

The Effectiveness of Trauma-Focused Interventions With Individuals Who Perpetrated Crimes: A Systematic Review

TRAUMA, VIOLENCE, & ABUSE

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Abstract

Post-traumatic stress disorder (PTSD) is disproportionately prevalent among individuals who have committed crimes compared to the general population. Simultaneously, PTSD is associated with several adverse outcomes, including increased risk of suicidality in prison, poorer treatment outcomes, and higher rates of recidivism. This review seeks to systematize trauma-focused therapies for adult justice-involved populations. It examines their effectiveness across diverse approaches, forensic settings (e.g., prisons, forensic hospitals, probation), and demographic groups (e.g., men, women), expanding on prior reviews. Six databases (PubMed, Scopus, Web of Science, B-On, PsycInfo, and Scielo) were searched, resulting in 20 studies included. Results showed that most studies were conducted in the United States, primarily involving female participants in prisons. The findings suggested that both EMDR therapy and the Seeking Safety program are promising approaches for improving mental health outcomes—including PTSD, anxiety, and depression—among men and women in both prison and non-prison settings. However, evidence regarding behavioral change remains inconsistent. These approaches and programs show potential as effective treatments for individuals who have committed crimes. However, methodological limitations within the studies prevent definitive conclusions about their effectiveness.

Keywords

post-traumatic stress disorder, trauma-focused interventions, adults who perpetrated crimes, juveniles who perpetrated crimes, effectiveness

Introduction

Individuals who perpetrate crimes can cause significant harm to their victims, their families, and the broader community (e.g., Guay et al., 2019; Hailes et al., 2019). Consequently, it is essential to create suitable and effective psychological interventions to reduce the risk of these individuals relapsing into criminal behavior. To date, cognitive-behavioral therapy (CBT) has been the most widely used and effective approach for addressing criminogenic needs (i.e., factors that contribute to an individual's likelihood of engaging in criminal behavior) (Butters et al., 2021; Gannon et al., 2019; Sousa et al., 2022). However, recent research on adverse childhood and traumatic experiences highlights the importance of addressing the psychological effects of these experiences in interventions targeting these individuals (Levenson et al., 2015; Sousa, Gouveia, et al., 2024).

Forensic samples often exhibited higher prevalence rates of adverse childhood experiences (ACEs) than the general

population (e.g., Malvaso et al., 2022; Umpunjun et al., 2024). For instance, a recent systematic review reported that nearly 87% of justice-involved youth across 13 countries had experienced at least one adverse event. The likelihood of experiencing at least one ACE was more than 12 times higher for justice-involved youth compared to their non-justice-involved peers (Malvaso et al., 2022). Additionally, the presence of ACEs was associated with several adverse outcomes, such as poor psychological and physical health and criminal behavior (e.g., Braga et al., 2018; Sebalo et al., 2023).

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Post-traumatic stress disorder (PTSD) tends to be one of the negative outcomes of ACEs and is highly prevalent among individuals who have perpetrated crimes (e.g., Baranyi et al., 2018; Bianchini et al., 2022; Ternes et al., 2020). However, prevalence rates varied across studies, likely due to differences in how “current” PTSD symptoms were defined (Goff et al., 2007). A study conducted in 2022 found that 41% of justice-involved individuals had a PTSD diagnosis, often resulting from multiple lifetime traumas rather than a single episode (Bianchini et al., 2022). In contrast, another study reported that 7.7% of male in prison met the diagnostic criteria for PTSD, while 16.7% met the criteria for complex post-traumatic stress disorder (CPTSD) (Facer-Irwin et al., 2022). Moreover, evidence from multiple studies reveals that PTSD is more prevalent in females than in males (e.g., Giarratano et al., 2017; Heffernan et al., 2015; Komarovskaya et al., 2011). Giarratano et al. (2017) reported that, among their male sample ($n = 301$), 18.6% met the criteria for a PTSD diagnosis, while 38.8% of women met the PTSD diagnostic criteria. In addition, the literature stated that individuals who perpetrated crimes can develop PTSD as a result of committing the crime (e.g., Soh et al., 2023).

ACEs and trauma are considered risk factors for criminal behaviors and for recidivism (e.g., Lattimore et al., 2022; Taylor et al., 2020; Wojciechowski, 2020). Additionally, PTSD has been linked to a higher occurrence of behavioral issues in custody, including aggression and suicidality (Facer-Irwin et al., 2019). Several studies and theoretical models have been proposed to explain the connection between ACEs/trauma and the onset and persistence of criminal behavior, both directly and indirectly (Craig et al., 2017; Vitopoulos et al., 2019). Specifically, adverse and/or traumatic experiences may impair an individual’s psychological functioning (Craig et al., 2017; Tripodi, Pettus-Davis, et al., 2019), leading to difficulties with emotional regulation and increased substance use (e.g., Sharma et al., 2015)—both key risk factors for criminal offending (Bonta & Andrews, 2017). In fact, poor self-regulation has been identified as a primary mechanism through which traumatic experiences raise the risk of recidivism (Dalsklev et al., 2019). Moreover, trauma exposure may interfere with interpersonal functioning throughout life, which may also contribute to reoffending. For instance, disturbances in self-regulation can lead to the misinterpretation of social cues, resulting in aggressive or socially avoidant behaviors that may heighten the potential for violence and lead to disengagement from prosocial activities (Vitopoulos et al., 2019). Therefore, the literature supports the importance of trauma-informed assessment and treatment for individuals who have perpetrated crimes.

Trauma-Focused Therapies

Trauma-focused therapies are the base for PTSD treatment in several recent guidelines (Courtois et al., 2017; National Institute for Clinical Excellence, Mahon, 2024; National

Institute for Health and Care Excellence [NICE], 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2021). The most recommended interventions include trauma-focused cognitive-behavioral therapy (TF-CBT) (Cohen & Mannarino, 2015), prolonged exposure therapy (PE) (Foa et al., 2007), cognitive processing therapy (CPT) (Resick et al., 2008), and eye movement desensitization and reprocessing (EMDR) (Shapiro, 1989). These therapies help individuals process their trauma in structured environments to reduce symptoms. TF-CBT focuses on altering negative thoughts, behaviors, and emotions related to PTSD (Cohen & Mannarino, 2015). PE reduces avoidance through repeated exposure to trauma-related stimuli (Foa et al., 2007), while CPT helps reframe distorted beliefs, such as self-blame (Resick et al., 2008). EMDR combines exposure with guided eye movements to reprocess memories, easing distress (Courtois et al., 2017; NICE, 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2021). These treatments are widely supported for their effectiveness in reducing PTSD symptoms across different populations (Courtois et al., 2017; NICE, 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2021).

In addition to these well-established methods, other trauma-focused therapies are validated but less frequently applied to people with PTSD. Narrative exposure therapy (NET) helps individuals integrate traumatic events into a coherent life story, proving especially useful for those with multiple traumas, such as refugees (Schauer et al., 2011). Cognitive therapy (CT) addresses negative thoughts in a way like CPT (Ehlers et al., 2005). However, CT mainly focuses on identifying and challenging negative thoughts (Ehlers et al., 2005), while CPT specifically targets distorted beliefs related to trauma, such as self-blame and guilt. Additionally, present-centered therapy (PCT; Shea et al., 2003) focuses on current challenges rather than traumatic memories. Stress inoculation training (SIT; Meichenbaum, 1977, 1985) and relaxation therapy (RT; Hayes-Skelton et al., 2015; Taylor et al., 2003) both equip individuals with practical tools to manage trauma-related stress and anxiety. SIT is a skills-based approach that teaches individuals to cope with stressful situations by introducing techniques like controlled breathing, muscle relaxation, cognitive restructuring, and problem-solving (Meichenbaum, 1977, 1985). The goal is to “inoculate” individuals against future stress by helping them build resilience through practice (Meichenbaum, 1977, 1985).

On the other hand, RT focuses on techniques such as progressive muscle relaxation, guided imagery, and deep breathing exercises to promote a state of physical and mental calm (Hayes-Skelton et al., 2015; Taylor et al., 2003). Newer approaches, such as reconsolidation of traumatic memories (RTM; Gray & Bourke, 2015), aim to reduce the emotional intensity of traumatic memories by reactivating those memories in a controlled environment and then introducing interventions that disrupt the process by which the brain

reconsolidates or strengthens the memory, thereby weakening its emotional impact. Brief eclectic psychotherapy (BEP; Gersons et al., 2004) combines various therapeutic techniques to help individuals confront trauma and manage related emotions. While these therapies are less emphasized in treatment guidelines, they have shown promise in treating PTSD (Courtois et al., 2017; NICE, 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2021). Some are specifically designed for PTSD, whereas others are more general in scope. Approaches such as CT, RT, SIT, and PCT—though applied to PTSD—were not originally developed to target trauma-specific symptomatology (e.g., Ehlers et al., 2005; Meichenbaum, 1977, 1985).

Trauma-Focused Therapies Within Forensic Settings

Some systematic reviews and meta-analyses have examined the effectiveness of psychological treatments, including trauma-focused interventions, among both adults and juveniles who perpetrated crimes (e.g., Bartlett et al., 2015; Malik et al., 2023; Malvaso et al., 2024; Yoon et al., 2017). For instance, Olaghere et al. (2021) conducted a systematic review to assess the effectiveness of trauma-informed treatment programs for justice-involved youth and those at risk of justice system involvement who had experienced trauma. The findings revealed that only 6 out of 29 studies specifically focused on justice-involved youth. However, the results suggest that TF-CBT is an effective intervention (Olaghere et al., 2021). Furthermore, Siehl et al. (2021) conducted a meta-analysis to evaluate the effectiveness of trauma-informed therapy, specifically NET, across various samples, including individuals who perpetrated crimes. The findings indicated that the six included studies demonstrated a large effect size for this therapy, showing it to be significantly more effective than both active and non-active control treatments for adults and juveniles who perpetrated crimes with PTSD. More recently, Malik et al. (2023) conducted a systematic review and meta-analysis on the effectiveness of trauma-focused interventions in prisons compared to control groups, identifying 16 eligible studies. The studies included adult and juvenile samples, reporting a small but statistically significant effect size for the interventions (Malik et al., 2023). Most recently, Malvaso et al. (2024) conducted an umbrella review aimed at summarizing existing evidence to support the implementation of trauma-informed approaches in youth justice systems. Out of all the studies screened, only nine systematic reviews met the inclusion criteria. Across these reviews, positive outcomes were consistently reported, including reductions in trauma-related symptoms, improvements in mental health and overall well-being, and decreased involvement with the justice system (Malvaso et al., 2024).

Current Study

Although some previous reviews were conducted, they present some limitations. First, some reviews focused mainly on a specific therapy (i.e., NET; Siehl et al., 2021), and with juvenile samples (Malvaso et al., 2024; Olaghere et al., 2021). Second, when the reviews included different intervention approaches, they were often restricted to specific forensic settings and populations (i.e., incarcerated individuals; Malik et al., 2023). The present study seeks to offer a comprehensive and extensive systematic review of the empirical evidence on trauma-focused therapies in forensic settings, encompassing both male and female justice-involved individuals across a range of contexts, including custodial (e.g., prisons) and non-custodial settings (e.g., community, forensic hospitals). Specifically, this review aims to systematize the various trauma-focused therapies for justice-involved populations and their effectiveness. This expands on previous reviews by incorporating a broader range of trauma-focused approaches, diverse forensic environments (e.g., prisons, forensic hospitals, probation services), and different groups of justice-involved individuals (e.g., men, women, and adults). Considering the impact of ACEs, trauma symptoms, and PTSD on the development and persistence of criminal behaviors, we aim to assess the effectiveness of trauma-focused therapies both in the short term (e.g., clinical changes in trauma and PTSD symptoms, as well as reductions in criminogenic needs—risk factors for recidivism) and in the long term (e.g., reductions in recidivism rates).

Method

Protocol and Registration

The protocol for this systematic review adheres to the guidelines set by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) (Moher et al., 2010) and was registered on OSF REGISTRIES (reference: 10.17605/OSF.IO/SMQWB).

Eligibility Criteria

To be eligible for inclusion, articles must be (a) empirical studies employing quantitative methods (i.e., excluding literature reviews, theoretical papers, qualitative studies, commentaries, or letters to the editor). Case studies were included only if they presented quantitative data. Additionally, the following criteria were considered: (b) studies involving adult male and/or female individuals who have perpetrated crimes and were serving either prison or community sentences; (c) studies examining trauma-focused therapies (or in combination with guideline-recommended

treatments) with no restrictions on the therapeutic format—whether individual or group—, and in outpatient or inpatient settings; (d) studies reporting outcomes related to clinical changes (such as statistically improvements in criminogenic needs and symptomatology), and/or recidivism rates; and (e) studies written in English, Portuguese, or Spanish. No restrictions were placed on the year of publication. The trauma-focused therapies included were based on the guidelines for traumatic symptoms and disorders (Courtois et al., 2017; NICE, 2018).

Information Sources and Search Process

The first and second authors independently conducted a thorough search across relevant databases, including PubMed, Scopus, Web of Science, B-On, PsycInfo, and Scielo, completing the search for pertinent articles in September 2024. The search utilized the following terms, combined in various ways to identify relevant articles: (“trauma-informed” OR “trauma informed” OR “trauma-sensitive” OR “trauma sensitive” OR “trauma-integrated” OR “trauma integrated” OR “trauma-based” OR “trauma based” OR “trauma-oriented” OR “trauma oriented” OR “trauma systems” OR “trauma services” OR “trauma-aware” OR “trauma aware” OR “trauma-focused” OR “trauma focused” OR “trauma-focused intervention*” OR “trauma focused intervention*” OR “trauma informed care” OR “trauma-informed care” OR “TIC” OR “trauma-focused CBT” OR “TF-CBT” OR “Eye movement desensitization and reprocessing” OR “EMDR” OR “Narrative exposure therapy” OR “Cognitive therapy” OR “CT” OR “Cognitive processing therapy” OR “CPT” OR “Prolonged exposure” OR “PE” OR “present-centered therapy” OR “PCT” OR “Stress inoculation training” OR “SIT” OR “Relaxation Therapy” OR “RT” OR “Reconsolidation of Traumatic Memories” OR “RTM” OR “Brief Eclectic Psychotherapy”) AND (“Incarcerat*” OR “Prison*” OR “Sentenced” OR “Detainee*” OR “Felon*” OR “Remand” OR “Criminal*” OR “Perpetrat*” OR “Batterer” OR “Offend*” OR “Inmate” OR “forensic” OR “committ*”) AND (“Effectiveness” OR “Program Effectiveness” OR “Efficacy”).

Study Selection and Data Extraction

Two research team members used Rayyan software (Ouzzani et al., 2016) to review and synthesize all articles. Initially, articles identified through the search strategy and other sources were imported, and duplicates were removed. The two team members then independently conducted the first review round to assess each article’s eligibility and inclusion based on titles and abstracts. Following this, articles were selected for full-text analysis. In the second round of review, the same reviewers independently extracted data from the selected full-text articles using a standardized Excel data extraction sheet. The research team met after each review round to discuss disagreements and reach a consensus.

Data extraction encompassed the country of origin, year of publication, sample characteristics (including treatment group, control group if applicable, number of participants, age, gender, and index offense), intervention details (such as type of therapy, number of sessions, and treatment duration), setting, and treatment outcomes measured at pre-, post-, and follow-up stages, including the effect sizes of the outcomes (if available), as well as dropout rates. Following PRISMA guidelines, interrater agreement was calculated and demonstrated strong consistency, as reflected by Cohen’s Kappa coefficient ($K = .98$).

Quality Assessment

The methodological quality of all included studies was evaluated using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). The MMAT features two initial screening questions (e.g., “Are the research questions clearly stated?” and “Do the collected data adequately address the research questions?”) along with five criteria tailored to assess the methodological quality based on the study design. The five criteria depend on the type of study design but may include information related to the sample (e.g., “Is randomization appropriately performed?” “Are the groups comparable at baseline?”), the measures (e.g., “Are there complete outcome data?”), and the intervention (e.g., “Are outcome assessors blinded to the intervention provided?” “Did the participants adhere to the assigned intervention?”) (for a full list of criteria, see Hong et al., 2018). Each criterion is rated as “yes,” “no,” or “can’t tell.”

Data Analysis

The method involved a narrative synthesis approach, including narrative descriptions and tabular data summaries. This format allows readers to evaluate outcomes while considering variations in study designs and potential sources of bias across the reviewed studies. A meta-analysis was not feasible due to substantial heterogeneity in study designs and the limited number of studies with a low risk of bias (Paul & Barari, 2022).

Results

Selection of Evidence Sources

In total, 4328 articles were retrieved from the data searches, and 41 studies were found through supplementary searches. After removing duplicates, 2076 titles and abstracts remained and were screened for relevance. A total of 72 potentially relevant studies were selected for further examination. Then, 52 studies did not meet the inclusion criteria. The main reasons for exclusion were as follows: studies involving individuals without convictions, studies with samples of young participants, interventions that were not trauma-focused, non-empirical,

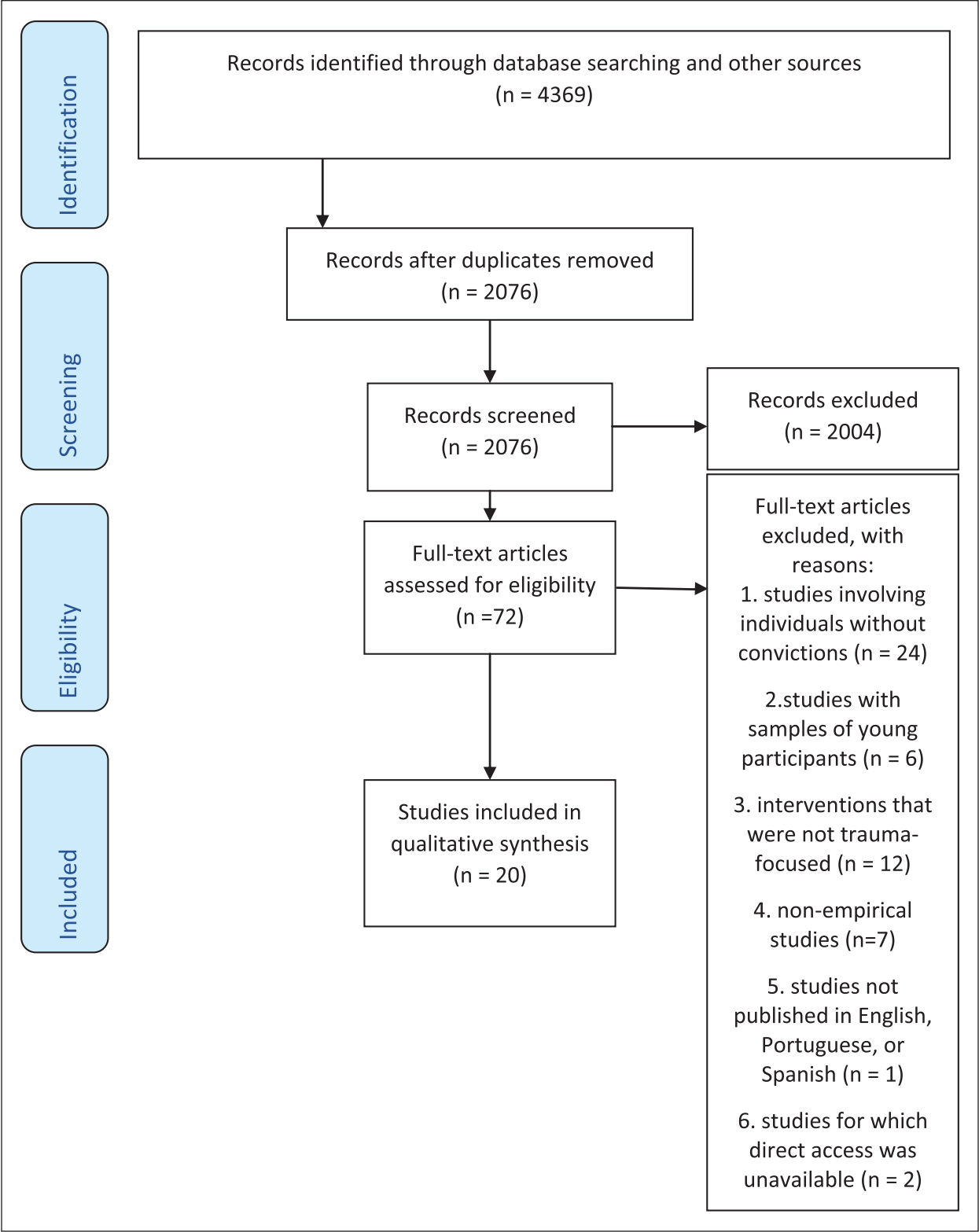


Figure 1. PRISMA flow diagram of the study selection process.

studies not published in English, Portuguese, or Spanish, and studies for which direct access was unavailable. Twenty papers were included in the final review. Figure 1 presents the

PRISMA flow diagram, detailing the number of studies included at each stage of the selection process and the reasons for their exclusion.

Quality Assessment

Several study designs were identified, namely, randomized controlled trials (RCT; $n=9$, Barrett et al., 2015; Cole et al., 2013; Every-Palmer et al., 2024; Ford et al., 2013; Kubiak et al., 2016; Tripodi, Mennicke, et al., 2019, 2022; Wolff et al., 2015; Zlotnick et al., 2009), descriptive studies ($n=7$; Bashir et al., 2023; Colosetti & Thyer, 2000; Fleurkens et al., 2018; Messina et al., 2016; Ward & Roe-Sepowitz, 2009; Wolff et al., 2012; Zlotnick et al., 2003), and non-RCT (e.g., cohort studies, non-randomized controlled trials) ($n=4$; Brown et al., 2015; Feingold et al., 2018; Lynch et al., 2012; Swopes et al., 2017).

Of the included studies, 1 study showed all criteria of excellence (Ford et al., 2013), 2 presented four out of five criteria of excellence (Lynch et al., 2012; Tripodi, Mennicke, et al., 2019), and 10 showed three out of five criteria (Barrett et al., 2015; Cole et al., 2013; Colosetti & Thyer, 2000; Every-Palmer et al., 2024; Fleurkens et al., 2018; Kubiak et al., 2016; Messina et al., 2016; Swopes et al., 2017; Ward & Roe-Sepowitz, 2009; Wolff et al., 2015). The remaining studies did not show an acceptable quality and low risk of bias, with four studies meeting only two criteria (Bashir et al., 2023; Feingold et al., 2018; Wolff et al., 2012; Zlotnick et al., 2003), and three studies presenting only one criterion (Brown et al., 2015; Tripodi et al., 2022; Zlotnick et al., 2009). Studies with unacceptable quality did not specify how randomization was conducted, merely stating that the assignment of participants to conditions was random. Furthermore, the groups were not compared on baseline variables of interest, and there was a significant loss of participants, with many participants failing to contribute to almost all measures. In non-randomized and descriptive studies, the limitations in study quality were related to the lack of sample representativeness, the absence of description of psychometric characteristics for the instruments used to assess the effectiveness of the approaches/programs, and the significant loss of participants by the end of the study (see Table 1)

Characteristics of Included Studies

Studies Characteristics. The publication years of the included studies ranged from 2000 (Colosetti & Thyer, 2000) to 2024 (Every-Palmer et al., 2024), distributed as follows: 2000 ($n=1$), 2003 ($n=1$), 2009 ($n=2$), 2012 ($n=2$), 2013 ($n=2$), 2015 ($n=3$), 2016 ($n=2$), 2017 ($n=1$), 2018 ($n=2$), 2019 ($n=1$), 2022 ($n=1$), 2023 ($n=1$), and 2024 ($n=1$). Most studies were conducted in the United States (USA, $n=17$), with others carried out in Australia (Barrett et al., 2015), New Zealand (Every-Palmer et al., 2024), and the Netherlands (Fleurkens et al., 2018).

Sample Characteristics. The sample sizes of the studies ranged from one participant (Fleurkens et al., 2018) to 323 participants (Wolff et al., 2015). The mean age of the

participants ranged from 30.77 (Swopes et al., 2017) to 43.07 (Tripodi, Mennicke, et al., 2019). The analysis revealed that most studies ($n=13$) exclusively included women. However, four studies included both women and men (Bashir et al., 2023; Brown et al., 2015; Every-Palmer et al., 2024; Feingold et al., 2018), while three studies focused solely on male participants (Barrett et al., 2015; Fleurkens et al., 2018; Wolff et al., 2015).

Regarding the types of crimes committed by the participants, five studies focused on violent crimes (Every-Palmer et al., 2024; Kubiak et al., 2016; Messina et al., 2016; Wolff et al., 2012, 2015), one on non-violent crimes (Lynch et al., 2012), one on drug-related crimes (Swopes et al., 2017), one on prostitution-related crimes (Ward & Roe-Sepowitz, 2009), and another on felony crimes (Zlotnick et al., 2003). Additionally, three studies included a variety of crimes (e.g., assault charges, theft, drug-related offenses, extortion) (Brown et al., 2015; Feingold et al., 2018; Fleurkens et al., 2018), while eight studies did not specify the participants' convictions (see Table 2).

Intervention Procedures. Most studies implemented the intervention in a group format ($n=12$), while only two employed an individual approach ($n=2$), and another two combined both group and individual formats. However, four studies did not report how the intervention was applied (Barrett et al., 2015; Bashir et al., 2023; Every-Palmer et al., 2024; Feingold et al., 2018). Furthermore, most studies took place in prisons ($n=16$), with only one study applying the intervention in a community setting (Brown et al., 2015) and another in a forensic psychiatric setting (Fleurkens et al., 2018). The remaining studies applied the intervention in various settings, such as one study applying in community and prison settings (Ward & Roe-Sepowitz, 2009) and another applying in community, prison, and forensic psychiatric settings (Every-Palmer et al., 2024). The interventions also varied in duration, ranging from a minimum of 8 sessions (Barrett et al., 2015) to a maximum of 28 sessions (Wolff et al., 2012).

As for the studies that included a sample of facilitators, five involved professionals who were trained and certified in EMDR therapy (Bashir et al., 2023; Brown et al., 2015; Colosetti & Thyer, 2000; Every-Palmer et al., 2024; Fleurkens et al., 2018). However, only one study specified the facilitators' professional background (Every-Palmer et al., 2024), identifying them as psychologists and psychiatrists. In addition, in seven studies, the facilitators were non-psychologist professionals, with diverse professional backgrounds including social workers, criminologists, counsellors, and clinicians (Brown et al., 2015; Feingold et al., 2018; Kubiak et al., 2016; Messina et al., 2016; Ward & Roe-Sepowitz, 2009; Wolff et al., 2012; Swopes et al., 2017). Moreover, one study included psychology facilitators (Barrett et al., 2015), and two studies involved a team with diverse professional backgrounds, some of whom were from the field of psychology (Ford et al., 2013; Wolff et al., 2015). Two studies did not specify the professional

Table 1. Findings From the Quality Appraisal of the Included Studies.

Items	Is randomization appropriately performed?	Are the groups comparable at baseline?	Are there complete outcome data?	Are outcome assessors blinded to the intervention provided?	Did the participants adhere to the assigned intervention?
RCTs Studies					
Barrett et al., 2015	Yes	No	No	Yes	Yes
Cole et al., 2013	Yes	No	Yes	No	Yes
Every-Palmer et al., 2024	Yes	No	Yes	No	Yes
Ford et al., 2013	Yes	Yes	Yes	Yes	Yes
Kubiak et al., 2016	Yes	No	Yes	No	Yes
Tripodi, Mennicke, et al., 2019	Yes	Yes	Yes	No	Yes
Tripodi et al., 2022	No	No	No	No	Yes
Wolff et al., 2015	No	Yes	Yes	No	Yes
Zlotnick et al., 2009	No	No	No	No	Yes
	Is the sampling strategy relevant to address the research question?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the research question?
Descriptive studies					
Bashir et al., 2023	No	No	Yes	No	Yes
Colosetti & Thyer, 2000	No	No	Yes	Yes	Yes
Fleurkens et al., 2018	No	No	Yes	Yes	Yes
Messina et al., 2016	Yes	No	No	Yes	Yes
Ward & Roe-Sepowitz, 2009	No	No	Yes	Yes	Yes
Wolff et al., 2012	No	No	No	Yes	Yes
Zlotnick et al., 2003	No	No	No	Yes	Yes
	Are the participants representative of the target population?	Are measurements appropriate regarding both the outcome and intervention (or exposure)?	Are there complete outcome data?	Are the confounders accounted for in the design and analysis?	During the study period, is the intervention administered (or exposure occurred) as intended?
Non-RCT					
Brown et al., 2015	No	No	No	No	Yes
Feingold et al., 2018	No	No	No	Yes	Yes
Lynch et al., 2012	No	Yes	Yes	Yes	Yes
Swopes et al., 2017	No	No	Yes	Yes	Yes

Table 2. Characteristics of the Included Studies.

Study	Design	Sample characteristics (n, M age, gender)	Country	Treatment program and type	Intervention format, timing, and setting	Control	Outcome measures	Outcome/dropout rates
Barrett et al., 2015	RCT	TG: n = 15, n/a, male CG: n = 15, n/a, male	Australia	SS + TAU	n/a, 8 sessions, prison	TAU	Clinical change (with follow-up)	Both treatment groups show differences in PTSD symptom severity (baseline-posttest: $d = 0.96$; baseline-follow-up: $d = 0.94$) and PTSD-related cognitions (baseline-posttest: $d = 1.4$; baseline-follow-up: $d = 1.2$) Dropout rate: 33.3% Significant reduction in PTSD scores from baseline to the other evaluation moments ($d = 1.6$) Dropout rate: 22.95%
Bashir et al., 2023	Descriptive study	n = 122, M = 34.5, both	USA	EMDR	n/a, 10 sessions, prison	n/a	Clinical change (with follow-up)	The recidivism rate for graduates who selected EMDR therapy was 12% The recidivism rate for graduates who declined EMDR therapy was 33% The recidivism rate for the control group (PAU) was 10% Dropout rate: 25.3%
Brown et al., 2015	Non-randomized study	TC: n = 150, n/a, both CC: n = 70, n/a, both	USA	SS + EMDR	Group and individual, n/a, community	PAU	Recidivism (postprogram conviction)	Decreases in trauma scores, but the symptomatology remains the same.
Cole et al., 2013	RCT	TC: n = 4, n/a, women CC: n = 5, n/a, women	USA	Trauma-focused intervention	Group, 16 sessions, prison	WL	Clinical changes	P1: no changes in all measures.
Colosetti & Thyer, 2000	Case series study	n = 5, M = 38.8, women	USA	EMDR + relaxation therapy	Individual, n/a, prison	n/a	Clinical changes (with follow-up)	P2: Anxiety and intrusive thoughts scores improved after EMDR. P3: In follow-up, anxiety was higher and intrusive thoughts and avoidant behavior was lower. P4: Deterioration at follow-up. P5: During EMDR there was deterioration.
Every-Palmer et al., 2024	RCT	TG: n = 12, M = 40.7, both CG: n = 12, M = 38.4, both	New Zealand	EMDR + TAU	n/a, 9 sessions, inpatient, custodial, and community	TAU	Clinical changes	Dropout rates: 0% There are significant reductions in PTSD scores depressive symptoms and disability. There are also better results in self-esteem, all in favor of treatment condition.
Feingold et al., 2018	Non-randomized study	n = 72, M = 39.26, both	USA	CPT + CBT + MI	n/a, 12 sessions, prison	n/a	Clinical changes	Dropout rate: 8.3% Symptoms of PTSD and depression decreased over time Dropout rate: 44%
Fluurkens et al., 2018	Case Study	n = 1, 35 years, men	Netherlands	EMDR	Individual, 12 sessions, forensic psychiatric setting	n/a	Clinical changes (with follow-up)	There is a decrease in PTSD symptoms and in the negative cognitions about the self, the world, and self-blame. Dropout rate: 0%
Ford et al., 2013	RCT	TG: n = 38, M = 34.6, women CG: n = 34, M = 38.0, women	USA	TARGET	Group, 12 sessions, prison	SGT	Clinical changes	Both interventions achieved statistically significant reductions in PTSD ($d = .13$) and associated symptom severity ($d = -.026$ to 0.42) and increased self-efficacy ($d = .06$), without significant differences between the interventions. Dropout rates: less than 10%
Kubiak et al., 2016	RCT	TG: n = 24, M = 33.79, women CG: n = 18, M = 33.66, women	USA	BV	Group, 20 sessions, prison	TAU	Recidivism	No woman from either condition returned to prison during the 12-month study period; there is significant differences between groups in jail stay; women who received BV were less likely to recidivate than those who received TAU (OR = 0.19). Dropout rates: 0%
Lynch et al., 2012	Non-randomized trial	TG: n = 59, n/a, women CG: n = 55, n/a, women	USA	SS	Group, 24 sessions, prison	WL	Clinical changes	Women in TC showed more significant decrease in depression ($d_{TG} = .96$, $d_{CG} = .28$), PTSD symptoms ($d_{TG} = 1.33$, $d_{CG} = .78$), maladaptive coping ($d_{TG} = .84$, $d_{CG} = .18$) and more interpersonal functioning ($d_{TG} = .70$, $d_{CG} = .28$) and adaptive coping ($d_{TG} = -.31$, $d_{CG} = .03$) than control group. Dropout rates: 3%
Massina et al., 2016	Descriptive study	n = 91, 37.3, women	USA	BV	Group, 20 sessions, prison	n/a	Clinical changes	There is a decrease in depression ($d = .44$), anxiety ($d = .49$) and other serious mental illness ($d = .35$) as well as in instrumental anger ($d = .57$) and aggression/hostility ($d = .42$). There is also a decrease in PTSD levels ($d = .44$).

(continued)

Table 2. (continued)

Study	Design	Sample characteristics (n, M age, gender)	Country	Treatment program and type	Intervention format, timing, and setting	Control	Outcome measures	Outcome/dropout rates
Swopes et al., 2017	Non-randomized trial	TG: n = 34, M = 38.53, women; CG: n = 22, M = 30.77, women	USA	HWR/ BT	Group, n/a, prison	n/a	Clinical changes	Treatment condition reported significantly fewer negative posttraumatic cognitions than the control condition following treatment ($\eta^2 = .15$). No differences were found by Time or Treatment condition for the remaining mental health symptoms (depression, anxious arousal, dissociation, and tension reduction). Dropout rates: 1% A clinically significant reduction in depressive symptoms at posttest ($\eta^2 = .16$). There was a clinically significant reduction in PTSD symptoms at posttest for the treatment group compared to the control group ($\eta^2 = .17$), with evidence of sustained improvement at the 4-month follow-up ($\eta^2 = .21$). Dropout rates: 35% Both treatments showed statistically significant improvements in anxiety ($\eta^2 = .38$), depression ($0 = .36$), PTSD ($\eta^2 = .38$), and coping self-efficacy ($\eta^2 = .25$). Only coping self-efficacy scores demonstrated a significant between-group effect ($\eta^2 = .98$), with the SS group reporting significant differences at posttest. Dropout rates: 50.6% There is a degree in PTSD symptoms, depression, intrusive experiences, defensive avoidance, dissociation, and impaired self-reference. Dropout rates: 0%
Tripodi, Mennicke, et al., 2019	RCT	TG: n = 20, M = 43.07, women CG: n = 20, M = 37.33, women	USA	SS	Group, n/a, prison	TAU	Clinical changes (with follow-up)	Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%
Tripodi et al., 2022	RCT	TG: n = 43, M = 42.43, women CG: n = 42, M = 38, women	USA	SS	Group, 25 modules, prison	STAIR	Clinical changes	A significant decrease was found in PTSD symptoms ($d = .56$) and mental health symptoms ($d = .47$) from pre- to post-intervention. Dropout rates: 22.2% M-TREM was found to improve PTSD severity and SS improved general mental health symptoms and psychological functioning. However, no clear superiority was found between the treatments. Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%
Ward & Roe-Sepowitz, 2009	Descriptive study	Group 1: n = 11, M = 36.73, women Group 2: n = 18, M = 30.89, women n = 74, M = 36.0, women	USA	Esua	Group, 12 sessions, prison and community	n/a	Clinical changes	A significant decrease was found in PTSD symptoms ($d = .56$) and mental health symptoms ($d = .47$) from pre- to post-intervention. Dropout rates: 22.2% M-TREM was found to improve PTSD severity and SS improved general mental health symptoms and psychological functioning. However, no clear superiority was found between the treatments. Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%
Wolff et al., 2012	Descriptive study	n = 74, M = 36.0, women	USA	SS	group, 28 sessions, prison	n/a	Clinical changes	A significant decrease was found in PTSD symptoms ($d = .56$) and mental health symptoms ($d = .47$) from pre- to post-intervention. Dropout rates: 22.2% M-TREM was found to improve PTSD severity and SS improved general mental health symptoms and psychological functioning. However, no clear superiority was found between the treatments. Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%
Wolff et al., 2015	RCT	TG: n = 230, 43.0, male CG: n = 93, 40.0, male	USA	SS + TREM	Group, 28 sessions, prison	WL	Clinical changes	A significant decrease was found in PTSD symptoms ($d = .56$) and mental health symptoms ($d = .47$) from pre- to post-intervention. Dropout rates: 22.2% M-TREM was found to improve PTSD severity and SS improved general mental health symptoms and psychological functioning. However, no clear superiority was found between the treatments. Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%
Zlotnick et al., 2003	Descriptive study	n = 18, M = 31.9, women	USA	SS + TAU	Group, 24 sessions, prison	n/a	Clinical changes and returning to prison	A significant decrease was found in PTSD symptoms ($d = .56$) and mental health symptoms ($d = .47$) from pre- to post-intervention. Dropout rates: 22.2% M-TREM was found to improve PTSD severity and SS improved general mental health symptoms and psychological functioning. However, no clear superiority was found between the treatments. Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%
Zlotnick et al., 2009	RCT	TG: n = 23, 36.5, women CG: n = 21, 32.2, women	USA	SS + TAU	Group and individual, 25 sessions, prison	TAU	Clinical changes (with follow-up)	A significant decrease was found in PTSD symptoms ($d = .56$) and mental health symptoms ($d = .47$) from pre- to post-intervention. Dropout rates: 22.2% M-TREM was found to improve PTSD severity and SS improved general mental health symptoms and psychological functioning. However, no clear superiority was found between the treatments. Dropout rates: 13.5% There is a decrease in PTSD symptoms in posttreatment, in 6 weeks follow-up, and 3 months follow-up. There is also a decrease in drug/alcohol use in 6 weeks follow-up and in 3 months follow-up. Within 6 weeks of release, 2 (11%) of the women returned to prison, and within 3 months of release 6 (33%) returned to prison. Dropout rates: 0% SS vs TAU: no significant differences overall, except during follow-up, where SS showed some advantages. Dropout rates: 22.2%

Note. BT = Beyond Trauma; BV = Beyond Violence; CBT = Cognitive Behavioral Therapy; CPT = Cognitive-Processing Therapy; EMDR = Eye Movement Desensitization and Reprocessing; HWR/ BT = Help Women Recover / Beyond Trauma; MI = Motivational Interview; n/a = Not applicable; PAU = Program As Usual; P = Participant; SS = Seeking Safety; TAU = Treatment-As-Usual; TREM = Trauma-Recovery and Empowerment Male; WL = Waiting List;

background of the facilitators, stating only that they had received training in the intervention programs applied (Tripodi, Mennicke, et al., 2019, 2022).

Among the included studies, 12 studies featured a control group: 5 studies used treatment-as-usual as the control, 3 used a waiting-list control group, and 3 applied other therapeutic programs to the control group (see Table 2).

Treatment Approaches and Programs. This section is dedicated to detailing the therapeutic approaches and intervention programs that emerged in the included studies. Therapeutic approaches refer to single, specific trauma-focused therapies, such as EMDR or CPT, applied individually. Intervention programs are structured, manualized protocols that combine multiple therapeutic components, including at least one trauma-focused therapy, and are analyzed as a whole rather than as separate therapies.

Fourteen studies examined specific treatment programs, while seven studies focused on broader treatment approaches (see Table 2). Among the studies examining general approaches, four focused on EMDR, either alone or in combination with other approaches (see Table 1). Additionally, one study evaluated a combination of multiple approaches, including CPT, cognitive behavioral therapy (CBT), and motivational interviewing (MI). One study did not specify the trauma-focused approach used (Cole et al., 2013).

EMDR (Shapiro, 1989) is an integrative psychotherapy model that focuses on addressing traumatic memories and their associated stress symptoms. Guided by the Adaptive Information Processing (AIP) model (Shapiro, 2001), it suggests that psychopathology arises from unprocessed, distressing memories. A key aspect of the EMDR process involves the patient recalling traumatic events while engaging in bilateral stimulation (BLS), such as eye movements, alternating sounds, or tapping. BLS is believed to enhance information processing, reducing the emotional intensity of traumatic memories and helping integrate them into the patient's overall life narrative. CPT (Resick et al., 2008) integrates education about PTSD symptoms, information processing theory, exposure, and CT.

Among the treatment programs, the most frequently studied was Seeking Safety (SS), which was evaluated both as a standalone intervention ($n = 4$) and in combination with other approaches, including SS plus Treatment as Usual ($n = 3$), SS plus EMDR ($n = 1$), and SS plus Trauma-Recovery and Empowerment Male ($n = 1$). Other intervention programs included the Beyond Violence (BV) program ($n = 2$), the TARGET intervention ($n = 1$), ESUBA ($n = 1$), and Help Women Recover/Beyond Trauma ($n = 1$).

SS is a present-focused CBT program designed to help clients manage trauma and substance-related issues (e.g., Brown et al., 2015). Emphasizing safety as its central theme, the program offers 25 treatment topics that address cognitive, behavioral, interpersonal, and case management skills. Among these, specific modules include: (a) PTSD: Taking

Back Your Power, (b) Detaching from Emotional Pain: Grounding, (c) When Substances Control You, (d) Asking for Help and Taking Good Care of Yourself, (e) Compassion, (f) Recovery Thinking, (g) Coping with Triggers, and (h) Healing from Anger (Barrett et al., 2015; Brown et al., 2015; Lynch et al., 2012; Tripodi, Mennicke, et al., 2019, 2022; Wolff et al., 2012, 2015; Zlotnick et al., 2003, 2009). BV is a trauma-informed, gender-specific intervention designed for women in the criminal justice system with a history of violent offenses. The program aims to prevent recidivism and further violent behavior while improving mental health, anger management, and reducing substance use. The intervention addresses women's experiences of victimization, gender socialization, and the prevalence of co-occurring substance use and mental health disorders (Kubiak et al., 2016; Messina et al., 2016). The TARGET program focuses on teaching a structured skill set to improve affect regulation. This approach helps individuals recognize and manage negative emotional states while fostering and sustaining positive ones. It also aims to address dysregulation by enhancing the ability to anticipate, prevent, and recover from intense emotional distress linked to traumatic experiences (Ford et al., 2013). Furthermore, ESUBA program is a psychoeducational intervention that aims to increase awareness of abuse and violence while teaching anger management and communication skills. It helps women understand the impacts of abuse, promotes the sharing of experiences to reduce isolation, shame, and fear, and fosters the development of social support and adaptive social skills (Ward & Roe-Sepowitz, 2009). Lastly, the Help Women Recover/Beyond Trauma program (Swopes et al., 2017) addresses both substance use and trauma symptoms, drawing on relational theory and gender responsiveness. It combines psychoeducation, cognitive-behavioral techniques, and expressive arts (e.g., drawing and music) to enhance coping skills and emotional expression following trauma (Swopes et al., 2017).

Intervention Outcomes

The outcomes in this section will be presented according to the type of intervention, distinguishing between therapeutic approaches and intervention programs.

Treatment Outcomes. Treatment outcomes were examined in relation to the short- and long-term effects, type of intervention, treatment setting (i.e., prison, forensic hospitals, community), participant gender (i.e., men and women), country, and study quality.

Outcomes at Short-Long Term. In the short-term, both EMDR and CPT (either alone or in combination with other approaches) consistently demonstrated benefits in reducing PTSD symptoms and depression (Bashir et al., 2023; Cole et al., 2013; Every-Palmer et al., 2024; Fleurkens et al., 2018). However, only Bashir et al. (2023) reported effect

sizes, which were large ($d > 0.80$; Cohen, 1988; see Table 2). In contrast, evidence on long-term outcomes, particularly recidivism, remains limited and inconclusive. Only one study directly assessed recidivism (CPT+CBT+MI) and reported higher rates compared to other approaches (Feingold et al., 2018).

Outcomes by Type of Intervention. Among the four studies that explore EMDR approach, three reported significant reductions in PTSD symptoms, depressive symptoms, and negative cognitions (Bashir et al., 2023; Every-Palmer et al., 2024; Fleurkens et al., 2018). The only study that reported the effect sizes (Bashir et al., 2023) revealed large effect sizes ($d > 0.8$; Cohen, 1988; see Table 2). However, the case series study conducted by Colosetti and Thyer (2000), which involved five women using EMDR combined with relaxation therapy, revealed inconsistent results across participants in anxiety and intrusive thoughts and avoidant behavior (see Table 1). In 2018, a research team examined the effectiveness of CPT combined with CBT and MI. Their findings revealed a reduction in PTSD and depression symptoms over time (Feingold et al., 2018). Cole et al. (2013) also investigated the effectiveness of a trauma-focused approach, though without specifying the type. While trauma-related scores decreased compared to a control group, the symptomatology (e.g., somatization, obsessive-compulsion, anxiety, hostility, depression) remained unchanged. Dropout rates for EMDR interventions ranged from 0% (Fleurkens et al., 2018) to 22.95% (Bashir et al., 2023) (see Table 1). The CPT, CBT, and MI combined intervention showed the highest recidivism rates; however, this approach was evaluated in only one study (Feingold et al., 2018).

Overall, both EMDR and CPT show promising results in reducing PTSD symptoms and related depression, with five studies in six supporting these findings (Bashir et al., 2023; Cole et al., 2013; Every-Palmer et al., 2024; Fleurkens et al., 2018; Feingold et al., 2018). Other trauma-focused approaches also show potential benefits in reducing trauma symptoms but not in overall symptomatology (Cole et al., 2013).

Outcomes by Gender. EMDR was the primary approach implemented with male participants, either in studies using exclusively male samples (Fleurkens et al., 2018) or mixed-gender samples (Bashir et al., 2023; Every-Palmer et al., 2024). One study employed CPT and CBT combined with MI in a mixed-gender sample (Feingold et al., 2018). These interventions were primarily implemented in different settings (Every-Palmer et al., 2024; Fleurkens et al., 2018), except for Bashir et al. (2023), which was conducted in a prison context. Overall, the results for both men and women showed reductions in PTSD and depressive symptoms across the different therapeutic approaches (Bashir et al., 2023; Every-Palmer et al., 2024; Feingold et al., 2018; Fleurkens et al., 2018), although only Bashir et al. (2023) reported effect

sizes. However, Cole et al. (2013), in a study with women, reported reductions only in trauma symptoms, and Colosetti and Thyer (2000), also working with a female sample, found inconsistent results.

Outcomes by Treatment Setting. In prison settings, interventions such as EMDR, CPT combined with CBT and MI, and other trauma-focused approaches were used. In contrast, in non-prison settings, EMDR was the sole approach applied (Every-Palmer et al., 2024; Fleurkens et al., 2018). Overall, the outcomes of EMDR were similar across both prison and non-prison settings, with studies reporting reductions in PTSD and depressive symptoms in the different contexts (Bashir et al., 2023; Every-Palmer et al., 2024; Fleurkens et al., 2018). However, only one study reported the effect sizes (Bashir et al., 2023), despite being large ($d > 0.8$; Cohen, 1988; see Table 2). Approaches other than EMDR, implemented in prison settings, also demonstrated reductions in PTSD symptoms (Cole et al., 2013) and in both PTSD and depressive symptoms (Feingold et al., 2018). However, Cole et al. (2013) reported no improvements in symptoms beyond PTSD, and the study by Colosetti and Thyer (2000), also conducted in a prison setting, produced inconsistent results.

Outcomes by Country (U.S. vs. non-U.S. Countries). The two studies conducted outside the United States—in New Zealand and the Netherlands—utilized EMDR (Every-Palmer et al., 2024; Fleurkens et al., 2018). Similar to findings from the U.S.-based studies (Bashir et al., 2023; Colosetti & Thyer, 2000), these studies reported significant reductions in PTSD and depressive symptoms, as well as decreases in negative cognitions about the self, the world, and self-blame (Every-Palmer et al., 2024; Fleurkens et al., 2018). Additionally, improvements in self-esteem were observed (Fleurkens et al., 2018).

Outcomes by Quality of Studies. Considering only the studies with acceptable quality, among the three studies conducted with EMDR, two found promising results in reducing PTSD symptoms (Every-Palmer et al., 2024; Fleurkens et al., 2018) while one reported inconsistent results (Colosetti & Thyer, 2000). In addition, the unspecified trauma-focused approach also showed significant reductions in PTSD symptoms, but not in overall symptomatology (Cole et al., 2013). Notably, none of these studies reported effect sizes.

Treatment Programs Outcomes. Treatment outcomes were examined in relation to the short- and long-term effects, type of program, treatment setting (i.e., prison, forensic hospitals, community), participant gender (i.e., men and women), country and quality of studies.

Outcomes at Short-Long Term. In the short-term outcomes, pre-post studies without a control group reported improvements in PTSD symptoms, mental health outcomes, and

alcohol/drug use (Wolff et al., 2012; Zlotnick et al., 2003), with small to medium effect sizes ($d=0.47-0.56$; Cohen, 1988; see Table 2). Controlled studies also found positive effects on PTSD symptoms, depression, self-efficacy, and interpersonal functioning (Lynch et al., 2012; Tripodi, Mennicke, et al., 2019, 2022; Wolff et al., 2015), with small to large effect sizes ($d=0.47-1.33$, Cohen, 1988; $\eta^2=.16-.38$, Richardson, 2011; see Table 2). However, one study observed improvements in PTSD symptoms and cognitions without significant group differences (Barrett et al., 2015), with a large effect size ($d>0.8$; Cohen, 1988; see Table 2), while another found more favorable SS outcomes only at follow-up (Zlotnick et al., 2009). Regarding long-term outcomes, the evidence was mixed: one study found lower recidivism rates in the control group compared to SS (Brown et al., 2015), whereas another pre-post study reported that 11% of women returned to prison within 6 weeks and 33% after 3 months (Zlotnick et al., 2003). The BV program also showed promising results. In terms of short-term outcomes, it was associated with reductions in depression, anxiety, PTSD, and anger/hostility/aggression (Messina et al., 2016), with small to medium effect sizes ($d=0.35-0.57$; Cohen, 1988; see Table 2). For long-term outcomes, an RCT demonstrated that women in the BV condition were less likely to re-offend compared to controls ($OR=0.19$; Kubiak et al., 2016). The TARGET intervention, evaluated against supportive therapy as treatment-as-usual, showed positive short-term outcomes, with both groups reporting significant reductions in PTSD symptoms and severity, with small to medium effect sizes ($d=0.13-0.42$; Cohen, 1988; see Table 2), as well as improvements in self-efficacy, although the small effect size ($d<0.2$; Cohen, 1988). However, no differences were found between the two treatments (Ford et al., 2013), and no long-term outcomes were reported. The ESUBA program, tested in a small pre-post study, was found to reduce PTSD symptoms, with a large effect size ($\eta^2>0.14$; Richardson, 2011; see Table 2). Though no long-term outcomes were reported (Ward & Roe-Sepowitz, 2009). Finally, Help Women Recover/Beyond Trauma demonstrated effectiveness in reducing negative posttraumatic cognitions (Swopes et al., 2017), but again, no long-term outcomes were reported.

Outcomes by Type of Program. The effectiveness of BV varied significantly. In studies without a control group, differences were observed between pre- and post-intervention, particularly in PTSD symptoms (Wolff et al., 2012; Zlotnick et al., 2003), with a medium effect size ($d \geq 0.50$; Cohen, 1988; see Table 2), and alcohol/drug use (Zlotnick et al., 2003). Additionally, the percentage of women who returned to prison was 11% within 6 weeks of release and 33% after 3 months (Zlotnick et al., 2003). Among the remaining studies, four reported differences between the SS group and the control group across various variables, including PTSD symptoms, depression, self-efficacy, and interpersonal functioning

(Lynch et al., 2012; Tripodi, Mennicke, et al., 2019; Tripodi et al., 2022; Wolff et al., 2015), with medium to large effect sizes ($d = 0.70-1.33$, Cohen, 1988; $\eta^2 = .16-.38$, Richardson, 2011; see Table 2). One study found improvements in PTSD symptoms and associated cognitions with a large effect size ($d>0.8$; Cohen, 1988; see Table 2) but no significant differences between the SS and control groups (Barrett et al., 2015). Another study reported that group differences emerged only at follow-up, with SS showing more favorable outcomes (Zlotnick et al., 2009). However, one study that evaluated SS effectiveness based on recidivism rates found that the control group had lower rates (Brown et al., 2015).

One study evaluated the effectiveness of BV using a randomized controlled trial with 24 women in the treatment group and 18 in the control group, finding that participants in the BV condition were less likely to re-offend compared to the control group ($OR=0.19$; Kubiak et al., 2016). In contrast, Messina et al. (2016), using a different methodology, found that among a sample of 91 women, the intervention led to reductions in symptoms of depression, anxiety, PTSD, and anger/hostility/aggression, with effect sizes ranging from moderate to large ($d = 0.35-0.57$; Cohen, 1988; see Table 2).

The Ford et al. (2013) study evaluated TARGET program with supportive therapy as treatment-as-usual in a sample of 72 women, finding that both interventions significantly reduced PTSD symptoms and severity while improving self-efficacy, with no notable differences between them; however, the effect sizes were generally small, with a minimal impact on self-efficacy ($d=0.06-0.42$; Cohen, 1988; see Table 2).

Ward and Roe-Sepowitz (2009) tested the effectiveness of the ESUBA program. The study included two groups of women (total $n = 29$) without a control group and found a reduction in PTSD symptoms. Lastly, the Help Women Recover/Beyond Trauma (Swopes et al., 2017) revealed that the intervention is effective in reducing negative post-traumatic cognitions, with a large effect size ($\eta^2>0.14$; Richardson, 2011; see Table 2), although no significant effects were found for other mental health symptoms such as depression, anxious arousal, dissociation, or tension reduction.

Overall, SS was evaluated in nine studies, six of which showed its effectiveness in reducing both general symptomatology and trauma-related symptoms. One study found the intervention to be effective only at follow-up. Conversely, one study did not find evidence of effectiveness, and another reported better outcomes in the comparison group than in those who received SS. In addition, the BV, TARGET, ESUBA, and Help Women Recover/Beyond Trauma programs showed positive outcomes in lowering recidivism and PTSD-related symptoms; however, their effectiveness was assessed in a more limited manner, with only one or two studies evaluating each. Dropout rates ranged from 0% to 50.6%, with one study not reporting this information (see Table 2).

Outcomes by Treatment Setting. All the intervention programs were implemented in a prison setting, except for the ESUBA program, which was both implemented in a prison and community setting (Ward & Roe-Sepowitz, 2009), and the SS program, which was implemented in a community-based sample (Brown et al., 2015). The authors did not report results by setting, but the overall findings revealed decreases in PTSD symptoms (Ward & Roe-Sepowitz, 2009) and recidivism (Brown et al., 2015).

Outcomes by Gender. Among the different programs assessed, only SS was implemented with men (Barrett et al., 2015; Brown et al., 2015; Wolff et al., 2015). SS program revealed reductions in PTSD and mental health symptoms in both male (Barrett et al., 2015; Wolff et al., 2015) and female samples (Lynch et al., 2012; Tripodi, Mennicke, et al., 2019; Wolff et al., 2012; Zlotnick et al., 2003), with small to large effect sizes ($d=0.47$ – 1.33 , Cohen, 1988; $\eta^2=0.16$ – 0.21 , Richardson, 2011; see Table 2). Among women, SS participants also revealed improvements in adaptive coping (Lynch et al., 2012; Tripodi et al., 2022), with small to large effect sizes ($d>0.5$; Cohen, 1988; $\eta^2<.014$; Richardson, 2011; see Table 2), and decreases in drug use (Zlotnick et al., 2003).

Outcomes by Country (U.S. vs. non-U.S. Countries). The only study conducted outside the United States evaluating the effectiveness of the SS program (Australia; Barrett et al., 2015) reported results comparable to those found within the U.S. (Lynch et al., 2012; Messina et al., 2016; Tripodi, Mennicke, et al., 2019, 2022; Wolff et al., 2012, 2015; Zlotnick et al., 2003), showing reductions in PTSD symptom severity and PTSD-related cognitions, with large effect sizes ($d>0.08$; Cohen, 1988; see Table 2).

Outcomes by Quality of Studies. Considering only the studies with acceptable quality, the SS program was found to be effective in three studies in reducing PTSD, depression, interpersonal problems, and improving self-efficacy (Lynch et al., 2012; Tripodi, Mennicke, et al., 2019; Wolff et al., 2015), with medium to large effect sizes ($d = 0.70$ – 1.33 , Cohen, 1988; $\eta^2 = .16$ – $.21$, Richardson, 2011; see Table 2), but was ineffective in the study conducted by Barrett et al. (2015). In the two studies conducted on BV, the program was effective both in producing short-term changes (i.e., reductions in depression, PTSD, anxiety and anger/hostility/aggression) (Messina et al., 2016), with small to medium effect sizes ($d=0.35$ – 0.57 ; Cohen, 1988; see Table 2), and in long-term outcomes in terms of recidivism ($OR=0.16$; Kubiak et al., 2016). Additionally, the TARGET program demonstrated a near-large effect size for the primary outcome (PTSD symptom severity) and small-to-moderate effect sizes for all other outcomes (Ford et al., 2013). It should be noted, however, that this study is the only one meeting all quality criteria and is therefore of excellent quality. The ESUBA program

showed effectiveness in reducing PTSD symptoms (Ward & Roe-Sepowitz, 2009), and the Help Women Recover/Beyond Trauma program was effective in reducing negative posttraumatic cognitions (Swopes et al., 2017), with a large effect size ($\eta^2>.14$; Richardson, 2011).

Discussion

PTSD is significantly more common among individuals who have committed crimes compared to the general population and is associated with various adverse outcomes, including an elevated risk of suicidality in prison, poorer treatment responses, and higher rates of recidivism (e.g., Lattimore et al., 2022; Taylor et al., 2020; Wojciechowski, 2020). This study aims to provide a thorough, detailed, systematic review of empirical evidence on trauma-focused therapies in forensic contexts involving justice-involved individuals.

A total of 20 studies met the inclusion criteria, with sample characteristics that should be highlighted. First, most studies were conducted in the United States, focused on female samples, and occurred in prisons. The predominance of female samples contrasts with findings from other systematic reviews examining the effectiveness of therapies or intervention programs in forensic populations (e.g., Cunha, Pereira et al., 2024; Sousa, Andrade et al., 2024; Sousa, Gouveia et al., 2024). However, it may be linked to the high prevalence of ACEs and/or PTSD diagnoses among females who perpetrated crimes (e.g., Giarratano et al., 2017; Heffernan et al., 2015; Komarovskaya et al., 2011; Sousa et al., 2025). For instance, Giarratano et al. (2017) found that 38.8% of women incarcerated met the diagnostic criteria for PTSD, compared to 18.6% of men. Moreover, these results may also reflect the relatively recent development of trauma-informed care in male correctional institutions, given that, for a long time, interventions were highly confrontational and predominantly risk-focused (Kubiak et al., 2016; Levenson et al., 2022). The limited number of studies on trauma-informed interventions outside prison settings is also surprising and concerning—particularly given that these contexts include, among others, forensic hospitals, which house populations with severe mental conditions and have been consistently linked to high levels of adversity (Juwariah et al., 2022). As such, they may require tailored programs or interventions designed to support their rehabilitation (Sousa, Cunha, et al., 2024). Second, most of the studies included individuals who committed violent or various types of crimes (e.g., murder, theft, extortion). An interesting observation is that none of the studies included individuals who committed sexual offenses, despite evidence showing that this population—particularly those who committed offenses against children—has a higher prevalence of ACEs compared to those who committed other types of crimes (Levenson et al., 2015, 2017). There are specific guidelines to ensure that this population's ACEs are addressed through trauma-focused therapies before implementing any crime-focused intervention (Sousa et al., 2025). The presence

of ACEs and/or PTSD may influence participants' responsiveness to treatment, which, according to the risk-need-responsivity model (Bonta & Andrews, 2017), could undermine the effectiveness of interventions aimed at reducing recidivism.

The studies included also allow us to observe a set of important characteristics of interventions and their modes of implementation. Regarding treatment approaches, half of the studies focused on evaluating the effectiveness of EMDR, while CPT was assessed less frequently. Both therapies are among the most widely recommended treatments for PTSD (Courtois et al., 2017; NICE, 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2021). Treatment programs, on the other hand, employed a range of methods, with TF-CBT and psychoeducational models being the most prevalent (Barrett et al., 2015; Brown et al., 2015; Lynch et al., 2012; Tripodi, Mennicke, et al., 2019, 2022; Ward & Roe-Sepowitz, 2009; Wolff et al., 2012, 2015; Swopes et al., 2017; Zlotnick et al., 2003, 2009). While TF-CBT is strongly recommended for addressing trauma-related conditions, psychoeducational approaches lack similar endorsement (Courtois et al., 2017; NICE, 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2021). Moreover, most interventions were delivered in a group format. Although the World Health Organization guidelines (WHO, 2013) advocate both individual and group therapies for children and adults with PTSD, the NICE clinical practice guidelines (NICE, 2018) suggest that individual therapy is more effective for adult populations. Certain studies have also observed this pattern (e.g., Lee & Bowles, 2020). Indeed, a systematic review examining the effectiveness of trauma-focused approaches for individuals who committed crimes and were serving prison sentences revealed that individual treatments resulted in more significant reductions in PTSD symptoms (Malik et al., 2023). Moreover, it was found that most of the studies included facilitators applying the interventions without formal training in psychology, which was a surprising result. According to the literature, better outcomes could be achieved in terms of effectiveness if a qualified psychologist were consistently present (Gannon et al., 2019).

In terms of intervention effectiveness, there are two main points that should be considered and highlighted, namely dropout rates and both clinical and behavioral changes (i.e., short- and long-term outcomes). Regarding the dropout rates reported in the included articles, we observed significant variations (i.e., 0–50.6%). Although some studies still report very high dropout rates, approximately half had dropout rates below 25%, with seven presenting rates below 10%. Non-completion of treatment concerns researchers, practitioners, and society, as non-completers are more likely to re-offend (e.g., Carl & Lösel, 2021; Cunha, Pedrosa et al., 2024). Several factors may account for the lower dropout rates observed in these programs/approaches compared to other interventions/approaches, including the therapeutic paradigm. Unlike deficit-centered approaches, trauma-focused

therapies emphasize fostering patient growth and well-being. Research has shown that this supportive and respectful methodology positively impacts patients' confidence, better preparing them to address criminogenic factors and reducing the likelihood of treatment dropout (Marshall, 2021).

Moreover, the findings indicate that EMDR and CPT demonstrated consistent benefits in reducing PTSD and depression symptoms (i.e., short-term outcomes), although the evidence regarding their long-term effectiveness—particularly in controlling recidivism—remains limited (e.g., Bashir et al., 2023; Every-Palmer et al., 2024; Feingold et al., 2018; Fleurkens et al., 2018). When focusing exclusively on high-quality studies, EMDR and other trauma-focused approaches show more favorable outcomes, though effect sizes are rarely reported. Although only a small number of studies have examined EMDR among men who have committed crimes, positive changes in PTSD and depressive symptoms have been reported in both male and female participants (e.g., Bashir et al., 2023; Every-Palmer et al., 2024; Fleurkens et al., 2018). Comparable improvements have been observed in studies implementing EMDR across prison and non-prison settings (Bashir et al., 2023; Every-Palmer et al., 2024; Fleurkens et al., 2018), as well as in different countries. In short, despite the homogeneity of existing research in terms of country, gender, and setting, preliminary evidence suggests that trauma-based interventions outside the United States, with men, and in non-prison environments yield promising results, particularly in reducing PTSD and depressive symptoms.

In terms of the intervention programs, most showed improvements in PTSD, depression, and psychological functioning, with effect sizes ranging from small to large (e.g., Lynch et al., 2012; Tripodi, Mennicke, et al., 2019; Tripodi et al., 2022; Wolff et al., 2015). These results on clinical changes are promising, given that trauma and ACEs are recognized as risk factors for criminal behavior (Braga et al., 2017, 2018). Recent studies have shown that childhood maltreatment causes measurable neurobiological changes, reflecting adaptations to early abusive environments (McCrory et al., 2017). These changes may lead to long-term disadvantages by impairing the ability to adjust to typical social and environmental contexts (McCrory et al., 2017). Research highlights include altered neural responses to threat processing (e.g., in the amygdala), reduced neural activity in response to reward anticipation and reception, and increased activation in the anterior cingulate cortex, suggesting more significant effort during emotional regulation (McCrory et al., 2017). However, these neurobiological systems are also implicated in the development of dynamic risk factors and the central eight criminogenic needs (Bonta & Andrews, 2017). Regarding their long-term effectiveness, the results are mixed, with only a small number of studies available. Specifically, in relation to SS, some studies reported positive outcomes in recidivism, while others were inconclusive or even more favorable for the control group (Brown et al., 2015; Kubiak et al., 2016; Zlotnick

Table 3. Key Findings of the Systematic Review.

Most studies were conducted in the United States.
Most studies included female participants.
Most studies were conducted in prisons.
Participants were predominantly convicted of violent crimes or a diverse set of offenses.
The majority of the studies implemented the intervention in a group format.
The studies included in the review assessed a range of treatment approaches and programs.
Trauma-focused approaches and programs have positive effects on mental health, negative cognitions associated with PTSD, and anger/hostility/aggression.
Trauma-focused approaches showed inconsistent results in relation to recidivism rates.

et al., 2003). In addition, BV and TARGET did not demonstrate the same effectiveness in the short term as in the long term (Ford et al., 2013). When only the higher-quality studies are considered, only the SS and BV programs showed robust effects. This scarcity of studies focused on evaluating the effectiveness of interventions through the traditional method—recidivism rates—across different settings and populations has been a consistent pattern in recent systematic reviews focused on trauma-informed and novel approaches (Cunha, Pereira, et al., 2024; Sousa, Andrade et al., 2024; Sousa, Gouveia et al., 2024). The shift toward the analysis of clinical indicators can be justified by the objectives of the interventions (i.e., some were not directly aimed at reducing recidivism, but rather at alleviating PTSD symptoms), as well as by concerns surrounding the traditional method—particularly the absence of a universal definition of recidivism (Ostermann et al., 2015; Zgoba & Simon, 2005), the underreporting of various crimes (Prentky et al., 1997), and the use of disaggregated measures of recidivism (i.e., defined specifically as parole violation, arrest, conviction, or incarceration), which provide an incomplete picture of treatment effectiveness (Bouchard & Wong, 2022). However, a behavioral change indicator would be highly relevant to assess the effectiveness of interventions at that level.

Curiously, SS was the only program implemented with male individuals, showing outcomes (Barrett et al., 2015; Wolff et al., 2015) comparable to those found in female samples (Tripodi et al., 2022; Wolff et al., 2012; Zlotnick et al., 2003). This program, along with ESUBA, was among the few that have also been implemented in community settings (Brown et al., 2015).

Limitations

Although this systematic review makes important contributions, it has some limitations. The main limitation identified was the low quality of most studies, which may result from the challenges of implementing RCTs with this population (Sousa et al., 2022). Notably, only one study reviewed met all the MMAT criteria, while eight fulfilled only one or two. Furthermore, only 10 studies employed RCT designs; most had small sample sizes, and 6 lacked follow-up assessments.

For those who included follow-ups, the duration was often brief. Moreover, the predominance of studies conducted in the United States limits the generalizability and transportability of findings and interventions to other contexts—especially to countries with different legal, healthcare, and cultural systems. Legal and cultural factors influence how individuals perceive themselves and interact with their environment across all levels of the ecological system. Therefore, it is essential to adapt interventions in culturally sensitive ways, ensuring they reflect and incorporate the values, norms, and lived experiences of individuals’ cultural backgrounds (e.g., Marsiglia & Booth, 2015). Additionally, the heterogeneity in study designs, treatment objectives, and sample sizes hampers the ability to draw definitive conclusions about the effectiveness of trauma-focused therapies. Some limitations regarding our methodological choices also need to be addressed. Specifically, our analyses did not account for the ethnicity of the study samples, and future research should include this differentiation, as the literature indicates that social and cultural factors, including ethnicity, religion, and socioeconomic status, influence trauma experience and the response to treatment (Ford et al., 2015).

Implications for Research, Practice, and Policy

This systematic review sought to provide an in-depth analysis of the empirical evidence on trauma-informed therapies in forensic settings involving individuals who have committed offenses. To our knowledge, this is the first review to present a thorough overview of intervention programs using these therapeutic approaches across various forensic environments, including prisons, forensic hospitals, and community settings, with both adult men and women. In conclusion, the findings suggest that trauma-focused therapies show promising results on a clinical level, offering initial support for their application with individuals who have committed crimes (see Table 3).

The results highlight the urgent need to develop more individualized intervention programs focused on evidence-based trauma-focused therapies (NICE, 2018), particularly for men convicted of crimes serving sentences both in the community and in prison, as well as for women serving

Table 4. Implications for Research, Practice, and Policy.

Implications
Urgent need for evidence-based, trauma-focused interventions, especially for men convicted of crimes serving community sentences.
Importance of developing intervention programs tailored to specific groups (e.g., individuals who perpetrated sex crimes).
There is a strong need for high-quality RCTs with robust control groups, larger sample sizes, and longer follow-up durations.
Prioritizing trauma in interventions is essential.
Professionals must develop expertise in this area to implement practices that reflect the latest scientific advancements.

community-based sentences. Furthermore, it is crucial to develop targeted intervention programs for specific groups, such as individuals who have committed sex offenses or those with mental disorders, as they exhibit a higher prevalence of ACEs compared to other populations (Juwariah et al., 2022; Levenson et al., 2015, 2017). Moreover, there is a need to highlight the necessity for facilitators to have training in psychology in order to enhance the outcomes of the interventions. In research, there is a pressing need for high-quality RCTs featuring well-structured control groups, larger sample sizes, and extended follow-up periods. However, we also acknowledge the significant challenges of conducting RCTs in the prison context, highlighting the importance of valuing new methodologies proposed for research in this setting (Lennox et al., 2022). It is also important to note that future studies should assess the ability of these interventions to produce behavioral changes, particularly in terms of recidivism rates, to understand whether changes in personal well-being are associated with changes in recidivism.

It is crucial to prioritize addressing trauma in interventions, given the prevalence of such experiences in this population and their potential to undermine responsiveness to treatment aimed at promoting well-being and reducing the risk of recidivism. Furthermore, practices that fail to address these experiences may contribute to institutional trauma (Levenson et al., 2022), whereby “inmates begin to re-enact the dynamics of their chaotic and abusive families. The more the system responds with authoritative measures, the more deeply the dynamics are repeated and reinforced” (Miller & Najavits, 2012, p. 3). Consequently, professionals must acquire expertise to adopt practices that align with the latest scientific advancements. Intervention programs for individuals who have committed crimes are often delivered by unqualified personnel, which can potentially compromise therapeutic outcomes (Malik et al., 2023). Moreover, applying trauma-focused therapies in forensic settings, particularly within prisons, presents significant challenges. These therapies require environmental safety, stability, and consistency, often lacking in prison environments (Levenson et al., 2018). Therefore, professionals working in these settings must be well-prepared and qualified to implement such interventions effectively, supported by robust organizational policies that promote and facilitate these practices (see Table 4).

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