Theoretical and Conceptual Paper

The crisis stabilisation and return response (CS-Return): Historical antecedents and an integrative framework

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Abstract

After serious incidents, some people experience significant disruption in safety, regulation, relationships, practical resources and ordinary roles while diagnosis remains uncertain and specialist trauma treatment may not yet be indicated. This conceptual paper presents the crisis stabilisation and return response (CS-Return), a brief, integrated qualified clinical early-response intervention for this level of disruption. It is intended when ordinary organisational support or Psychological First Aid is insufficient, while urgent and disorder-specific care remain available when indicated. CS-Return operates through three recurrent clinical operations—clinical triage and functional formulation, integrated clinical intervention, and real-life functional review with clinical re-triage—supported by six practitioner competencies. Stabilisation, continuation or return, and coordination are integrated rather than sequential. Each session generates a real-life action; where further work is required, change between sessions informs the next cycle. The intervention emerged from Complex Trauma Institute (CTI) training and practice from 2019, building on Embodied Reprocessing and fourth-generation stabilisation and fifth-generation functional-return principles. Its complete configuration requires prospective evaluation.

Keywords: serious incidents; crisis intervention; stabilisation; functional recovery; reintegration; CS-Return

ISSN 2635-0807 | Perspectives on Complex Trauma, Volume 6, Issue 1 (2025)
Published: December 2025

Introduction

After a serious incident, clinicians and appropriately qualified mental-health professionals may encounter people whose immediate needs must be addressed before the longer-term diagnostic trajectory is clear and before specialist trauma treatment is necessarily indicated. A person may need help to sleep sufficiently, travel, care for dependants, re-enter a particular place, complete a safety-critical duty, communicate with colleagues or manage an immediate practical problem. Yet post-incident pathways are frequently organised around counselling, screening, peer support, signposting or referral to treatment. Each can have a legitimate purpose, but none by itself answers the wider clinical question: what has the incident disrupted, what needs to change now, who is responsible, and how will real-life recovery be reviewed?

This paper starts from a distinction that is simple but consequential. A serious incident is the event. In this paper, serious incident is used operationally for an event capable of causing significant disruption to safety, coping, functioning or ordinary roles; the term does not imply that every such incident meets DSM-5-TR or ICD-11 criteria for traumatic exposure (American Psychiatric Association, 2022; World Health Organization [WHO], 2024). A crisis is the disruption the event causes to safety, coping, functioning or ordinary life. A trauma-related disorder is a clinical condition established through appropriate assessment. Severe distress can occur without PTSD or complex PTSD (CPTSD), and exposure alone does not establish a need for trauma-focused treatment (Hudson et al., 2024; National Institute for Health and Care Excellence [NICE], 2018). Some people need humane organisational contact only; some require urgent medical, psychiatric or safeguarding action; some need a brief structured response to current disruption; and some also require targeted or specialist treatment.

The early post-incident period is clinically important because substantial distress and functional disruption may be present while the longer-term trajectory remains uncertain. Under DSM-5-TR, acute stress disorder can be diagnosed from 3 days to 1 month after trauma, whereas PTSD requires symptoms to persist for more than 1 month (American Psychiatric Association, 2022). ICD-11 takes a different approach: acute stress reaction is placed among factors influencing health status rather than mental disorders, while PTSD requires the characteristic syndrome to persist for at least several weeks and cause significant impairment (WHO, 2024). NICE therefore supports neither premature pathologising nor therapeutic inactivity: it recommends active monitoring for subthreshold PTSD symptoms within the first month, while offering individual trauma-focused CBT to adults with acute stress disorder or clinically important PTSD symptoms during that period (NICE, 2018). The first weeks are therefore a period of diagnostic and prognostic uncertainty in which proportionate support may be needed while active review and escalation remain available.

The crisis stabilisation and return response (CS-Return) is proposed for this often-missing early clinical space. It is a brief, integrated qualified clinical early-response intervention for significant current disruption following a serious incident. It is not organised around a single

psychotherapy or a fixed set of recovery skills; according to clinically identified need, it may integrate psychotherapeutic, psychological, psychosocial, relational, systemic, practical and multi-agency methods within one response. Its central proposition is that stabilisation and continuation or return to ordinary life are recovery functions in their own right and should begin together, rather than treating stabilisation only as preparation for therapy and return only as aftercare. In CS-Return, return includes safe continuation, adaptation or return to the particular role, relationship, place, responsibility, routine or activity disrupted by the incident; it is not limited to return to work. CS-Return is positioned not as a PTSD-prevention programme but as qualified clinical early intervention when current disruption in safety, functioning, resources or ordinary roles requires more than general support.

Exposure alone does not indicate CS-Return. Four broad response routes are distinguished: ordinary humane organisational contact or Psychological First Aid where qualified clinical intervention is not required; urgent medical, psychiatric or safeguarding action where risk or acute clinical need requires it; CS-Return where significant current disruption requires a qualified clinician-delivered early response; and targeted or specialist treatment where a specific clinical need is identified. These routes can overlap and can change as the person is reviewed. The complete CS-Return response is delivered only by appropriately qualified mental-health professionals practising within their professional scope who have received additional training across all six CS-Return practitioner competencies. Effective recovery may nevertheless require coordinated actions from occupational, medical, organisational, family and other services. Figure 1 summarises these response routes.

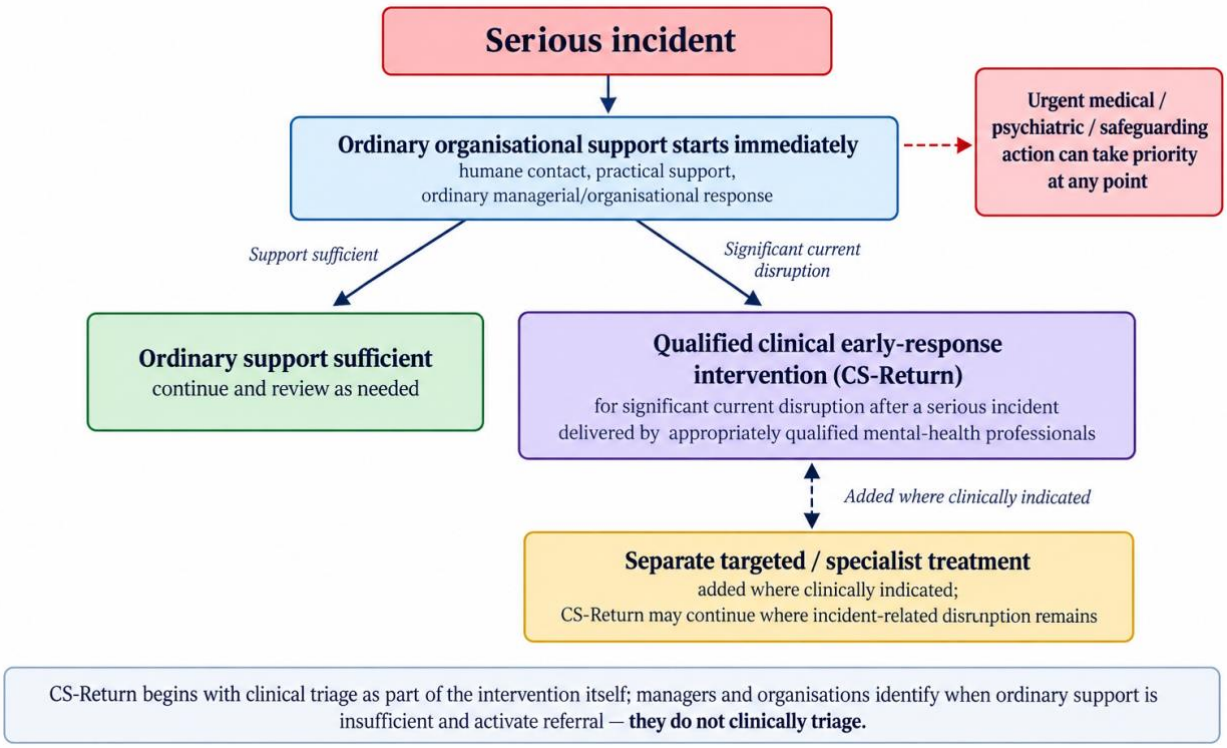

Figure 1. Response routes after a serious incident

Conceptual framework: crisis, functioning and proportionate response

CS-Return rests on three connected propositions. First, the person is more than a disorder. In the early aftermath of a serious event, the primary question is often not 'Which diagnosis explains this?' but 'What has become unsafe, unreliable or difficult in this person's actual life?' This shifts attention towards current impact while leaving diagnostic assessment available when clinically indicated. The distinction is particularly important in organisational settings, where managers need decisions about immediate safety, duties, travel, practical needs and support without being asked to diagnose.

Second, recovery includes agency, activity and participation, not symptom reduction alone. The World Health Organization's International Classification of Functioning, Disability and Health (ICF) conceptualises functioning through activities, participation and environmental factors rather than through symptoms alone (WHO, 2001). Trauma-related conditions can produce marked functional impairment, while social and occupational difficulties may remain important even when individual symptoms improve (Jellestad et al., 2021; Purnell et al., 2021). A person can feel calmer during a session and still be unable to take the route, enter the workplace, care for children or resume a necessary routine. For CS-Return, real-life functioning is therefore not a secondary outcome; it is part of the object of intervention.

Third, intervention should be proportionate to necessity. Early help does not require a detailed trauma narrative unless that information is needed for safety, safeguarding, a legal duty, an agreed clinical process or another necessary decision. Davies and Stoneham (2025) formulate the Principle of Necessity for Trauma (PNT) around not requiring people to verbalise or recollect traumatic experience unless this is necessary for a consented process and the information cannot reasonably be obtained another way. CS-Return applies that principle operationally to asking, recording and sharing trauma-related information: use only what is necessary for the decision or intervention at hand. This is not an argument against later narrative or trauma-processing work. It is an argument against making disclosure the price of receiving practical or stabilising help. Together, these three propositions produce a function-led, low-disclosure and stepped response: clinically triage and formulate current disruption, use no more intervention than is necessary, and add specialist treatment when assessment identifies a separate clinical need.

Approach to the literature

This is a conceptual and historically informed paper rather than a systematic review. Sources were identified purposively through targeted bibliographic and guideline searches, reference chaining and consultation of primary historical sources where accessible. Contemporary searches were updated before publication. Selection focused on traditions relevant to crisis, stabilisation, resource restoration, functioning, continuation or return, and early post-incident support. The search was not pre-registered, exhaustive or conducted to PRISMA standards. Historical sources are used to identify conceptual antecedents and changes in practice, not to estimate effectiveness or imply a direct developmental lineage to CS-Return.

Historical antecedents: recurring ideas of disruption, adaptation and return

The ideas assembled in CS-Return have a much longer history than modern PTSD, but historical continuity should not be confused with evidence of effectiveness. Early texts cannot validate a contemporary framework, and retrospective diagnosis is hazardous. Their value is narrower: they show that people have long recognised that frightening events can disturb bodily state, behaviour, role and belonging.

Historical descriptions interpreted as resembling post-combat stress appear in Assyrian sources from approximately 1300 to 609 BCE, although retrospective diagnosis with modern PTSD concepts is inappropriate (Abdul-Hamid & Hacker Hughes, 2014). A more direct antecedent to ideas of disrupted belonging and return appears in 1688, when Johannes Hofer introduced nostalgia to describe severe homesickness associated with separation from family and social environment (Fuentenebro de Diego & Valiente Ots, 2014). Nostalgia was not trauma theory, but it illustrates an early recognition that suffering can be linked to rupture from place, relationships and ordinary context.

A more recognisable trauma lineage emerges in the late nineteenth century. Pierre Janet's work contributed to phase-oriented understandings of post-traumatic difficulties, later interpreted through stabilisation, work with traumatic memories and reintegration or rehabilitation (Janet, 1889; Van der Hart et al., 1989). Janet is important here not because CS-Return reproduces his treatment model, but because safety and functional integration were not treated as incidental to psychological recovery.

During the First World War, Thomas Salmon described forward psychiatric practice organised around prompt intervention, proximity to the person's ordinary military role and an expectation of functional recovery (Salmon, 1917). Later formulations of proximity, immediacy and expectancy became influential, but historical re-analysis cautions against treating return-to-duty rates as proof of clinical effectiveness and asks whether rapid return serves the individual, the organisation, or both (Jones & Wessely, 2003). For CS-Return, return therefore means safe continuation, adaptation or graded participation—not pressure to resume an unsafe role.

Abram Kardiner's The Traumatic Neuroses of War (1941) further framed traumatic disturbance in relation to adaptation rather than as a simple sign of personal weakness. In 1944, Erich Lindemann's study of acute grief after sudden bereavement helped establish crisis-intervention thinking concerned with acute disruption, coping and adaptation (Lindemann, 1944). Grinker and Spiegel's Men Under Stress (1945), based on wartime clinical work with aircrew, similarly emphasised the effects of extreme stress on otherwise functioning people. These traditions shifted attention from presumed character defect towards the interaction between person, demand and environment.

Civilian crisis theory developed further through Tyhurst's account of changing reactions to community disaster and Caplan's emphasis on coping, resources and support when customary problem-solving is overwhelmed (Tyhurst, 1951; Caplan, 1964). This is close to the CS-Return concept of crisis: the relevant question is not simply whether an event

occurred, but whether functioning and coping have become disrupted and what resources may restore them.

Later developments brought these ideas into closer convergence. Herman foregrounded safety and later reconnection with ordinary life (Herman, 1998). Hobfoll's Conservation of Resources theory linked stress to threatened or actual resource loss, while the five essential elements for mass-trauma intervention emphasised safety, calming, efficacy, connectedness and hope (Hobfoll, 1989; Hobfoll et al., 2007). The ICF formalised activity, participation and environmental context as core dimensions of functioning (WHO, 2001).

Fourth- and fifth-generation trauma practice

These developments can also be understood as two further shifts in trauma practice. In this paper, fourth-generation trauma practice refers to movement beyond predominantly verbal and cognitive approaches towards direct work with embodied, sensorimotor, autonomic and regulatory processes, with safety and stabilisation treated as active therapeutic targets. Contemporary evidence on body- and movement-oriented interventions supports this broader embodied direction while also showing heterogeneity and the need for stronger trials (van de Kamp et al., 2023). The generational terms are used here as a conceptual organising framework rather than as an established chronological taxonomy of trauma therapies.

Fifth-generation trauma practice refers to a further shift towards functional return: recovery is pursued through renewed participation in ordinary relationships, roles, routines, work, education, caring responsibilities and community life, rather than being understood only as symptom reduction inside the therapy room. This draws on Herman's reconnection stage, the International Classification of Functioning emphasis on activity, participation and environmental factors, and reintegration research in CPTSD (Herman, 1998; WHO, 2001; Purnell et al., 2021). Functioning is therefore not only an outcome measured after treatment; appropriately supported participation can itself contribute to recovery and consolidate change. CS-Return brings these fourth- and fifth-generation principles together by integrating stabilisation with continuation or return and with relational, practical and organisational coordination from the beginning of qualified clinical intervention.

Psychological First Aid (PFA) represents a broad psychosocial early-response approach that can be delivered by trained helpers who do not hold mental-health professional qualifications and does not require detailed trauma retelling (World Health Organization et al., 2011; World Health Organization, 2013). Skills for Psychological Recovery (SPR) is a later structured skills-based approach that its developers explicitly describe as not formal mental-health treatment and that is not restricted to independently qualified mental-health professionals (Berkowitz et al., 2010; National Center for PTSD, 2025). These approaches are relevant comparators rather than equivalents to a qualified clinical intervention.

Contemporary evidence also warns against assuming that any one named post-incident programme constitutes a complete response (Billings et al., 2023). Phase-oriented trauma practice places safety and stabilisation before trauma-memory processing, and Phase 1

interventions can themselves reduce CPTSD symptoms (Herman, 1998; Darby et al., 2023). CS-Return retains this stabilisation-before-processing position but never includes trauma processing. Where trauma-focused treatment is indicated, it is delivered outside CS-Return as a distinct treatment pathway and only when sufficient safety, orientation, regulation, choice and capacity for informed participation are present (NICE, 2018). A relevant brief low-disclosure example is the Rewind Technique, which does not require detailed trauma disclosure; a randomised controlled trial found a large reduction in clinician-rated PTSD symptoms compared with waitlist, maintained at 16 weeks (Astill Wright et al., 2023).

Development of the contemporary CS-Return intervention

The contemporary intervention has a separate and much more recent development history. Its clinical model emerged within the Complex Trauma Institute (CTI), United Kingdom, through a one-year training programme begun in 2019 as Advanced Practitioner in Complex Trauma Practice and subsequently developed as the Advanced Certificate in Complex Trauma Practice. This work brought staged trauma practice together with present-focused stabilisation, systemic assessment, embodied and non-narrative regulation, practical support, proactive relational work and movement back into ordinary relationships and roles. The developing model was not tied to a single therapeutic school; methods were selected according to the current disruption and the function that needed to change.

An important earlier clinical precursor was Embodied Reprocessing (ER), developed from 2012 by Karpuk and Dawson and subsequently through clinical-academic collaboration with Stoneham and Davies (Karpuk & Dawson, 2012, 2024; Karpuk et al., 2019; Stoneham et al., 2021). ER is a short-term staged trauma therapy integrating systemic, experiential and embodied interventions. Its emphasis on internal and external safety, autonomic regulation and minimal dependence on narrative retelling reflects fourth-generation practice, while systemic intervention and deliberate re-engagement with daily activities, relationships, work and community life reflect fifth-generation functional return. CS-Return does not carry ER's trauma-processing component forward; the principles retained were embodied stabilisation, low-disclosure and non-narrative practice, systemic intervention, and deliberate connection of clinical change to ordinary-life functioning and return.

From 2020, the emerging approach was delivered through the Complex Trauma Therapists Network (CTTN) and progressively refined through short-term crisis and trauma-related work. The practice emphasis was increasingly specified around current impact rather than automatic diagnosis, function rather than technique, low-disclosure assessment, active change rather than supportive contact alone, practical and multi-agency action, and planned transition rather than open-ended therapy. A CTI clinical handbook was developed in 2025 under the earlier Crisis & Trauma Stabilisation title to codify this practice model (Complex Trauma Institute, 2025).

From 2022 to 2025, the developing approach was also taught to Ukrainian psychologists under the working title Crisis and Trauma Stabilisation Framework. During subsequent codification, the name crisis stabilisation and return response (CS-Return) was adopted to

make explicit a principle that had become increasingly central in practice: stabilisation should be linked from the outset to safe continuation, adaptation or return to ordinary functioning. The change in terminology therefore represents conceptual refinement and consolidation of the developing practice model rather than the introduction of an unrelated intervention.

The repeated clinical cycle was also informed by action-research logic. Lewin (1946) described action research as a spiral of planning, action and fact-finding about the results of action. CS-Return does not treat clinical work as research; it adapts that learning logic clinically. Each session engages clinical triage and functional formulation, integrated intervention and real-life functional review with clinical re-triage, and generates the next real-life action. Where another session is required, change occurring between sessions is reviewed at the following session and simultaneously becomes the starting point of the next cycle. Successive sessions therefore form a clinical spiral of intervention, real-life testing, learning and adjustment rather than a predetermined linear sequence.

What CS-Return integrates

CS-Return is a brief, integrated qualified clinical early-response intervention for significant current disruption following a serious incident. Significant current disruption means incident-linked impairment in safety, coping, functioning or role performance that warrants more than ordinary humane contact or general psychosocial support. CS-Return occupies the qualified clinical early-response level within a stepped post-incident pathway, while urgent medical, psychiatric or safeguarding needs take precedence and disorder-specific treatment can be added whenever indicated. Clinical triage and functional formulation use assessment of safety, functioning, coping, resources, continuing exposure and practical barriers to determine the response route, understand what is maintaining disruption and identify the priority functional target. No validated CS-Return threshold currently exists. Its two connected purposes are to stabilise what has become unsafe or unreliable and to support safe continuation, adaptation or return to the affected role, place, relationship, responsibility or routine.

CS-Return operates through three recurrent clinical operations supported by six defined practitioner competencies (Figure 2; Table 1). These are not psychotherapy stages, and the competencies are not six separate sessions or a fixed skills curriculum. Each session engages: (1) clinical triage and functional formulation; (2) integrated clinical intervention in which stabilisation, continuation or return and coordination operate together according to need; and (3) real-life functional review and clinical re-triage. Where another session is required, learning from the real-life test changes the starting point of the next cycle.

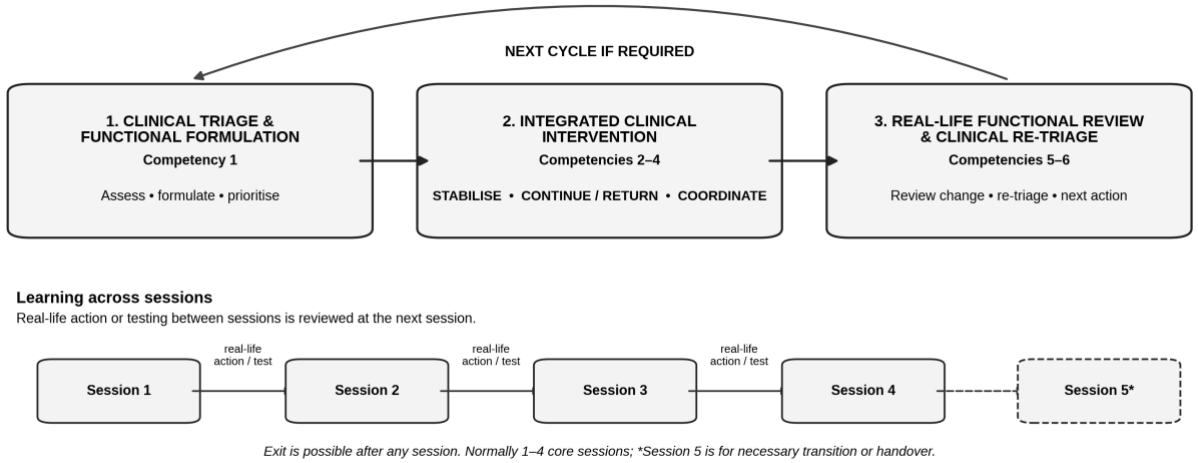

Figure 2. How CS-Return works: recurrent clinical operations and learning across sessions

The six competencies define what a CS-Return practitioner must be trained to do; the three operations describe how those competencies are integrated in practice. Competency 1 covers clinical triage and functional formulation. Competencies 2–4 are integrated during intervention: stabilisation; continuation, adaptation and return; and relational, practical, organisational and multi-agency coordination. Competencies 5–6 combine real-life functional review with clinical re-triage, transition and escalation. What changes outside the session determines whether to close, adjust, continue another cycle or arrange separate targeted or specialist care. Table 1 summarises the six practitioner competencies.

Table 1
The six CS-Return practitioner competencies

Competency	Core capability
1. Clinical triage & functional formulation	Establish current impact, risk, functioning, maintaining factors, functional priorities and the appropriate response route.
2. Stabilisation intervention	Restore sufficient safety, regulation, orientation, choice and functional capacity for reliable participation.
3. Continuation, adaptation & return intervention	Support safe movement into the role, relationship, place, responsibility, routine or activity disrupted by the incident.
4. Relational, practical, organisational & multi-agency coordination	Address barriers in relationships and systems, coordinate necessary actions and make responsibility for those actions explicit.
5. Real-life functional review	Determine what actually changed outside the session and what remains disrupted.
6. Clinical re-triage, transition & escalation	Use new information to continue, modify or close CS-Return, hand over where necessary, or arrange separate care.

Competence in one psychotherapy, adjacent intervention or individual CS-Return competency does not constitute competence to deliver the complete CS-Return intervention.

CS-Return integrates several contemporary clinical and theoretical foundations rather than deriving from a single therapeutic school. Crisis theory contributes the focus on disruption of coping and functioning. Phase-oriented and fourth-generation trauma practice contribute

safety, embodied regulation and stabilisation as direct clinical targets (Herman, 1998; van de Kamp et al., 2023). Fifth-generation and reintegration perspectives extend recovery towards functional participation and return to ordinary relationships, roles, routines, work, education and community life (Herman, 1998; WHO, 2001; Purnell et al., 2021). Systemic and ecological traditions locate disruption and recovery within relationships, organisations and environments as well as within the individual (Harvey, 1996), while resource theory highlights restoration of practical, relational and material resources (Hobfoll, 1989). The ICF reinforces attention to activity, participation and environmental factors (WHO, 2001); PNT contributes a low-disclosure ethical principle; and action-research logic informs the spiral of formulation, intervention, real-life testing, review and clinical re-triage (Lewin, 1946). These are selected foundations rather than an exhaustive genealogy.

CS-Return should also be distinguished from broad psychosocial, peer-led and skills-based post-incident approaches. PFA can be delivered by trained helpers without mental-health professional qualifications, while SPR is not formal mental-health treatment and is not restricted to independently qualified mental-health professionals (World Health Organization et al., 2011; Berkowitz et al., 2010). The complete CS-Return intervention is restricted to appropriately qualified mental-health professionals additionally trained across all six practitioner competencies. It is therefore not equivalent to PFA, SPR, counselling or EAP provision, peer support, MHFA, TRiM or CISM/CISD, although these may exist separately within wider organisational responses.

Within CS-Return, stabilisation, continuation or return, and relational, practical or organisational coordination are deliberately integrated rather than treated as sequential stages. Fourth-generation principles inform active work with embodied regulation, autonomic and survival responses and present-state safety. Fifth-generation principles extend intervention into functioning itself: safe participation in relationships, roles, routines, work, education and community life is treated as part of recovery rather than merely an outcome after treatment. Systemic and practical action can therefore contribute directly to stabilisation and return. Interventions may include body-focused non-narrative regulation, grounding or pacing, sleep and routine support, co-regulation, graded re-engagement, facilitated conversations, temporary adjustments, and resolution of practical or organisational barriers. Return must never mean pressure to resume an unsafe or unsustainable role. Adjacent work-directed evidence suggests that workplace-focused components can sometimes accelerate return to work, although certainty is low and the evidence is not specific to PTSD (Brämberg et al., 2024).

Current CTI implementation normally uses one to four core sessions, with an exceptional fifth session reserved for necessary transition or handover; one or two sessions may be sufficient when the defined purpose has been achieved. Each case is held within a session-linked two-clinician structure rather than relying only on routine periodic supervision. One qualified clinician ordinarily delivers the client session, while a second qualified clinician contributes pre-session co-formulation and post-session clinical review. Together they consider risk, functional priorities, intervention planning and the learning that informs clinical

re-triage and the next cycle. These delivery, supervision and governance arrangements are current CTI implementation specifications, not established therapeutic doses or evidence that five sessions are intrinsically superior (Complex Trauma Institute, 2025).

Clinical and organisational implications

For practitioners, CS-Return begins with clinical triage and functional formulation rather than a detailed event narrative: What is difficult now? What has become unsafe or unreliable? What remains working? What is maintaining the disruption? Which functional change is the immediate priority? Each session is change-oriented: intervention is linked to a real-life target, and subsequent review asks what actually changed in the affected role, place, relationship, responsibility or routine—not simply whether the person felt better in the session. That information drives clinical re-triage: close, adjust, continue another cycle or arrange separate care. Low-disclosure practice does not restrict necessary assessment of suicide or self-harm risk, safeguarding, psychosis or severe disorganisation, intoxication or withdrawal, medical instability, ongoing threat or other urgent concerns. The complete intervention is delivered only by appropriately qualified mental-health professionals practising within scope, additionally trained across all six competencies and working within the session-linked supervision and governance model. Competence in an adjacent intervention, a single psychotherapy or only some competencies does not constitute competence to deliver the complete CS-Return response.

For organisations, CS-Return implies that psychological support cannot carry responsibilities that belong elsewhere. Temporary duties, travel arrangements, medical review, safeguarding, family assistance and operational decisions require the relevant manager or service. Conversely, a manager should not be asked to diagnose PTSD or determine a clinical treatment. A coordinated response makes those boundaries explicit while keeping one view of the person’s current recovery needs.

Specialist treatment remains important when assessment identifies clinically significant symptoms, risk, complexity or an existing condition requiring care, and it may be indicated during the first month. NICE (2018), for example, recommends individual trauma-focused CBT for adults with acute stress disorder or clinically important PTSD symptoms during that period. CS-Return does not displace such treatment or operate as a mandatory gateway, but trauma processing is never undertaken within CS-Return. Where trauma-focused treatment is indicated, it is delivered outside CS-Return as a distinct pathway and only when sufficient safety, orientation, regulation, choice and capacity for informed participation are present.

Limitations and evidence boundary

This paper is conceptual and practice-derived. It does not report a trial of CS-Return and cannot establish effectiveness, cost-effectiveness, prevention of PTSD or superiority over PFA, SPR, counselling, occupational-health approaches or trauma-focused treatments. CS-Return should not be inferred to be necessary for everyone exposed to a serious incident; indication depends on significant current disruption and the response route required. Clinical

triage and functional formulation, including thresholds for significant disruption and prioritisation of functional targets, have not yet been validated as CS-Return instruments or cut-offs. Historical and adjacent literatures establish rationale and antecedents, not validation of the complete configuration.

The one-to-four-session frame, exceptional transition session and session-linked two-clinician supervision model are current CTI implementation specifications. Delivery is restricted to appropriately qualified mental-health professionals additionally trained across all six practitioner competencies, but the detailed competency framework, training requirements, supervision model and optimal intensity require prospective evaluation. The CTI handbook is a first-party implementation description rather than independent evidence of benefit. ER sources are cited to document a developmental influence and likewise should not be interpreted as independent evidence for CS-Return effectiveness. The work-directed evidence cited above is also indirect and cannot establish the effectiveness of the continuation or return component after traumatic incidents.

Future research

Prospective evaluation should test process and outcome: feasibility, acceptability, adverse events, fidelity to the three recurrent operations and six competencies, practitioner competence, unnecessary disclosure, time to appropriate referral, validation of clinical triage and functional formulation, thresholds for significant disruption, prioritisation of functional targets, and completion of agreed actions. Outcomes should include validated functioning and participation measures alongside safety, sleep, sustainable continuation or return, absence, repeated referral, service use, trust and symptom measures.

Comparative research should examine who benefits, which competencies and intervention components drive change, when ordinary support is sufficient and when specialist treatment should be added. Evaluation should test low-disclosure practice, fidelity to the action-and-review spiral and operationalisation of sufficient stabilisation without creating a rigid fixed-duration phase. A specific CS-Return hypothesis is that stabilisation may produce different functional outcomes when integrated from the outset with continuation or return and relational, practical and environmental action rather than delivered as an isolated preparatory phase. Evidence synthesis should also map intervention families and methods that can contribute to these functions individually and in combination.

Conclusion

CS-Return is a contemporary clinical early-response intervention, but the problems it addresses are old. Across very different historical traditions, practitioners have repeatedly returned to safety, adaptation, resources, functioning, connection and restoration of role. Modern services have often separated these recovery tasks across general psychosocial support, counselling, crisis services, workplace action, rehabilitation and specialist treatment, leaving no single qualified clinical response responsible for integrating them when significant current disruption requires more than general support.

CS-Return is proposed as a brief, integrated qualified clinical early-response intervention for significant post-incident disruption. Its contribution is not the invention of each principle or method, but their configuration within an accountable clinician-delivered model. Three recurrent clinical operations—clinical triage and functional formulation, integrated clinical intervention, and real-life functional review with clinical re-triage—organise six practitioner competencies. Fourth-generation embodied stabilisation and fifth-generation functional return are integrated with relational, practical and organisational coordination rather than treated as sequential stages. Methods are selected according to formulation rather than a fixed skills curriculum. Successive sessions form an action-and-review spiral in which real-life change informs the next cycle. CS-Return never includes trauma processing; where trauma-focused treatment is indicated, it is delivered separately after sufficient stabilisation. The complete configuration is conceptually coherent and evidence-informed at component level, but requires prospective evaluation.

Declarations

Ethics statement

Ethical approval was not required because this conceptual paper does not report new empirical research involving human participants. It is informed by clinical and training experience but contains no identifiable client material or formal case study.

AI-use statement

Generative AI tools were used to support literature searching, structural development and language editing. The authors reviewed and revised the manuscript and remain responsible for its argument, accuracy, citations and final content. No confidential client material or identifiable case data were entered for this article.

Conflict of interest

The authors are affiliated with the Complex Trauma Institute (CTI), which codifies and supports implementation of CS-Return, provides trauma-related training including Rewind training, and may provide CS-Return-related services, training or supervision. Perspectives on Complex Trauma is published by CTI. The CTI handbook is cited as a first-party description of current implementation and is not treated as independent evidence of effectiveness.

Funding

No external funding was received for the development of this conceptual paper.

Data availability

No empirical dataset was generated or analysed for this article.

Acknowledgements

The authors acknowledge clinicians within the Complex Trauma Therapists Network whose delivery experience contributed to the progressive refinement of the practice model.

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