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Review Article

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HELD: What Changes When Individuals Are Supported Instead of Fixed — A Relational and Nervous System–Informed Framework for Grief, Burnout, and Suicidal Ideation

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ABSTRACT

Grief, burnout, and suicidal ideation are commonly addressed through models emphasizing assessment, intervention, and symptom reduction. While clinically essential, these approaches may inadvertently overlook a foundational component of recovery: the experience of being safely held—emotionally, relationally, and physiologically—prior to expectations of behavioral change. This paper introduces HELD, a relational and nervous system–informed framework examining what shifts when individuals experiencing profound distress are supported rather than corrected. Drawing from trauma-informed principles, somatic regulation research, attachment theory, and adjunct community-based programming, the framework integrates co-regulation, non-pathologizing language, agency restoration, and meaning reconstruction. Clinical and programmatic observations suggest that when individuals are met with containment and relational safety rather than urgency or correction, observable shifts occur in nervous system stabilization, shame reduction, emotional regulation, and suicidal intensity. Suicidal ideation frequently reframes from a desire for death to a desire for relief from intolerable internal states or identity fragmentation.

Safety and relational presence may function as primary mechanisms in behavioral health recovery. Support-centered models may reduce shame, increase engagement, and complement interdisciplinary treatment environments. Further empirical investigation is warranted to evaluate long-term clinical outcomes.

HELD is intended as an adjunctive framework designed to complement — not replace — psychiatric stabilization and evidence-based treatment modalities.

Keywords: Suicidality, Grief, Burnout, Trauma-Informed Care, Nervous System Regulation, Relational Support, Shame Reduction, Meaning Reconstruction

Introduction

Suicide remains a major public health concern and is strongly associated with mood disorders, substance use disorders, chronic stress exposure, and neurobiological dysregulation [1,2]. Current clinical management prioritizes pharmacological stabilization, structured psychotherapy, and acute risk mitigation. While essential and lifesaving, these interventions may not fully address the physiological and relational substrates of suicidality, particularly autonomic dysregulation and shame-mediated withdrawal.

Individuals experiencing profound psychological distress frequently report feeling evaluated, managed, or corrected before they feel safe. The language individuals use to describe their emotions may be pathologized or stigmatized. Emerging trauma-informed and attachment-based frameworks suggest that perceived safety—emotional, relational, and physiological—is not merely supportive but foundational to therapeutic effectiveness (Bowlby, 1988) [3]. Without a felt sense of safety, higher-order cognitive processing, behavioral flexibility, and insight may remain neurologically inaccessible. This often translates somatically into profound disconnection, described in lived-experience literature as identity fragmentation [4].

This paper introduces HELD, a relational and nervous system–informed framework designed to complement existing clinical interventions by prioritizing containment before correction. HELD proposes that suicidality may frequently represent not solely a wish for death, but a crisis of identity, detachment, and nervous system overwhelm. When individuals are supported

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rather than fixed, shifts occur in shame intensity, emotional regulation capacity, and treatment engagement. This state of disconnection has been described in lived-experience literature as profound identity fragmentation [4].

Suicidality Beyond Symptom Reduction

Traditional models of suicidality emphasize identifying risk factors, reducing access to lethal means, and managing acute crisis [5]. While necessary, symptom-focused approaches may inadequately address underlying drivers of despair, including perceived burdensomeness, thwarted belongingness, and acquired capability for self-harm [6].

Joiner's Interpersonal Theory of Suicide posits that the desire for suicide emerges when individuals simultaneously experience perceived burdensomeness and thwarted belongingness, combined with acquired capability to enact lethal self-harm [6]. This framework highlights relational disconnection as central rather than peripheral to suicidality.

Research on shame further reinforces this perspective. Chronic shame correlates strongly with suicidal ideation and contributes to cognitive constriction and social withdrawal (Bryan et al., 2013) [7]. Shame narrows perception and reinforces internal narratives of defectiveness, making help-seeking more difficult.

Burnout and prolonged grief similarly involve emotional exhaustion and identity depletion [8,9]. In these contexts, suicidal ideation may represent an attempt to escape intolerable internal states rather than a fixed intent to die. These observations suggest that suicidality is often relational and regulatory in origin. Therefore, the conditions under which individuals are met may significantly alter trajectory.

The Neurobiology of Safety and Distress

Autonomic Nervous System Dysregulation

Polyvagal Theory proposes that autonomic states significantly influence psychological experience [10]. The autonomic nervous system operates across three primary states: ventral vagal (social engagement and safety), sympathetic activation (fight or flight), and dorsal vagal shutdown (collapse and numbness).

Suicidal ideation frequently emerges in states of sympathetic hyperarousal (panic, agitation, racing thoughts) or dorsal vagal hypoarousal (numbness, hopelessness, dissociation). In these states, executive functioning decreases, threat detection increases, and future-oriented cognition becomes impaired. Urgency-driven corrective interventions, though protective, may inadvertently amplify threat perception if introduced before stabilization.

Co-Regulation as Precondition

Human nervous systems are co-regulatory [11]. Attachment theory demonstrates that safety emerges in relational presence (Bowlby, 1988). Oxytocin release during perceived connection decreases cortisol and moderates stress response [12].

When individuals feel safely witnessed rather than corrected, autonomic regulation may shift toward ventral vagal activation, increasing cognitive flexibility and emotional tolerance. From a neurobiological perspective, safety is not a secondary benefit of treatment but a prerequisite for therapeutic accessibility.

The HELD Framework

HELD operationalizes support-before-correction through four interrelated components.

Honored Presence

Honored Presence refers to relational witnessing without immediate corrective pressure. This approach aligns with person-centered therapy principles emphasizing unconditional positive regard [13]. Clinically, this may involve slowing session pacing, reflective listening, and normalizing stress responses. The individual is treated as overwhelmed rather than defective.

Emotional and Physiological Regulation

After relational safety is established, regulation skills are introduced. Evidence-based modalities integrated within this stage may include Dialectical Behavior Therapy distress tolerance skills, Acceptance and Commitment Therapy defusion techniques, Internal Family Systems parts awareness, and somatic grounding practices [14-16]. Regulation is framed as nervous system stabilization rather than symptom suppression.

Language Reframing

Language shape's identity construction [17]. Pathologizing language may reinforce defect narratives. Reframing includes shifting from "maladaptive behavior" to "adaptive survival strategy" and from "disordered response" to "protective nervous system pattern." This reduces shame and increases agency.

Directed Reintegration

Directed Reintegration focuses on meaning reconstruction and identity expansion. Research suggests that purpose buffers against suicidality [18,19]. Reintegration may include values clarification, community reconnection, and identity expansion beyond crisis narrative.

Clinically, suicidal ideation often reframes from "I want to die" to "I cannot continue as this version of myself." This represents identity distress rather than literal death-seeking.

Community-Based and Adjunct Support Models

Adjunct environments operating alongside clinical treatment may provide structured containment. These environments can reduce isolation, increase bonding, provide pacing outside acute crisis settings, and enhance treatment adherence.

Preliminary programmatic observations suggest reductions in suicidal rumination intensity, increased help-seeking behavior, improved emotional articulation, and higher engagement in follow-up care. Such environments are not replacements for psychiatric intervention but may function as regulatory bridges between crisis and sustained recovery.

Lived Experience as Therapeutic Bridge

Peer support research indicates that lived-experience integration reduces stigma and increases treatment engagement [20]. Hearing from individuals who have navigated suicidality and stabilized recovery may reduce internalized shame and activate hope. Structured lived-experience inclusion may enhance therapeutic alliance while maintaining professional boundaries [21,22].

Discussion

From a systems perspective, suicidality may represent dysregulated stress physiology interacting with cognitive constriction and relational isolation. Pharmacological intervention can reduce depressive symptom severity; however, autonomic stabilization and relational repair may enhance treatment responsiveness.

Support-centered frameworks such as HELD may function as adjunct regulatory scaffolding, increasing patient adherence, reducing shame-based avoidance, and facilitating neurobiological stabilization necessary for sustained recovery.

Correction without containment may increase distress. Containment before correction may increase engagement.

Limitations

This framework is conceptual and based on translational integration of clinical observation and established research. Quantitative validation is required. Cultural adaptation and sensitivity are essential in language reframing. HELD is not a substitute for psychiatric stabilization or pharmacological intervention.

Future Research Directions

Future studies may evaluate pre- and post-intervention measures using the Beck Scale for Suicidal Ideation (Beck et al., 1979), Meaning in Life Questionnaire (Steger et al., 2006), Internalized Shame Scale, heart rate variability for autonomic tracking, and longitudinal relapse rates. Randomized controlled trials comparing HELD-informed adjunct programming with standard psychoeducation are recommended.

Conclusion

Safety and relational presence may function as primary mechanisms in behavioral health recovery. When individuals are supported rather than fixed, shame decreases, agency increases, identity stabilizes, and engagement improves. Being safely held may not be secondary to treatment but foundational to its effectiveness.

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