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Author (year) Country	Aim	Sample (& diagnosis/trauma)	EMDR Intervention (e.g., duration, frequency, number of sessions)	Design & Outcome measure(s)	Results (main findings relevant to our review)	Author conclusions
Bashir et al. (2023) USA Quantitative	To measure changes in PTSD symptom severity in response to EMDR therapy in incarcerated individuals with PTSD and SUD.	N = 122 (60 females, 62 males); Mean age 34.5 years (SD = 8.3); 91% White, 9% Black. All met PTSD criteria and had SUD. Trauma types not specified.	Up to 10 sessions planned; Mean sessions: males 4.8 (SD = 1.9), females 5.6 (SD = 2.2). 30-40 minutes each	Pre-post design with follow-up at 2 weeks and 1 month. Measures: PCL-C, IES-R	Significant reduction in PCL-C scores from baseline (M = 53.2/post M = 15.2), $t(93) = 19.27$, $p < 0.001$ (Cohen's $d = 1.631$). Improvements maintained at 2 and 4 weeks. IES-R scores decreased significantly from Session 1 M = 56.0/Session 2 M = 48.9. No gender or racial differences.	EMDR therapy was effective in reducing trauma-related symptoms in incarcerated populations across gender and race. Staff reported reduced sanctions for infractions among treated residents
Colosetti & Thyer (2000) USA Quantitative	Compare the relative effectiveness of EMDR versus relaxation training in treating PTSD symptoms in battered women prisoners	N = 5 females; Ages 25-50 years; 4 White, 1 African American. All met DSM-IV PTSD criteria with history of intimate partner violence including physical, sexual abuse. Trauma incidents from 1969-1993	3 EMDR sessions (Participant 1 received additional sessions in a second EMDR phase)	Single-subject A-B-C design (baseline-relaxation training-EMDR). Measures: Beck Anxiety Inventory (BAI), Impact of Events Scale (IES) avoidance and intrusive thoughts subscales	Only 1 of 5 participants (Participant 2) showed improvement on BAI and intrusive thoughts during EMDR phase. Remaining 4 participants showed no meaningful improvement with EMDR beyond relaxation training effects	EMDR appeared no more effective than credible placebo treatment (relaxation training). Results suggest EMDR may not be sufficient to ameliorate effects of chronic abuse in this population
Every-Palmer et al (2024)* New Zealand	To assess the efficacy and safety of EMDR for people with PTSD and	N=24 adults with psychotic disorders and PTSD under forensic care (inpatient,	9 sessions of EMDR therapy (one 60-min case conceptualization session + eight 60-min processing sessions) using Shapiro's	Single-blind randomized controlled trial (RCT), 1:1 allocation, wait-list control Primary:	Primary outcome (CAPS): EMDR group had lower scores at 6 months: 21.8 (13.3) vs control 31.5 (20.7). Mixed linear model estimate difference: 11.4 [1.3, 21.4], $p=.028$. PTSD diagnosis: At 6 months, 16.7% EMDR group vs 36.4% control group still met PTSD criteria	EMDR appears safe and effective for treating PTSD in people with psychotic disorders in forensic

Quantitative	psychotic disorders receiving forensic care, including inpatients and prisoners	custodial, community). Mean age 39.5 years (SD=11.5), 67% male, 42% NZ European, 46% Indigenous Māori. Diagnoses: schizophrenia (58%), bipolar affective disorder with psychotic features (17%), unspecified psychosis (13%), schizoaffective (8%), major depression with psychotic features (4%). Trauma: Multiple lifetime traumas (M LEC score=31/51), primary trauma included index offense (n=10), childhood abuse (n=6), adult sexual/physical assault (n=3/n=3), other (n=2)	eight-phase standard protocol. Eye movements used as dual-attention stimulus. No stabilization period before starting EMDR	Clinician Administered PTSD Scale (CAPS) Secondary: PSS-SR, adverse events, psychotic symptoms (PSYRATS), social functioning, disability (WHODAS), self-esteem (RSES), depression (BDI-II), ~~posttrauma cognitions~~ <u>Posttraumatic Cognitions Inventory</u> (PTCI), Treatment Acceptability <u>/Adherence</u> Scale (TAAS)	(RR=0.46, (95% CI [0.10, 2.03])). Secondary outcomes: Significant improvements in self-esteem (p=.006), reduced depression (p=.005), reduced disability (p=.013), improved post trauma cognitions (p=.047) at 10 weeks. No significant differences in psychotic symptoms or adverse events. Acceptability: 83% completed therapy, mean TAAS scores above midpoint indicating positive attitudes	settings. Results support EMDR as appropriate treatment for PTSD comorbid with serious mental illness in forensic settings. No evidence of symptom exacerbation or increased adverse events. Treatment was well-tolerated and acceptable to participants
Ricci, Clayton & Shapiro (2006) United States	To examine therapeutic effects of adding EMDR trauma	N=10 adjudicated men who had offended sexually against children	Average of 6 EMDR sessions using standardized protocols (Shapiro, 2001).	Pre-post design with control comparison groups (n=22 total	PPG: Significant pre-post reduction in deviant arousal (pre/post × EMDR/control ANOVA interaction: $F(1,30)=17.520$, $p<.001$.) The t-test for the EMDR group alone is $t(9)=2.384$, $p=.04$ sustained at follow-up ($p=.03$).	Adding EMDR to CBT-RP treatment significantly improved treatment

(same sample as Ricci & Clayton 2008) Quantitative	treatment to standard Cognitive-Behavioural Therapy-Relapse Prevention sex offender treatment, particularly focusing on treatment motivation, empathy, and emotional tolerance	with reported childhood sexual abuse histories. Selected as more difficult/treatment-resistant clients based on inability to discuss offending, lack of emotional internalization, and repeated emotional triggers	Treatment considered complete when participants reported SUDS as low as expected	controls: 8 with CSA history, 14 without). Measures: TSI, SOTRS, polygraph, penile plethysmography (PPG). Follow-up PPG at 6-12 months (n=8)	Control groups showed no significant change. SOTRS: Significant improvements on all 6 subscales (insight, sexual thoughts, risk awareness, motivation, empathy, disclosure). SUDS: Significant reduction from 6.9 to 1.9 (p=.002). Sexual thoughts, motivation, and empathy correlated with PPG changes	outcomes. Most importantly, EMDR produced sustained reduction in deviant sexual arousal - a key predictor of recidivism. Results suggest EMDR addresses etiological trauma mechanisms underlying sexual offending behaviour
Ricci & Clayton (2008) United States (same sample as Ricci, Clayton & Shapiro 2006) Qualitative	To examine the underlying processes contributing to improved outcomes when EMDR is added as an adjunct to standard CBT-RP treatment for men who had offended sexually against children with histories of childhood sexual abuse	N=10 adjudicated men who had offended sexually against children, aged 18-52 years (M=37.5), all White, on community probation/parole. All had reported history of CSA and were having difficulty fully engaging in CBT-RP treatment. Trauma: childhood sexual abuse	Average of 6 EMDR sessions using standardized protocols. Processing focused on CSA memories believed to interfere with CBT-RP treatment engagement. SUDS considered complete when participants' reports were as low as expected	Qualitative study using grounded theory analysis. Measures: SUDS (0-10 scale), Sex Offender Treatment Rating Scale (SOTRS); 6 subscales, grounded theory analysis of transcripts and interviews	SUDS: Mean scores declined from 6.9 to 1.9 (p=.002). Once denial was processed, mean disturbance was 9.2, reducing to 1.9 post-treatment (p<.001). SOTRS: Statistically significant improvement on all 6 subscales (insight, sexual thoughts, risk awareness, motivation, empathy, disclosure, all p<.01). Qualitative themes: Recognition of contributors to distorted beliefs, increased empathy, improved participation in group therapy, clarification of thoughts, raised consciousness as self-management tool, enhanced self-esteem, better emotion recognition and management	Adding EMDR to standard CBT-RP treatment enhances treatment outcomes for child molesters. EMDR helps resolve trauma-related cognitive distortions and improves treatment engagement. Results suggest trauma resolution should be incorporated at the outset of CBT-RP programs to promote treatment readiness while addressing

						etiological mechanisms
Soberman, Greenwald, & Rule (2002), USA Quantitative	To examine whether trauma-focused EMDR would reduce conduct problems in boys by addressing underlying traumatic memories	N=29 boys (ages 10-16) with conduct problems in residential/day treatment. Primary diagnoses: Conduct Disorder (59%), PTSD (31%), ADHD (17%), Learning Disability (14%), Substance Abuse (13%), ODD (3%). All had traumatic memories	3 weekly 1-hour EMDR sessions following Shapiro (1995) protocol with population-specific adaptations for children/adolescents. Incomplete sessions used containment visualization	Randomized controlled trial. Treatment group (n=14) vs control group (n=15). Measures: SUDS, IES-8, CROPS, PROPS, PRS, BRS at pre-, post-, and 2-month follow-up	SUDS: Large significant reduction (6.1 vs 1.79 points, $p=.0001$). PRS: Significant reduction at 2-month follow-up ($p=.024$). IES scores moved to non-clinical levels in both groups ($p=.964$); no significant difference between conditions. PROPS showed a statistically significant reduction $F(1,19) = 5.10$, $p=.036$, favouring EMDR.	EMDR effectively reduced trauma-related distress and conduct problems. Findings support theory that trauma contributes to conduct problems and that effective trauma treatment can reduce behavioural symptoms. However, study limitations include single therapist and small sample size
Wright, Palmer, Kelly & Derefaka (2024) United Kingdom Qualitative	Gather detailed descriptions of the therapeutic process from individuals who experienced EMDR therapy for CSA memories; to explore changes in perceptions of abuse and offending	N = 5 males Ages 32-42 years (M=37.2) All White British All convicted of sexual offenses against children (contact, internet and/or exposure offenses) Victims aged 2-16 years All had disclosed being victims of CSA	Average 30 sessions (range 23-36) Standard EMDR protocol (Shapiro, 1995, 2018) All therapists were Clinical Psychologists trained in EMDR working in forensic psychology service No concurrent interventions	Qualitative study using Interpretative Phenomenological Analysis (IPA) Semi-structured interviews Data analysed to identify themes describing participants' experiences and changes	Three superordinate themes identified: (1) Changing Perceptions: Participants' views of CSA changed from consensual/positive to abusive/harmful. Realized they were victims leading to empathy for their own victims and remorse. No longer sexually attracted to children. Reduced sexual preoccupation. (2) Safety and Control: Felt safe around others including children. No longer triggered by seeing children. Escaped "cycle" of offending. Gained sense of control. EMDR enabled safe access to abuse memories without reexperiencing trauma. (3) Connectedness to Others: Recognized emotional connection with abuser. Understood motivations for offending included seeking emotional connection. Developed desire for healthy adult relationships. Improved social functioning.	EMDR led to adaptive changes in cognitive, emotional, sexual, & social functioning. Participants reported altered sexual arousal to children, increased victim empathy, greater accountability, reduced sexual preoccupation, and improved capacity for healthy adult relationships. Changes likely to

						positively impact risk of reoffending. EMDR may be used as adjunct to standard CBT interventions for individuals whose CSA contributed to sexual offending. Results consistent with previous EMDR research with this population.
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Note: ADHD = Attention-Deficit/Hyperactivity Disorder; ANOVA = analysis of variance; BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory-II; BRS = Behavioral Reward Scale; CAPS = Clinician-Administered PTSD Scale; CBT = cognitive behavioural therapy; CBT-RP = Cognitive-Behavioural Therapy-Relapse Prevention; CI = confidence interval; CJS = criminal justice system; CROPS = Child Report of Post-Traumatic Symptoms; CSA = childhood sexual abuse; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; EMDR = eye movement desensitization and reprocessing; IPA = interpretative phenomenological analysis; IES = Impact of Events Scale; IES-8 = Impact of Events Scale-8 Items; IES-R = Impact of Events Scale-Revised; LEC = Life Events Checklist; M = mean; N = number; NZ = New Zealand; ODD = oppositional defiant disorder; PCL-C = PTSD Checklist—Civilian Version; PPG = penile plethysmography; PROPS = Parent Report of Post-Traumatic Symptoms; PRS = Problem Rating Scale; PSS-SR = PTSD Symptom Scale-Self Report; PSYRATS = Psychotic Symptom Rating Scales; PTCI = Posttraumatic Cognitions Inventory; PTSD = post-traumatic stress disorder; RCT = randomized controlled trial; RR = relative risk; RSES = Rosenberg Self-Esteem Scale; SD = standard deviation; SOTRS = Sex Offender Treatment Rating Scale; SUD = substance use disorder; SUDS = Subjective Units of Distress Scale; TAAS = Treatment Acceptability/Adherence Scale; TSI = Trauma Symptom Inventory; WHODAS = World Health Organization Disability Assessment Schedule. ~~Note: ADHD = Attention Deficit Hyperactive Disorder; BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory-II; BRS = Behavioral Reward Scale; CAPS = Clinician Administered PTSD Scale; CBT-RP = Cognitive Behavioral Therapy Relapse Prevention; CROPS = Child Report of Post-Traumatic Symptoms; CSA = Childhood Sexual Abuse; IES = Impact of Events Scale; IES-8 = Impact of Events Scale-8 Items; IES-R = Impact of Events Scale-Revised; LEC = Life Events Checklist; ODD = Oppositional Defiant Disorder; PCL-C = PTSD Checklist for DSM-5—Civilian Version; PPG = Penile Plethysmography; PROPS = Parent Report of Post-Traumatic Symptoms; PRS = Problem Rating Scale; PSS-SR = PTSD Symptom Scale-Self Report; PSYRATS = Psychotic Symptom Rating Scales; PTCI = Posttraumatic Cognitions Inventory; PTSD = Post-Traumatic Stress Disorder; RR = Relative Risk; RSES = Rosenberg Self-Esteem Scale; SOTRS = Sex Offender Treatment Rating Scale; SUD = Substance Use Disorder; SUDS = Subjective Units of Distress Scale; TAAS = Treatment Acceptability/Adherence Scale; TSI = Trauma Symptom Inventory; WHODAS = World Health Organization Disability Assessment Schedule~~

*Every-Palmer et al. (2024) included a mixed forensic inpatient/custodial/community sample; findings were not disaggregated by criminal justice status and are treated as contextual evidence rather than direct CJS evidence in this review.