and delivered a derivate of ACT termed Acceptance and Forgiveness Therapy, based on ACT principles. This was applied to treating MI, without using MI measures to

track changes, having retention dropping down to 50%, restricted population to American veterans, and yet they claim it is a promising intervention (Pernicano et al., 2022).

Discussion

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy seeks to improve function and psychological flexibility, over decreasing symptoms, delineating between adaptive responses and problematic behavioural responses such as avoidance and control. This has been phrased as functional contextualisation, and this contextualisation is why researchers argue ACT is invaluable in not pathologising MI experiences but still effectively conceptualising and, hopefully, treating MI (Evans et al., 2023). For MI, ACT operates on the assumption that there may not be distorted thoughts present, contrary to cognitive therapies, and that the moral emotions present may not require correction. Importantly, a person's moral values are both socially informed and orientated but are not classified as cognitive distortions. Moral injury harms these moral values and so ACT promotes forgiveness as an action on this harm to facilitate healing (Evans et al., 2023).

The ACT protocol developed for MI, ACT-MI, does not differ significantly from ACT itself (Evans et al., 2023). Painful moral emotions, such as guilt and shame, can be interpreted as showcasing an intact moral worldview, so ACT-MI does not directly change or eliminate these painful moral emotions and thoughts (Walser & Wharton, 2021). Instead it is the experiential avoidance of, or attempts to control, these painful moral emotions that ought to be focus of clinical intervention (Farnsworth et al., 2017). ACT-MI postulates that MI is maintained by how the individual responds to their moral injury symptoms and, therefore, targeting behaviours seeking to avoid or control moral pain ought to also resolve their MI (Borges et al., 2022). Moreover, ACT, with its focus on behaviours congruent with values, assists the client suffering from MI in discovering what it means to live consistently with

their values. Therefore, ACT theory applied in MI assists clients to renew their aspirations and capacity in living out their moral values-based life (Farnsworth et al., 2017).

ACT was first researched as a MI intervention in 2015 (Nieuwsma et al., 2015). This predominately explored and intervened on the shame present in moral injury, which is only one component of MI, which it claimed efficacious despite Nieuwsma et al. (2015) not including a control. Therefore, it is unknown if it was more effective than no-treatment or treatment-as-usual. Farnsworth et al., progressed this research in 2017 with the development of ACT-MI (Farnsworth et al., 2017), yet this was specifically stated to be for military populations. This study did not include a control group, furthermore their participants were inpatients receiving co-occurring evidence-based PTSD treatment (Farnsworth et al., 2017) limiting both findings and generalisability. This study explored functional analysis as a point of difference, with its distinction between not pathologising the moral emotions corresponding with a moral injury and yet addressing the maladaptive moral injury behaviours maintaining the injury (Farnsworth et al., 2017). Farnsworth et al. (2017) study showcased a helpful theoretical approach to MI, suggesting the feasibility of ACT-MI for MI treatment, but only displayed cautious preliminary results. However, there exists concerns around ACT, and ACT-MI, as a MI intervention due to the lack of RCT studies demonstrating significant outcomes post-treatment and at follow-up (Griffin et al., 2019). This is a recurring theme in the literature. Research into ACT for MI is supported theoretically, as it appears both acceptable and feasible as an intervention and yet most, if any data exists, is qualitative, lacks controls, or is simply anecdotal as in Borges et al. (2022). Borges et al. (2020), inadvertently compound this issue further by noting moral injury exists for first responders and claim that ACT-MI will be helpful, theoretically. However, Borges (2019) was unable to establish the efficacy of ACT-MI as an evidence-based intervention, let alone in applying it to first responders. Which Evans et al. (2018), also note, as they only found two studies on the

matter. Another scoping review on MI found a total of four studies examining ACT (Jones et al., 2022), which further underscores the limited research on the intervention. Furthermore, Evans et al. (2018), concluded that there is not one ACT-MI intervention, but many existing MI interventions employ many of the ACT principles in treatment.

No RCT studies on ACT-MI have occurred, though Evans et al. (2023), do note that there are some RCT studies on ACT-MI underway. Yet they also highlight another issue in previous studies about the lack of control groups (Evans et al., 2023). So, while previous studies saw some benefits it is unknown what those benefits are compared to control or treatment-as-usual groups. Furthermore, some previous studies into ACT-MI co-occurred with participants also undergoing other modalities that were also targeting co-morbid conditions, such as CPT for PTSD in the Farnsworth et al. (2017) study, which cast doubt on study results. This further ratifies the necessity for the review, establishing what evidence-base there is for ACT for MI and noting discrepancies, as many clinicians are likely to be using facets of ACT and recommending for MI (Nishikawara & Maynes, 2023) simply due to its conceptual fit but without thought to its demonstrated effectiveness as a treatment.

ACT-MI was conducted in both group and individual formats as well as in-person and via telehealth. Current ACT-MI protocol suggests between 8 to 12 sessions, partly informed by Farnsworth et al. (2017) study which only had six sessions and had participants report as inadequate treatment length. ACT has been effective in those studies in reducing depression and PTSD post-treatment but without maintaining effectiveness at follow-up (Jones et al., 2022) as well as little evidence of impact on MI, however, that is likely due to poor choice of measures for MI. Telehealth treatment was positively received by clients which is promising to be able to deliver interventions where there may otherwise be logistical disadvantages. Interestingly, despite limited follow-up effects, participants mentioned they would recommend the intervention to their peers, in that veteran specific study (Jones et al., 2022).

Furthermore, a US veteran conveyed a greater appreciation and value from receiving ACT-MI compared to previous cognitive and trauma focused therapies (Borges, 2019). However, positive qualitative data, while valuable, cannot be mistaken as an appropriate evidence-base for a psychological intervention.

Moral Injury Aetiology

From the review of the literature, it was important to understand MI's aetiology, regarding predictive factors as to why certain individual's suffer MI and what are MI's mechanism of injury, and, therefore, who would be more susceptible to both injury and treatment. A simple understanding of MI's aetiology is that exposure to events that are morally injurious cause moral injury, this hypothesis can be defined as events-based moral injury (Litz, 2009). Moral injury causation could also be understood as the result of Bi-Directional Meaning-Making. This is based on the concept that an individual's perception of the world influences their experiences in life, and that a morally injuring experience is either incorporated into their preexisting moral worldview or, alternatively, they fail to integrate their experiences in life which then progresses into moral injury (Barr et al., 2022; Farnsworth et al., 2017; Nieuwsma et al., 2015). This understanding of aetiology and maintenance underscores much of the ACT for MI principles. A final theory is based upon developmental theory, called psycho-spiritual values development, which is based upon Fowler's stages of faith and Kohlberg's earlier theory of moral development (Harris et al., 2015). This postulates that people typically progress from earlier psycho-spiritual stages with its concrete and rigid application of moral values to latter stages with its more abstract, flexible, and principled application of the same moral values. This also suggests that earlier stages are more susceptible to violations to one's moral values and, therefore, MI. Whereas the progression to latter stages are a protective factor to incurring MI, despite a moral violation occurring. The framework from which a person formulates MI was relevant to the

perceived efficacy of ACT as a study (Borges, 2019) as studies defining MI through an event-based moral injury theory were less likely to recommend ACT as a viable treatment. Psycho-spiritual values development and bi-directional meaning making were theories more aligned with ACT as a treatment of MI, however, there also remains some limitations in understanding causation.

Moral Injury Assessment

Following from the importance of the aetiological framework in understanding MI, correct "diagnosis" was, additionally, critical to the effective treatment of MI (D'Alessandro-Lowe et al., 2025). A major concern regarding using ACT for MI is how MI is assessed and ACT's efficacy is measured. Due to the historical heterogeneity in the definition of 'moral injury', research was focused on construct validity and much of the construct validity was inconsistent. Consequently, there are more MI measures available than there are valid measures, with majority of valid measures pertaining to specific populations instead of being generalisable (Hall et al., 2022).

Moral injury scales, such as Moral Injury Experiences Scale for Youth and the Moral Injury Events Scale (MIES) (Nash et al., 2013), have been developed and validated as screening tools. Yet they provide limited value in treatment as they do not identify treatment effects, only indicating the presence of MI, as once a morally injurious event has been experienced it will always have been experienced. Therefore, MIES, and any screening tool, is inappropriate to track treatment progress and immediately invalidates any evaluation, as the existence of exposure does not equal existence of a disorder. Ironically, Bluett (2017) study showcases the issues of using MIES as the treatment measure, as their participant scores, and the number of participants identifying with moral injury events, increased post-treatment.

There exists a couple of validated self-report measures for MI. These scales move away from simple exposure of symptom clusters and progressed to broader domains of impact. Moral Injury and Distress Scale (MIDS), which was developed by the American Veterans Association's National Center for PTSD (Norman et al., 2024) and the Moral Injury Outcome Scale (MIOS) (Litz et al., 2022) which has also been normed to Australian population. However, there were no studies found that examined ACT-MI's efficacy and tracking treatment progress with the MIOS.

Limitations and Future Directions

The reviewed studies highlight the predominant concerns with ACT for MI. First, previous studies do not always effectively measure MI in a manner to track outcomes. Secondly, some ACT studies have limited effects on follow-up. Third, ACT studies are often population specific, with small sample sizes, and thus results may not be generalisable to first responders. Moreover, while RCT studies are underway to address these issues, there are many different formats of ACT being research with various protocols (Evans et al., 2023), which may only increase the heterogeneity concerns than establish efficacy. Finally, beyond the distinct lack of RCTs, with no demonstrable causal links between treatment and recovery, there are no comparison studies in ACT against other MI intervention protocols. However, encouragingly, this has been acknowledged in literature and will be remedied (Borges et al., 2022). Therefore, while there are strong theoretical foundations for ACT as a MI intervention with some emerging findings, there needs to be far stronger empirical evidence-base before it can be recommended as a preferred evidence-based treatment for first responders, let alone any population group.

There is also an evident lack of longitudinal studies regarding impact, treatment efficacy, and lasting recovery within MI research, despite the increasing quantity of MI articles. Moreover, there is limited diversity in moral injury literature regarding interventions

despite the wide-ranging population and demographic groups suffering from it, as well as a lack of critically evaluated treatments tailored for specific populations (ter Heide & Olff, 2023). Thus, a review, evaluating the efficacy of theoretically informed interventions is valuable. Furthermore, majority of the research has focused on military populations, using military language in MI scales and interventions, which highlights a need to review literature to find suitable treatments and measures for first responders. Additionally, there may be a gap between the moral values of a first responder and those of their employing organisation. This takes MI from an individual issue to a more systemic one. Yet, limited research was found on MI or ACT with first responders when their employing organisation is transgressing the first responder's moral values and they elect to remain in this working environment, without using experiential avoidance, despite a continuing violation of their personal moral values. Adding to this, despite MI being identified within Australian first responders (Phelps et al., 2023), there is no research assessing ACT efficacy as a MI intervention for first responders or in Australia.

Limitations of this review include a language bias. As only studies published in English were reviewed that may have introduced a language bias as well as discounted critical studies that could have been generalisable to the stated aim. The methodology of this paper was a narrative review which is inherently limiting due to not being an objective synthesis of all data and papers and thus findings are potentially skewed due to personal bias. Additionally, there is a selection bias present due to lack of a systemised full database search. Therefore, a systematic review of all MI interventions, and a meta-analysis of their efficacy, is recommended to be able to accurately discern the most appropriate MI treatment for first responders suffering from MI.

In conclusion, MI for first responders is of growing clinical importance due to its integration into the DSM-5-TR and its increased likelihood within the first responder context.

Yet there is no evidence-based intervention for Australian first responders with MI. ACT-MI has been proposed as a possibly effective intervention, as traditional PTSD interventions are inappropriate. However, despite literature recommending the theoretical feasibility and effectiveness of ACT-MI, no RCTs exist. Furthermore, the limited existing ACT-MI studies do not adequately account for confounds, do not include adequate controls, have minimal sample sizes which are predominately American veterans, demonstrate lackluster results at follow-up, and fail to measure MI appropriately. Therefore, it is hard to recommend ACT-MI as an appropriate intervention for MI in first responders anywhere let alone in Australia. Fortunately, no harm was identified in any ACT-MI literature, and the lack of alternatives merely underscores the urgent need for additional research, especially RCTs, into the efficacy for ACT-MI for first responders. Until then, ACT-MI may be clinically appropriate but must be employed with caution by the clinician.

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