

**Beyond The Uniform: How to
Join With First Responders in Therapy**

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Lottie
Internal Therapy
Dog



ASHEVILLE

POLICE DEPARTMENT



Agenda

Introduction

Public Safety

Barriers to treatment

Recognize hypervigilance

Attachment-informed approach

Self-disclosure

Clarify confidentiality

Understanding Public Safety Culture: Who are they?

Police/Detectives

Crime Scene
Investigators

Firefighters

Medic

Public
Works/Emergency
Management

Dispatch

Estimated Suicides: 127-143

Reported in 2024

ALL FIRST RESPONDERS

127-143 SUICIDES

Suicide Numbers Are Aggregated Across First Responder Roles

- ▶ Data from **First H.E.L.P. Advocacy Group**
- ▶ No Official Govt Breakdown Available
- ▶ Tracking First Responder Mental Health

LAW ENFORCEMENT
Largest Share

FIREFIGHTERS
Included in Total



EMS / PARAMEDICS
Included in Total



EMS / PARAMEDICS
Included in Total



DISPATCHERS
Included in Total



in the United States

Higher Suicide Rates in Certain Parts of the U.S.

Exact locations and numbers are not fully published—geographic trends below based on general suicide data and first responder stress risk factors.



Who joins public safety careers?



Makes sense right?

For some individuals, early ACE with unpredictability, high-responsibility, or emotional suppression may shape comfort with high-intensity roles later in life & it is worth doing some *preventative care* to make sure there is **psychological safety** for both the responder and the public.



What prevents this from becoming a norm in this culture?

Protector Identity: A relational template forms

The **Protector Identity** is a core self-structure organized around:

- ▶ Responsibility for others' safety
- ▶ Rapid threat detection
- ▶ Emotional containment under stress
- ▶ Self-sacrifice
- ▶ Loyalty to team
- ▶ Control under chaos

- ▶ **High Autonomy** (handle situations independently) + **Emotional Suppression** = Attachment system becomes subordinated to the threat-response system
 - ▶ Reduced access to softer affect states/fear of intimacy
 - ▶ Seeking safety from a loved one is overpowered by threat-response system

What cultural barriers are impacting mental health treatment?

Trained to ACT not PAUSE
(normalization of trauma)

Workplace messaging/shame

Access to care

Trust Issues with 'outsiders'

Confidentiality concerns

Time Constraints

Responder
Culture Norms

Family of
Origin Themes
around MH

Societal
Cultural Norms



Responder
Culture Norms

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Shame



▶ “You don’t want to see me; I am too messed up.”

Common Statements: Dismissive



"I promise you
can't 'fix' me."

Common Statements: Dismissive



“Ah! I’m fine, I’ve been doing this job a long time.”

Common Statements: Dismissive



“How will I know
they will really
'get' me.”

Common Statements: Dismissive




“They are just
going to tell me
to quit”

Common Statements: Dismissive



“I heard a friend
at work went on
medication and
it messed them
up.”

Common Statements: Dismissive

An illustration of a man in profile, facing right. He has dark hair and is wearing a dark blue cap and a dark blue jacket. A white speech bubble with a grey shadow is positioned to his right, containing text. The background is a light blue gradient with a dark teal curved shape at the bottom.

“Only x more
years until
retirement, then
I’ll be fine.”

Common Statements: Dismissive

How does this start presenting?



Strain in relationships (fear of intimacy)

Feeling stuck

instant gratification loops/dopamine seeking

Dysregulation/Loneliness

Difficulty creating balance

Basic needs are affected



How long does the
body stay
hypervigilant?

Hypervigilant Cycle: Average 48hrs

On-shift:

high sympathetic activation

1

Off-shift:

slow, delayed return to baseline

2

Long-term: baseline becomes permanently elevated, difficult to come down fully over-time

How would this autonomic 'hyperalert'
response present:

In
therapy?

With loved
ones?

In public
settings?

Hypervigilance: In public

- ▶ Situational avoidance ex. Large public outings
- ▶ Positioning of how they seat themselves in public ex. Back to the wall
- ▶ Startle sensitivity
- ▶ Worried about how they are being perceived/recognized



Hypervigilance: With loved ones

- ▶ Rapid problem-solving instead of empathy
- ▶ May not show presence as they are trying to shift out of the work mindset
- ▶ Irritability at minor disruptions/sensory output

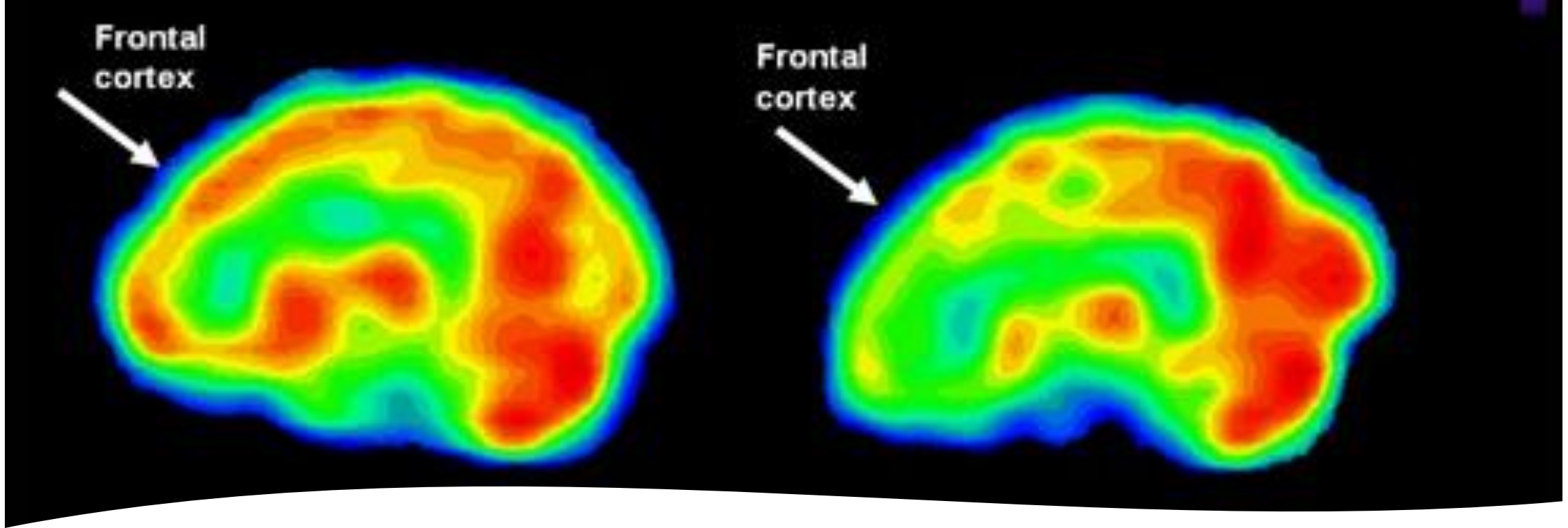
- ▶ ***“They’re always on edge.”***
- ▶ ***“I feel like I’m being evaluated.”***
- ▶ ***“I can’t relax around them.”***
- ▶ ***“They’re here physically but not emotionally.”***



Hypervigilance: In Therapy

- ▶ Coming into your office, scanning the room and asking direct questions.
- ▶ Sitting by the door in the waiting room or even offering to walk you to your car if they are your last client.
- ▶ Assume protection over **you**.
- ▶ Focus on functionality “I am having difficulty falling/staying asleep”
- ▶ Emotional suppression (difficulty accessing)
 - ▶ Disconnect between body and brain





Often Overactive:

Amygdala (threat & emotional alarm)

Stress system (cortisol response)

Pain-processing regions (social pain)

Often Underactive or Dysregulated:


Prefrontal cortex (reasoning & impulse control)

Reward system (motivation & hope)

Suicidal thoughts are linked to brain dysregulation — not character weakness.



These types of responses can trigger our own hypervigilance, and we need to be mindful of the balance of ethics and protecting their trust.

An illustration of a woman with brown hair, wearing black-rimmed glasses and a light green top. She is shown in profile, looking towards the left. Four thought bubbles of different colors (orange, dark orange, and brown) are connected to her head by thin lines. Each bubble contains a question. The background is a plain, light cream color.

Do I feel
pressure to
work harder?

Does this
person remind
me of
someone?

Do I like this
client?

Are my
beliefs being
challenged?

Understanding Hypervigilance Through an Attachment Lens

- ▶ If they're scanning the room, they're not "resistant" rather they're **assessing** safety.
- ▶ Instead of:
- ▶ **"You seem distracted." (trying to reduce the symptom)**
- ▶ Try:
- ▶ **"I notice you're taking in the room, what do you think?"**
- ▶ That simple validation lowers defensiveness.

Understanding Hypervigilance Through an Attachment Lens

- ▶ If they say: “So what’s your experience with cops? You get what we deal with?”
- ▶ Instead of:
- ▶ **Trying to overcompensate or feel like you need to win them over**
- ▶ Try:
- ▶ ***“It sounds like a part of you needs to make sure I’m competent before you decide what to bring in here. That makes a lot of sense. I can tell you that I am open to understanding and will relay to you if something is outside of my scope”***
- ▶ That simple validation lowers defensiveness.

What works to build trust? *(Attachment- informed)*

Curiosity and following the client's lead
(collaborative control)

Respect the hypervigilance &
acknowledge the wins

If you are going to refer to higher level of
care, what are agencies and treatment
centers that are first responder focused?

Use psychoeducation as a bridge

What else
works to build
trust?
(Attachment
focused)

Documenting trauma
anniversaries

Create predictability/reliable
presence

Being curious instead of
pathologizing

Understanding need for some
deflection (ex. humor)

Self- disclosure

When disclosures are done well and ethical, it can strengthen relationships, build rapport quickly & serve the needs of the client.

Types of Self-Disclosures

Three Types:

Neutral Disclosures – Sharing low-risk information (discusses things like weather, Lottie, sports, coffee etc.)

Humanizing Disclosures – Highlight humanity of therapist without too much personal detail (ex. I don't sleep well on stressful days either)

Similarity Disclosures - Revealing personal challenges/experiences – (ex. I understand how your partner may feel, my husband is a firefighter)

Data on Disclosures

“Patient satisfaction only rose when disclosures were brief, relevant & quickly refocused on the patient,” (Arroll & Allen, 2015).

“Trauma clients sometimes felt more connected when clinicians used careful intent disclosure, but when it was poorly timed, it backfired,” (LaMaster, 2018).

Confidentiality

Common Scenarios:

- “Can I trust that working with you or getting on medication won't get me fired?”
- “Since you work with responders what if you work with someone I work with?”
- “I am scared that you will IVC me if you heard what I see every day”



Thank you!