

When Lived Experience Becomes Professional Purpose

By Samantha Keegan

There is a difference between knowing about suffering and standing beside someone you love while they are living through it.

Before becoming the Therapist, I am today, I experienced healthcare from the other side: as a mother searching for answers, trying to understand what was happening to my child and desperately looking for something that would tell me that recovery was possible.

My daughter developed an eating disorder at thirteen. When an eating disorder enters a family, it rarely affects only the person with the diagnosis. It changes the atmosphere of a home. Meals change. Conversations change. Relationships change. Fear can begin to organise family life without anyone consciously deciding that it should. As a parent, you are trying to remain calm while internally asking questions you never expected to have to ask.



What am I supposed to do? What am I saying wrong? How frightened should I be? Who understands this? Will my child recover? And underneath all of those questions was the one I returned to repeatedly:

Where is the hope? I could find information about pathology, symptoms, risks and treatment.

What I struggled to find was enough language about possibility — about the person beyond the illness and about families surviving something that can, at times, feel all-consuming.

My daughter is now recovered, but those years changed me. They gave me something no academic qualification could have given me: an understanding of what it feels like to sit on the other side of the therapeutic relationship.

Later, professional education gave me something equally important: the responsibility to ensure that lived experience never becomes a substitute for clinical knowledge, ethical practice or professional boundaries. I believe both matter. Lived experience opened the door. Professional integrity determines how I walk through it.

My personal experience inevitably influences the therapist I have become. It strengthened my interest in eating disorders, body image, trauma and the complex emotional worlds that often exist beneath behaviours that, from the outside, can appear irrational or resistant. But one of the most important lessons in becoming a psychotherapist has been understanding that my story

is not my client's story. This matters enormously.

Lived experience can increase empathy.

It can help a professional understand the exhaustion of families, the fear surrounding food, the frustration of setbacks and the courage hidden inside seemingly tiny steps. But lived experience can also become dangerous if a therapist assumes, I understand because I have been there.

I may recognise something. I may understand aspects of it. I may have stood close to something similar. But I have never lived inside another person's mind, body, family, culture or history. Professional integrity therefore requires humility. It means remaining curious when it would be easier to assume. It means asking rather than telling. It means listening for the client's meaning rather than imposing my own.

And it means being willing to say, I don't know yet. Help me understand. The person must never disappear behind the diagnosis. Eating disorders have reinforced this principle for me more than perhaps any other area of my work.

We need diagnoses. We need medical assessment. We need nutritional rehabilitation, evidence-informed treatment and multidisciplinary collaboration where appropriate. But somewhere in that necessary clinical structure is a human being.

A person whose eating disorder may have become intertwined with safety, identity, control, perfectionism, trauma, belonging, sensory experience, self-worth or emotional regulation.

If we focus exclusively on removing the behaviour without trying to understand what function that behaviour has come to serve, we risk entering a battle with the symptom while losing contact with the person. This is one of the reasons my therapeutic intention is to continually ask: What happened to you? What does this mean for you? And what does this behaviour do for you that you currently do not know how to do another way? That does not mean colluding with illness or ignoring medical danger.

Compassion and clinical responsibility are not opposites.

Sometimes good care requires firmness. Sometimes safety has to take priority. Sometimes professionals must have

conversations clients do not want to hear. But even within those moments, dignity can remain intact.

A person can be challenged without being shamed. **A** boundary can be held without withdrawing compassion. Medical necessity can coexist with psychological safety. Therapy is not something I do to another person. This principle sits at the centre of my work. The client brings expertise about their own life.

I bring training, therapeutic knowledge, clinical judgement and responsibility. The work happens where those two forms of knowledge meet. I work integratively because people are not standardised. One person may benefit from understanding attachment. Another may need practical cognitive or behavioural tools. Someone else may need to understand the protective parts of themselves that developed in childhood. Another may initially need very little interpretation and a great deal of safety, predictability and regulation.

Neurodivergent clients may experience food, body sensations, uncertainty or therapeutic environments differently.

Trauma may change what safety feels like. Shame may make direct confrontation counterproductive. A person who has spent years feeling controlled may need collaboration before they can risk trusting treatment.

The question therefore becomes less: Which model am I going to apply to this person? and more: What does this particular person need from therapy, and what is the evidence and clinical reasoning for providing it? That is where professional intent must be matched by professional accountability. Good intentions are not enough.

Integrity means examining ourselves too. Therapists ask clients to look inward, and I believe we have an obligation to do the same. Our personalities enter the room. Our histories enter the room. Our assumptions about bodies, health, success, family, relationships and recovery can enter the room unless we are prepared to examine them.

Supervision, ongoing education, reflection and personal development are therefore not administrative requirements to me. They are part of protecting the people who trust us with their most vulnerable experiences.

I never want to become so certain of my expertise that I stop asking whether I might be wrong. I never want experience to become complacency. And I never want a qualification to silence curiosity.

Professional integrity includes recognising the limits of our competence and referring or collaborating when somebody needs expertise beyond our own. It also means being able to hear feedback. If a client tells me that something is not helping, I need to be capable of exploring that without experiencing it as a personal attack.

Therapy should have room for the client's voice — including disagreement.

What healthcare professionals carry matters too. There is another part of this conversation that deserves attention. Healthcare professionals are human beings.

We repeatedly sit beside grief, trauma, fear, uncertainty, illness and loss.

We hear stories that stay with us. We may leave a difficult session and have another person waiting outside the door who deserves our full attention.

Compassion cannot mean limitless self-sacrifice. If professionals are expected to continually absorb distress without reflection, support or appropriate boundaries, eventually both practitioner and patient can pay the price. Looking after the practitioner is therefore not separate from patient care. Supervision matters. Rest matters. Teams matter. Being able to say, I need support with this case, matters.

Creating professional cultures where vulnerability is not confused with incompetence matters. Resilience, to me, is not learning to tolerate unlimited pressure. It is knowing how to remain human while doing difficult work. And I keep returning to hope.

Years ago, as a frightened mother, hope was what I went searching for. Today, it remains one of the most important things I try to protect in my work. Not false reassurance. Not promises.

Not telling somebody that everything will be fine when none of us can guarantee that. Therapeutic hope is quieter than that. Sometimes hope is simply holding the possibility of change when the person sitting opposite you cannot yet hold it themselves. It is saying: We do not have to solve everything today.

There is a reason this developed. We can become curious about it rather than ashamed of it. You are more than the thing you are struggling with. And we can begin from where you actually are. My lived experience taught me why those words matter.

My professional training taught me the responsibility that comes with saying them. And my work continues to teach me that expertise and humanity should never have to compete with one another.

The healthcare professional I want to continue becoming is not the person who believes she has all the answers. It is the person who is knowledgeable enough to guide, reflective enough to question herself, ethical enough to know her limits, courageous enough to challenge when necessary and human enough to sit beside another person without reducing them to a diagnosis.

That, for me, is professional integrity. And behind it remains the same intention that began years ago when my own family needed it: