OPINION

When alarms are ignored: clinical reflections on ignorance culture in eating disorder care

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BJPsych Bulletin (2026) Page 1 of 3, doi:10.1192/bjb.2026.10257

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First received 9 Feb 2026, final revision 25 Apr 2026, accepted 30 Apr 2026

Summary In his analysis of 'ignorance culture' in eating disorder services, Downs describes how repeated alarms raised by patients, carers and clinicians are routinely ignored, deflected or reframed as individual pathology. In this Opinion piece, I reflect on the clinical implications of that analysis, arguing that ignorance culture is enacted through everyday treatment structures that misread multi-layered presentations, invalidate advocacy and displace responsibility. Drawing on dialectical theory and biosocial frameworks, and using multidiagnostic eating disorder–dialectical behaviour therapy as an illustrative example, I suggest that addressing ignorance culture requires treatment models that operationalise responsibility rather than merely espouse it.

Keywords Anorexia nervosa; ethics; feeding or eating disorders; patients and service users; psychological treatments.

Ignorance culture as clinical invalidation

In 'Ignorance culture and eating disorders: lived experience analysis of alarms being ignored', Downs[1] offers a compelling account of how systemic failures in eating disorder services are sustained not simply through gaps in knowledge or resources, but through organisational practices that suppress feedback, deflect responsibility and normalise care withdrawal over time. By naming this phenomenon as 'ignorance culture', Downs[1] provides language for dynamics long recognised by patients, carers and clinicians yet rarely articulated so clearly within psychiatric discourse. Writing from a Canadian clinical context, it is notable that the dynamics described by Downs resonate closely with patterns observed across different healthcare systems, suggesting that ignorance culture is not confined to any single national structure. These patterns also unfold within systems that place considerable emotional, ethical and organisational demands on clinicians, shaping how decisions are made and how responsibility is enacted in practice.

Rather than revisiting Downs'[1] analysis in detail, this Opinion piece focuses on how ignorance culture is enacted in everyday clinical practice, and how treatment models themselves can either reproduce or interrupt the patterns he describes. The focus here is deliberately clinical: how responsibility is enacted, deferred or displaced through routine decision-making, treatment eligibility criteria and model design, and how these structures shape whether alarms are heard or ignored. From a clinical standpoint, ignorance culture functions as a form of chronic – and often traumatic – invalidation,[2] particularly for individuals with long-standing and/or multidiagnostic presentations.

Downs situates ignorance culture within broader discussions of epistemic injustice and organisational blindness, highlighting how repeated alarms raised through lived experience, safeguarding processes and clinical concern are frequently ignored or reframed as individual pathology.[1] Clinically, these dynamics closely resemble what dialectical behaviour therapy (DBT) has long described as invalidating environments.[3,4] In eating disorder care, however, invalidation is often enacted not through overt interpersonal dismissal, but through procedures, thresholds and decisions presented as neutral, necessary or evidence-based.

Eligibility criteria based on weight, rigid diagnostic silos, binary notions of readiness and fragmented service pathways frequently function as mechanisms through which concern is deflected rather than addressed. Individuals may be deemed 'too well' for specialist services while simultaneously being 'too unwell' to engage meaningfully in out-patient care. This tension has become increasingly visible as labels such as 'terminal anorexia' enter clinical discourse, positioning individuals as beyond recovery while also characterising them as manipulative, non-compliant or insufficiently motivated to change.[5] Such contradictions reflect enduring conceptual incoherence within the field regarding the nature, course and treatability of anorexia nervosa.

Others experience withdrawal or withholding of care because their presentations do not align with dominant eating disorder narratives, stereotypical clinical presentations or service expectations, particularly when neurodivergence, chronic medical complications, trauma histories or co-occurring psychiatric conditions are present. In these cases, complexity itself becomes grounds for

exclusion or referral to other services ill-equipped to manage eating disorder symptoms. What Downs[1] describes as ignorance culture can therefore be understood clinically as a form of chronic invalidation embedded within care structures themselves. These structures implicitly communicate that certain forms of distress fall outside what the system is designed to notice or respond to.

The clinical consequences of such invalidation are familiar: escalating emotion dysregulation, entrenchment of eating disorder behaviours, increased risk of suicide, self-injury, significant physiological compromise and profound hopelessness.[2] From a DBT-informed perspective, these outcomes reflect predictable responses to sustained invalidation within the treatment environment and help explain how exclusionary practices can inadvertently reinforce the very difficulties they are intended to manage.

MED-DBT and the redistribution of responsibility

One way of responding differently to these patterns is illustrated by multidiagnostic eating disorder–dialectical behaviour therapy (MED-DBT), a model developed for individuals with eating disorders in the context of co-occurring medical, psychiatric and neurobiological complexity.[6,7] In its original formulation, Linehan's biosocial theory conceptualises emotion dysregulation as arising from a transactional and ongoing interaction between biological vulnerability and chronically invalidating environments, rather than from individual pathology alone.[3,4] MED-DBT extends this biosocial model to multidiagnostic eating disorder presentations by conceptualising responsibility as emerging at the interface between biological vulnerability and a range of chronically invalidating environments, spanning interpersonal, sociocultural and healthcare contexts, rather than locating failure or pathology within the patient alone.[6] Recent debates within eating disorder care have increasingly turned towards the creation of additional diagnostic subcategories to account for complexity, including terms such as 'terminal anorexia' or other proposed designations for long-standing and severe presentations. Whereas these efforts often aim to improve recognition, they also risk reifying complexity as a fixed patient attribute, rather than examining how existing treatment structures fail to accommodate diverse clinical presentations. From this perspective, responding to multidiagnostic and atypical presentations does not necessarily require further categorisation, but rather the development of treatment frameworks capable of adapting to variability in need, context and trajectory, as MED-DBT attempts to do.

Within this framework, repeated exclusion, treatment misalignment and procedural deflection are conceptualised as potent invalidating contingencies that amplify emotion dysregulation and reinforce eating disorder behaviours as functional attempts to restore predictability, safety or legitimacy. MED-DBT therefore targets invalidation not only through relational validation, but also through structural practices including pre-treatment exploratory work, collaborative case formulation, consultation to the client, a clearly articulated and agreed upon target hierarchy and mandatory consultation teams for providers, which reduce the likelihood that advocacy, distress or complexity will be misread as treatment interference.

Importantly, MED-DBT embeds epistemic humility directly into its clinical assumptions. Assumptions such as 'clients are doing the best they can' and 'clients cannot fail treatment', shifting attention towards how treatment structures may fail to meet the needs of the individual, are not merely therapeutic stances – they function as safeguards against premature certainty and moralised explanations of non-response. By directing attention away from patient deficits and towards mismatches between individual needs and treatment structures, these assumptions interrupt a central mechanism of ignorance culture: the tendency to explain systemic failure through individual pathology.

When advocacy is reframed as pathology

Downs notes that patient and caregiver concerns are frequently met with silence, deflection or blame.[1] In clinical settings, this often manifests as the pathologisation of advocacy itself. Individuals who persistently request different methods of treatment coordination or alternative approaches to feeding or weight monitoring are often labelled as 'demanding', 'non-compliant' or 'difficult', with these descriptors sometimes carrying diagnostic weight. Advocacy becomes evidence of illness rather than a rational response to unmet need. This reframing echoes lived-experience analyses showing how assumptions about motivation and engagement often obscure structural barriers to care, leading advocacy to be misread as pathology rather than understood as a response to unmet need.

From a clinical perspective, this reframing has significant consequences. Behaviours that might otherwise be understood as attempts to secure safety, regulation or continuity of care are treated as treatment-interfering. Responsibility is shifted away from systems and onto individuals, silencing the very feedback required to improve services. This pattern can be seen in settings where patient or family concerns prompt efforts to re-establish structure or collaboration, such as recommitment meetings or temporary treatment pauses, when the underlying issue is less about motivation and more about whether the treatment model adequately accommodates the person's needs.

Within MED-DBT, behaviours such as advocacy urgency and emotional intensity are approached through a functional, biosocial lens.[6] Rather than asking whether a patient is being 'cooperative', clinicians are encouraged to consider what a behaviour is attempting to resolve within the current treatment context. This stance does not remove limits or negate risk management but reframes how these are negotiated, emphasising transparency, collaboration and shared responsibility rather than unilateral decision-making. In this way, advocacy is treated as data, not defiance.

Multidiagnostic presentations and responsibility culture

Downs[1] highlights diagnostic overshadowing as a particularly acute manifestation of ignorance culture, especially for neurodivergent individuals. This concern extends to a wider group of patients whose eating disorders intersect with

https://doi.org/10.1192/bjb.2026.10257 Published online by Cambridge University Press

medical instability, trauma, suicidality and long-standing psychiatric symptoms. For many, the problem is not that treatment has failed, but that it was never structurally designed to accommodate their intersecting needs.

Recent conceptual work situates eating disorders within broader disability frameworks, illustrating how ableism, inaccessible care structures and diagnostic rigidity contribute to both the development and maintenance of eating disorder symptoms.[8,9] From this perspective, exclusion from care is not an unfortunate anomaly but a predictable outcome of systems that privilege normative bodies, linear recovery trajectories and modes of engagement that align with dominant assumptions about motivation and compliance.

In his conclusion, Downs[1] calls for a shift towards responsibility culture characterised by accountability, reflexivity and shared learning. Clinically, such a shift cannot be sustained without structures that support clinicians in tolerating uncertainty, moral distress, burnout, weight bias and countertransference. In many eating disorder settings, clinicians meet regularly to 'round on' and discuss patients and plan treatment, yet there is a lack of structured forums to examine how their own emotional responses and institutional pressures shape decision-making.

Within MED-DBT, responsibility culture is supported through mandatory, weekly consultation team meetings for all providers to focus not on what patients are doing, but on how clinicians are thinking, feeling and intervening.[6,10] These teams distribute responsibility across a collective rather than locating it within individual clinicians or patients. Responsibility culture here is not synonymous with blame: it is a disciplined practice of staying engaged when certainty is unavailable and outcomes are unclear. Although such structures are formalised within DBT, similar principles may be implemented across a range of clinical settings that do not adopt DBT as a full treatment model. Regular, structured opportunities for reflective practice, attention to clinician emotional responses and decision-making processes, and shared responsibility for clinical outcomes, can help mitigate the individualisation of both patient difficulty and clinician burden. In this way, the core mechanisms supporting responsibility culture are not limited to specific treatment models but can be translated into broader service design and team practices.

Downs' analysis makes clear that the central problem in eating disorder care is not a lack of alarms, but the conditions under which these are heard or ignored. Although clinical models cannot resolve systemic failures on their own, they play a critical role in determining whether responsibility is enacted or deferred. Treatment frameworks encode assumptions about legitimacy, risk and worth, shaping both clinician behaviour and patient experience. Approaches informed by dialectical and biosocial principles, including but not limited to DBT-based models, may offer one pathway for operationalising such responsibility within eating disorder care. A responsibility culture in eating disorder care requires more than relational goodwill: it demands structurally embedded practices that safeguard dignity, distribute accountability and recognise lived experience as a legitimate source of knowledge.[8] Attending to how treatment models operationalise responsibility, rather than merely invoking it, may be one way in which the field begins to respond meaningfully to the ignorance culture that Downs so clearly names.

Acknowledgements

The author thanks the individuals with lived experience, families and clinicians whose repeated efforts to raise concerns about eating disorder care have shaped this work. Their persistence continues to inform both critique and innovation in the field.

Funding

This work received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

The author is a co-developer of MED-DBT and co-author of a treatment manual referenced in this article. No financial conflicts of interest are declared.

References

1 Downs J. Ignorance culture and eating disorders: lived experience analysis of alarms being ignored. *BJPsych Bull* [Epub ahead of print] 15 Jan 2026. Available from: https://doi.org/10.1192/bjb.2025.10199.

2 Harned MS. *Treating Trauma in Dialectical Behavior Therapy: The DBT Prolonged Exposure Protocol (DBT-PE)*. Guilford Press, 2022.

3 Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. Guilford Press, 1993.

4 Linehan MM. Validation and psychotherapy. In *Empathy Reconsidered: New Directions in Psychotherapy* (eds AC Bohart, LS Greenberg): Ch. 17. American Psychological Association, 1997.

5 Bryant E, Touyz S, Oldershaw A, Treasure J, Maguire S. Anorexia nervosa: 150 years of critical theory. *J Eat Disord* 2026; **14**: 49.

6 Federici A, Wisniewski L. *Treating Eating Disorders with DBT: The MED-DBT Protocol*. Guilford Press, 2026.

7 Ben-Porath D, Duthu F, Luo T, Gonidakis F, Compte EJ, Wisniewski L. Dialectical behavioral therapy: an update and review of the existing treatment models adapted for adults with eating disorders. *Eat Disord* 2020; **28**: 101–21.

8 Downs J, Adams M. Toward dignity-centred ethics in the treatment of longstanding and severe eating disorders: a lived experience-led narrative review. *Acad Ment Health Well Being* 2025; **2**. Available from: https://doi.org/10.20935/MHealthWellB7942.

9 Steinhoff MF, Longhurst P, Gillikin L, Cascio MA, Burnette CB, Gilbert K, et al. Disabilities and eating disorders: a theoretical model and call for research. *Eat Behav* 2025; **56**: 101951.

10 Sayrs JHR. Running an effective DBT consultation team: principles and challenges. In *The Oxford Handbook of Dialectical Behaviour Therapy* (ed. MA Swales): Ch. 8. Oxford University Press, 2017.

https://doi.org/10.1192/bjb.2026.10257 Published online by Cambridge University Press