THE SYNTROPY FOUNDATION — ERSA Institute
Clinical Perspective Paper | Relational Dislocation Series

The Signal and the Shield

Distinguishing genuine unsafety from defensive avoidance in clinical and relational work

Dr Steve Halls | Keystone Therapy | ERSA Institute

There is a question that sits at the heart of a great deal of clinical and relational difficulty, and it is deceptively simple: is this person unsafe, or do they feel unsafe?

The distinction matters enormously. A person who is genuinely at risk — in a relationship where harm is real, in an environment that is objectively threatening — needs protection, safety planning, and practical support. A person who is physiologically activated, whose nervous system is reading danger where none currently exists, needs something different: compassionate presence, regulation support, and — carefully, carefully — the gradual expansion of their Window of Tolerance.

Treating the second as if they were the first does not help them. It confirms the threat narrative, reinforces avoidance, and — in relational contexts — can cause real harm to the people around them who are being experienced as dangerous when they are not.

This is the clinical problem The Signal and the Shield is designed to address.

Two responses that look the same

Polyvagal Theory, developed by Stephen Porges, gives us a precise language for understanding what happens in the nervous system when we encounter threat. The autonomic nervous system is not a simple on/off switch. It operates through a hierarchy of responses: social engagement when we feel safe; mobilisation — fight or flight — when threat is perceived; and immobilisation — collapse, shutdown, freeze — when threat is overwhelming and escape seems impossible.

What Polyvagal Theory also teaches us is that these responses are automatic, fast, and frequently disconnected from conscious appraisal. The nervous system does not wait for a cognitive risk assessment before activating a threat response. It reads cues — Porges calls this neuroception — and it acts. And because it is shaped by history, it sometimes reads danger in situations that are, by any objective measure, safe.

> ***The nervous system is a historian. It remembers what hurt, and it protects against its return — sometimes long after the original threat has passed.***

This is adaptive. A nervous system that has been shaped by early trauma, chronic stress, or relational injury is doing exactly what it evolved to do: detecting threat early and activating protective responses before harm can occur. The problem is not that these responses are irrational. The problem is that they are often outdated — calibrated to a past environment that no longer exists.

The signal and the shield

In clinical work, I find it useful to distinguish between two fundamentally different experiences that can look identical from the outside — and that can feel identical from the inside.

The Signal

A genuine response to real present danger. The environment is actually unsafe. The relationship is actually harmful. The threat is current, not historical. This experience deserves to be trusted, named, and acted upon. Safety is the priority.

The Shield

A protective response to perceived danger that is rooted in past experience rather than present reality. The nervous system has activated its defences because the situation resembles something that was once threatening. The shield is well-intentioned but it is blocking something that is actually safe.

The clinical and relational challenge is that these two experiences — the signal and the shield — generate the same internal phenomenology. Both feel like danger. Both produce activation, withdrawal, the compelling urge to escape or defend. A person in the grip of a shield response is not performing or exaggerating. They are genuinely experiencing threat. The nervous system does not flag its own errors.

This is why the distinction requires clinical skill and considerable care. It is never made by dismissing the person's experience. It is made — slowly, collaboratively, with deep respect for the protective function of the shield — by helping the person develop the reflective capacity to ask: 'Is this happening now, or does this feel like something that happened before?'

Clinical markers: signal vs shield

No single indicator is sufficient, and the clinician must always hold the possibility that what appears to be a shield is actually a signal. The following markers are offered as guides to clinical thinking, not as diagnostic criteria.

Domain	The signal — markers of genuine unsafety	The shield — markers of defensive activation
Temporal quality	Threat is present-tense. Specific, current behaviours are identified.	Threat feels present but references to the past are

		frequent. ‘You always’, ‘this is just like’.
Proportionality	Response is proportionate to identifiable events or patterns.	Response intensity exceeds what the current situation would typically generate.
Relational history	Pattern of harm is observable across time and witnesses.	Harm is experienced subjectively; others in the same situation do not report similar threat.
Regulation capacity	Person can access regulated states with appropriate support.	Dysregulation is rapid, intense, and difficult to exit. Window of Tolerance is narrow.
Reflective capacity	Person can consider alternative perspectives when regulated.	When activated, alternative perspectives feel impossible or invalidating.
Response to safety	Demonstrable safety reduces distress.	Demonstrable safety is not experienced as safe; the nervous system remains vigilant.

The cost of the shield

The shield is not pathology. It is wisdom — the accumulated protective intelligence of a nervous system that learned, in conditions of genuine threat, that danger must be anticipated rather than waited for. Honouring that intelligence is the beginning of all productive clinical work with defensive activation.

But the shield has costs. In relational contexts, it is one of the most common sources of sustained disconnection between people who genuinely care about each other. When one partner’s nervous system is reading the other as dangerous — not because they are dangerous, but because something in the interaction pattern maps onto an older wound — the relationship becomes organised around the threat response. The ‘dangerous’ partner adapts, withdraws, or escalates. The dynamic calcifies.

In therapy, the shield can present as resistance, rupture, or disengagement. A client whose early relational experiences taught them that vulnerability is dangerous will activate protective responses in the therapeutic relationship itself — precisely when the work is getting close to something important. The therapist who does not understand this will experience it as the client pulling away. The therapist who understands it will recognise it as the moment the work deepens.

> ***The shield was built for survival. The work of therapy is not to tear it down, but to help the person discover that they no longer need it in every room they enter.***

Working clinically with the distinction

The ARCHR²™ framework locates this work primarily within the Awareness and Regulation domains, with the Healing domain engaged as the work deepens. The clinical sequence is broadly as follows.

First: regulate before you reflect. A dysregulated nervous system cannot engage in the kind of reflective processing that distinguishes signal from shield. The first task is always to support the person back into their Window of Tolerance — through co-regulation, grounding, and the consistent experience of a safe therapeutic relationship.

Second: name the shield with respect. When it is clinically appropriate to introduce the distinction, it is introduced as an observation about the intelligence of the nervous system, not a challenge to the person's account of their experience. 'Your system learned to protect you in this way. That makes complete sense given what you've been through.'

Third: build reflective capacity gradually. The capacity to ask 'is this the past or the present?' in a moment of activation is a skill. It develops through repeated practice in the regulated therapeutic space before it becomes available in the heat of a relational moment.

Fourth: never foreclose the signal. Throughout this work, the clinician holds open the possibility that what appears to be a shield is actually a signal. This is not just clinical caution — it is a fundamental ethical commitment. We do not talk people out of their experience of danger. We help them develop the capacity to investigate it.

About this paper

This paper is part of the Relational Dislocation Series, produced by the ERSA Institute at The Syntropy Foundation. The series addresses the neurological, relational, and clinical dimensions of disconnection and its treatment, drawing on the ARCHR²™ integrative framework, Polyvagal Theory, interpersonal neurobiology, and memory reconsolidation science.

Dr Steve Halls
BSc Hons, PhD, Cert Neurosci., Dip Clin Hypn & Psychotherapy, CAISP
Clinical Psychologist & Behavioural Neurotherapist | Keystone Therapy, Byford WA