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Counselling Psychology Quarterly

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ccpq20

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To cite this article: Marius Veseth, Mari Ese, Per-Einar Binder & Christian Moltu (18 Mar 2023): ‘Holding on to regret as a kind of enrichment’ – a qualitative exploration of the role that work-related regrets play in therapists’ clinical practice, Counselling Psychology Quarterly, DOI: 10.1080/09515070.2023.2191310

To link to this article: https://doi.org/10.1080/09515070.2023.2191310

Published online: 18 Mar 2023.

COUNSELLING PSYCHOLOGY QUARTERLY
https://doi.org/10.1080/09515070.2023.2191310

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'Holding on to regret as a kind of enrichment' – a qualitative exploration of the role that work-related regrets play in therapists' clinical practice

Marius Veseth [a,b], Mari Ese[a], Per-Einar Binder [a] and Christian Moltu [b]

[a]Department of Clinical Psychology, University of Bergen, Bergen, Norway; [b]Department of Psychiatry, District General Hospital of Førde, Førde, Norway

ABSTRACT

In this reflexive thematic analysis, we explore 17 psychotherapists' accounts of work-related regrets. Based on individual interviews with experienced clinical psychologists, we report how they describe these regrets as emotionally intense experiences with potential for development. To communicate how participants view work-related regrets to impact on their clinical practice, we formulated an overarching theme called "holding on to regret as a kind of enrichment." Three subthemes summarize different aspects of this process: (a) increased awareness; (b) working to accept and model fallibility; and (c) the process of making changes based on regret experiences. We discuss our findings in relation to theory and research, and explore methodological strengths and limitations.

ARTICLE HISTORY
Received 25 October 2021
Accepted 12 March 2023

KEYWORDS
Qualitative research; thematic analysis; therapists' experiences; regret; therapeutic development

Introduction

How do experiences of work-related regret shape and influence the practice of conducting psychotherapy? In this qualitative study, we explore and discuss this question based on a thematic analysis of 17 psychotherapists' experiences as reported in individual interviews.

Regret, a complex human experience, has been described as a comparison-based emotion arising from a person's realization that a current situation would have been better had they decided differently in the past (Zeelenberg & Pieters, 2007). As such, the experience of regret is elicited by juxtaposing "what is" with "what could have been" (Brassen, Gamer, Peters, Gluth, & Büchel, 2012). Regret is a common and universal emotion (Morrison, Epstude, & Roese, 2012), an inescapable part of human life. As Zeelenberg and Pieters (2007) gloomily remark, "Regret is what you get" (p. 4).

Although regret is depicted mostly as an unpleasant and aversive experience of self-blame, the capacity to acknowledge what is regrettable offers an important opportunity for self-development (King & Hicks, 2007), prompting the pursuit of goals and optimizing

CONTACT Marius Veseth Department of Psychiatry District General Hospital of Førde, Førde, Norway marius.veseth@uib.no

future behavior (Zeelenberg & Pieters, 2007). As such, regret is a common human denominator – an emotion expressing a shared existential ground which unites us as people. How we make meaning of regret and how we carry it, however, are individual matters.

In every line of work, there is a risk for technical mistakes which can result in serious consequences. An accountant could, for example, inadvertently add a digit too much in a report and consequently be held liable for large sums of money. A psychologist could enter the wrong diagnostic code into a medical record with negative downstream effects. In the field of psychotherapy, however, qualitative studies have demonstrated how therapists struggle to regulate their emotions when meeting therapeutic stalemates (Moltu, Binder, & Nielsen, 2010) and navigate their personal vulnerabilities when working to help clients (Bernhardt, Nissen-Lie, Moltu, McLeod, & Råbu, 2019). We commonly understand therapeutic practice not only as a technique, but rather as a real encounter between humans in a committed relationship (Gelso, Kivlighan, & Markin, 2018; Miller, 2004). This understanding influences the meaning of missteps and errors. A mere technical error will have a different experiential meaning than a personal mistake in a committed relationship to another person. Indeed, therapeutic mistakes regularly lead to client drop-out, and relational dynamics are often part of such failures (Maggio, Molgora, & Oasi, 2019). In the psychotherapeutic environment, the potential for personal mistakes and subsequent regrets is ever-present, but the consequences for psychotherapists are not yet fully understood. Following this, the in-depth study of psychotherapists' experiences with regret seems warranted and important.

Professions in healthcare are often characterized by uncertainty, a heavy workload and time pressure, all factors potentially conducive to making mistakes and suffering subsequent regrets. Accordingly, Von Arx et al. (2018) conducted interviews with physicians and nurses to explore how they dealt with experiences of regret. Researchers found that strong feelings of work-related regret had enduring repercussions on participants' health, work-life balance, and medical practice. The most important coping resources included the employment of social capital and the development of active compensation strategies (Von Arx et al., 2018). In this study, mobilizing social support involved seeking emotional support from colleagues or friends. Superiors were also found to play a key role in reaffirming participants professional identity and confidence in their medical competence. Participants' compensation strategies included relaxation techniques and engaging in sport in their spare time. In addition to these aforementioned compensation strategies, participants used the way home from work as a time to mitigate consequences of regrets, actively and cognitively choosing to leave behind everything that had happened during the day (Von Arx et al., 2018).

Courvoisier et al. (2011) similarly studied physicians' and nurses' experiences of regret associated with providing healthcare. Researchers found that such painful experiences could lead to professional growth, as well as to the suppression of thoughts and ruminations on the situation where the mistakes were made. Participants described, for example, concentration difficulties and loss of confidence as important consequences of work-related regrets (Courvoisier et al., 2011). These findings also resonate with research on surgeons' reflections following the death of patients in their care. Examining their responses in a free-text field on a form habitually completed after losing a patient,

Boyle, Allen, Rey-Conde, and North (2020) found that participants experienced a high level of ambiguity, complexity and situational pressures, ultimately calling for better communication with patients and colleagues to improve decision-making and find ways of coping with regret.

In the present study, we expand on a growing tradition that attempts to understand phenomena in psychotherapy by studying therapists' experiences (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Råbu, Moltu, Binder, & McLeod, 2016). We aim to develop knowledge about psychotherapists' experiences of regret through an in-depth exploration of the following research questions: How do therapists experience work-related regret? And how do their work-related regrets influence their clinical practice?

Methods

Our investigation of psychotherapists' experiences of work-related regret was designed as a reflexive thematic analysis (Braun & Clarke, 2019) based on in-depth, semi-structured, and open-ended individual interviews (Brinkmann & Kvale, 2015). We characterize our methodology as "reflexive" to emphasize how knowledge is co-created by researchers and participants through all steps of studies (Veseth, Binder, Borg, & Davidson, 2017). From this perspective, meaning is considered contextual and realities are multiple (Braun, Clarke, Hayfield, & Terry, 2019). Epistemologically, we view our approach as hermeneutic phenomenological, given that our goal is to generate descriptive knowledge of participants' everyday experiences through dialogical engagement (Binder et al., 2016; Finlay, 2011). This approach necessarily involves interpreting the data through the lens of our own experiential history, sociocultural positions and theoretical assumptions, in addition to scholarly knowledge (Braun, Clarke, Hayfield, & Terry, 2019).

Data collection

Individual interviews with 17 participants were conducted by the first (11 interviews) and second (6 interviews) authors between May 2019 and February 2020. We worked closely together to correspond our approaches to the interview situation, listening to each other's interviews and discussing our personal characteristics to prevent these from coloring responses. When considering the resulting data material as a whole we cannot find differences in depth or type of content between interviewers. Snowball sampling, also known as chain sampling, was used to recruit participants. This means that we accessed participants through contact information provided by other participants and our network (Noy, 2008). The interviews lasted between 40 and 108 minutes ($M = 69$ minutes). All were audiotaped and thereafter transcribed verbatim by the second author. We developed an interview guide inspired by a 2018 study by von Arx et al. investigating healthcare-related regrets among physicians and nurses. Modeling the aforementioned study, our interview guide was organized around six broad questions upon which participants were to reflect: (A) what regret means to them; (B) what their most intense feeling of regret in their job as a psychologist was; (C) how they handled the situation; (D) what consequences the situation had for them; (E) what values they consider these regrets to be an expression of; and (F) what meaning the situation had for them in the bigger picture. Follow-up strategies were used when participants gave descriptions which

required additional clarity, as well as at the end of the interview we aimed to be more open to general reflections. As the format was semi-structured, each interview was guided by the participant's story and reflections rather than a strict observance of the above-mentioned order of questions. As such, this study needs to be considered as participant-led.

Participants

Of the 17 participants we interviewed, 11 were women and six were men. Participants were aged 28 years to 69 years ($M = 48$ years). All participants were white Europeans working in different areas of Norway, including the western, southern, eastern and central regions. Participants were located in both urban and rural areas. In addition, participants reported a variety of occupational settings; some were private practitioners, while others held a broad range of public mental health positions. The latter category included employment at outpatient clinics for adults, children, and youth, at inpatient wards, as well as at assertive community teams. Additional participant occupations included specialized services for university students and people with substance use disorders, as well as family therapy services. Sixteen participants were specialists in clinical psychology. Participants reported they had worked as clinical psychologists from 10 to 39 years ($M =$ 19 years).

Data analysis

While collecting the data, we spent time discussing our initial impressions with one another, representing the first step of preliminary analysis. These conversations were guided by the question, "What have we learned so far?", enabling us to reflect on the material as it developed. For reflexive purposes, we also discussed our own experiences with regret and how they may impact the process of conducting this study. After completing the data collection, the first and second authors arranged a one-day analytic meeting with the fourth author to facilitate a team-based analysis of the material (Binder, Holgersen, & Moltu, 2012). Before this meeting, the three of us examined the entire dataset and made preparatory notes related to our first impressions, observations, and insights. Thereafter, we discussed these observations with the third author, who was not familiar with the material, to obtain an outside view on our provisional ideas and begin relating them to the literature. The process of analysis proceeded through the following six steps of reflexive thematic analysis led by the first and second authors: (1) familiarization with the data; (2) coding; (3) generating initial themes; (4) developing and reviewing the themes; (5) refining, defining and naming the themes; and (6) writing up the report (Braun & Clarke, 2006, 2019). Braun, Clarke, Hayfield, and Terry (2019) describe the objective of this approach in the following words:

> The aim of coding and theme development in reflexive TA is not to "accurately" summarize the data, nor to minimize the influence of researcher subjectivity on the analytic process, because neither is seen as possible nor indeed desirable. The aim is to provide a coherent and compelling interpretation of the data, grounded in the data (p. 848).

In the present project, this process of interpretation involved reading and re-reading the material with a focus on how therapists believed their experiences of regret impacted on their clinical practice. Following this step of familiarizing ourselves with the dataset, we started to code the material. This phase involved identifying units of meaning that represent different aspects of participants' experiences and generating labels to capture these features. Here, descriptive codes were developed in the first person to maintain fidelity to the participants' own words, for example: "I understand myself better;" "I don't need to be perfect anymore;" and "I am aware of my influence and power." These codes were thereafter examined to identify broader patterns of meaning, a process termed "developing candidate themes" by Braun and Clarke (2006, 2019).

In this process, we engaged with the data and each other through discussing the tentative ideas we had developed to ensure that the themes captured meaningful aspects of the data material. This involved a process of stepping back and considering what the participants were trying to tell us in the interviews. After this phase, we developed a detailed description of the themes, working out their focus and outlook, a process referred to by Braun and Clarke (2006, 2019) as determining the "story" of each theme. This process included deciding on names that we all could agree on. Based on Braun and Clarke's (2006, 2019) description of analysis as a recursive process, we followed these steps sequentially, allowing ourselves to shift back and forth when necessary.

Reflexivity

Following our methodological approach, we were guided by a focus on reflexivity and transparency in conducting the study (Finlay, 2011; Veseth, Binder, Borg, & Davidson, 2017). To help readers contextualize the results, we will briefly describe ourselves here as clinical psychologists with an interest in humanistic and relational approaches to change processes. In line with this perspective, we acknowledge that therapists are human beings who will make mistakes and experience a range of emotions in the clinical situation, including regret, and we consider these experiences as relevant and important. Our backgrounds may be an advantage in making it possible to explore relational regrets in depth with our participants, but it may also have constricted our openness for other important aspects of the participants work-related regrets. All of us have experienced regret in our professional practice as psychotherapists, and have found this meaningful, and also painful. These experiences include situations where we have felt mildly uncomfortable in our work role, to more intense and bodily experiences leading to periods of losing faith in ourselves as therapists.

As researchers, we share an interest in qualitative research in the field of mental health. The second author participated in the project as part of her master's thesis, whereas the other three authors have broad experience with conducting clinical psychology research. Our practice experience varies, ranging from recently starting a career as a psychotherapist (second author), to 10 (first author), 15 (fourth author), and 25 years of clinical experience (third author).

Ethics and participant protection

All therapists in this study provided written informed consent prior to participation. Here, they received information about voluntary participation and were given an opportunity to ask questions about the study. They were also informed that they could withdraw from the study at any time. We omitted private details from the transcriptions to provide anonymity. Care was taken not only to protect participants, but also to keep third parties in mind (for example participants' patients). All research procedures were approved by the Norwegian Centre for Research Data on April 4th, 2019 (project number 667,125) and conducted in accordance with national standards.

Findings

An emotionally intense experience with potential for development

In this first part of the findings section, we present analyses pertaining to the first research question: How do therapists experience work-related regrets? All participants except one could easily access experiences of work-related regret in the interviews, and most of them could identify several relevant situations. Work-related regrets thus seemed to be an experience that resonated with the participants and that they felt motivated to share information about.

We found great variance in the kind of events participants recounted as their most prominent work-related regret. Regret seemed to involve both things participants had done as well as situations in which they had failed to act. An important commonality was that regret was an experience with heightened emotional intensity. For some, their experience of regret was immediate and pressing, while for others it had developed more gradually over time.

The situations that the participants described as the origins of their most intense regrets included experiences from clinical work with patients (eight participants), occurrences with compounding professionals and private roles (three participants), partnership situations with colleagues (three participants), and events concerning collaborations with patients' next of kin (two participants). As such, one important commonality across accounts seemed to be that participants experienced regret in the context of relational encounters. However, the specific relationships or roles from which these experiences emerged varied.

The emotional intensity reported by participants describing regret was severe and visceral. Typically, participants described regret events as painful and uncomfortable. For many, regret was associated with aversive emotions such as shame, guilt, sadness and anger. The emotional intensity is illustrated in the following extract from the conclusion of an interview:

> Participant (P): I feel I have gained a lot of insight. I had a horrible feeling in the pit of my stomach when I told you about what I had said.
>
> Interviewer (I): Mhm.
>
> P: Because I haven't actually told anyone other than my wife.
>
> I: No.

> P: Ehm. So my stomach was in turmoil. But now I feel quite calm. Or now I feel calm, and I don't feel anything in my stomach . . . From, from it. So I think it was . . . I think it was . . .
>
> I: There was something . . . There was something intense there.
>
> P: Yeah, there was (interview 10).

As illustrated in the quote, feeling shame, including the need to hide the regret situation from the eyes of others, is evidently one emotional component of the experience. A quote from another participant also serves to illustrate this emotional component. In the interview, the participant referred to the work-related regret he had experienced as difficult to handle:

> [It] affects me . . . I feel it a lot in my stomach and in my sweat glands and in the corner of my eye. And problems sleeping, in fact. It affects me much more than the other things I had in mind, which were examples of what I could talk to you about. [. . .] No, for me there's a real uneasiness with regret (interview 3).

While emotional components such as shame, sadness and anger could be involved in the regret experience, we found that the work-related regret phenomenon was not reducible to an emotional experience alone. Rather, across all accounts it involved a cognitive appraisal of a relational situation, as well as of one's role and responsibility. At the time of the interviews, participants described regret as lingering emotional strain, as work in progress, or as a situation that they had worked through and moved on from. Importantly, and irrespective of where participants found themselves in their individual processes, it seemed that the experience of regret also had a forward-oriented component to it. That is, the structure of regret seemed to motivate some form of movement on the therapists' part. Some of the therapists described how the regret situation had led to short-term fatigue and a need for sick leave. They reported having been frustrated with themselves and with others, as well as a sense of stress and anxiety. However, participants also spoke of the potentially constructive phenomenon of regret motivating movement. Ultimately, the process of regret was generally perceived as not only manageable, but also as having a valuable potential for learning and development. One participant, for example, dryly remarked that she would regret contributing to this study if we were aiming to eliminate therapists' experiences of regret. Another emphasized the value of regret in the following words:

> In a way, there can be a positive and negative side to it, I think. You have both the lessons learned, and then you have some troublesome thoughts on the other hand . . . in that learning process. But I, I think I would retain that ability to . . . In a way to regret things a bit. Because it . . . It means something to me as well (interview 17).

In summary, psychotherapists' experiences with work-related regret were described as having roots in a relational situation. While closely associated with intense and painful emotional experiences, it seemed to be a phenomenon that included cognitive appraisals of one's own role in a situation, which also motivated development both on a personal and work-related level. In this perspective, participants appreciated and valued their experiences with regret.

Holding on to regret as a kind of enrichment: Experiences of potentials for professional development

Our second research question in the study was: How do therapists' experiences with work-related regrets affect their clinical practice? The overarching theme resulting from these analyses is coined, "Holding on to regret as a kind of enrichment." One important benefit of work-related regrets seemed to be its potential for development and growth, both on a personal and professional level. We found that participants viewed their work-related regrets as being closely connected to and motivating growth as a therapist. As illustrated in this quote, regrets were something the therapists wanted to use for the good:

> I think, today, I think that regret is a gift. You know. That it's . . . That it . . . Ehm . . . And makes me the person I am by . . . Holding on to regret as a kind of enrichment, you know. It's a painful enrichment, but it's . . . It's something that has enriched me as a human being (interview 12).

Our analyses of these experienced potentials of regret resulted in three subthemes describing how participants found the complex regret experience to be an enrichment potentially supporting growth. The subthemes are as follows: (a) increased awareness; (b) working to accept and model fallibility; and (c) the process of making changes based on regret experiences. We consider these thematic results as strong in the sense that they are covered by most of the participants we interviewed. Following Hill et al. (2005) categorization, we view the overarching theme as a general result, meaning that accounts from all participants contribute to it, while the three subthemes are typical, meaning that accounts from more than half of the participants contribute to each of them.

Increased awareness

This subtheme summarizes participants' experiences of how the work-related regret contributed to increased awareness about themselves and heightened sensitivity in their clinical encounters. One of the therapists, for example, disclosed a situation in which he had hesitated to report a colleague's neglect of professional accountability. It was not until another co-worker confronted him with his avoidance that he was able to step in and intervene:

> I thought I knew who I was, but then I wasn't that person after all. At least not my behavior. Ehm. I thought I was a . . . A person who would intervene when things went too far. But then I wasn't that person (interview 2).

Later in this interview, the participant described how he felt this experience had deepened his understanding of himself, which was critical for his development as a therapist:

> But I also think that some of these experiences make . . . Make . . . You become aware of the importance of your own . . . morality, you know. Really. [. . .] An experience that's been an important part of my development. Both as a human being and as a psychologist. [. . .] After it happened, I think that something happened to me as well. Which means I would never allow it to happen again . . . (interview 2)

Several participants experienced regret related to situations in which they had not been able to detect or make use of important signals from their patients or themselves. One

described, for example, how, despite a feeling of unease, she had stopped fighting for a person whom the healthcare system viewed as treatment resistant. This regret experience was linked to increased awareness; the participant now was committed to using such experiences as grounds for actions when she became aware of them. Another participant eventually became aware of how, early in her career, she had tended to intervene based on her own aspirations to be viewed as an expert. This risked leading patients to feel even more shameful at the end of her sessions. In discussing one of her patients, she commented, "If she felt a bit incapable and stupid and hopeless and alone in the world before her appointment, I think she just felt even more alone when she left." In working with this regret, however, the participant increasingly became aware of this pattern. This taught her the importance of being open and aware of the other person's experiential reality:

> I feel more often that I'm a . . . Better therapist now. I'm less concerned with . . . Following my process. When I meet patients, in a way. Not focused on myself at all. I'm much more focused on being able to be open and curious. And present (interview 8).

Yet another participant shared the distressful event of losing a patient by suicide. In the interview, she was openly affected when she looked back on their final session:

> P: Because I remember her eyes when she was leaving. You know. And that look. Then it's like. . . Because that's how I can think afterwards, what. . . What was going on in her head when she looked at me? Because she. . . Yeah. Because I can remember that she. . . I had another office, and then you came out of the office and then you go along a corridor, and then. . . [. . .] I think I say to her "Yes, we'll talk. You have to remember this. Over the weekend". The girl had trouble sleeping, so she was a bit out of it the day we spoke. Then I said, "You have to remember this now". And then I just see her eyes.[. . .]
>
> I: What is it that you imagine that her eyes were telling you?
>
> P: Mhm. . . No, because it's, it's that. But, you know, when I hear what happened later, what she chose to do. Ehm. Then I start thinking that she was actually saying goodbye then. To me.
>
> I: Yes. . .
>
> P: Mhm.
>
> I: Mhm.
>
> P: Yes. . . So. Mhm. . . There may be thoughts that. . . Was there a doubt there? Because it's, you know, an alternative narrative. Was there a doubt there, did she want me to say something more, right? Yeah. Was there any driving force there? In that choice. I mean, how determined was she? When she did it, she was determined, but then, how out of it was she? That's the thing. How many opportunities were there to be in a dialogue. And that look. . . Yeah (interview 12).

The participant referred to this event as a milestone in her therapist development. However, she needed time to find ways of putting the experience to use in her day-to-day work with patients. She explained, "Because with regret, there's a lot . . . I mean, the camera turns inwards. So. . . Trying to turn the camera outwards and see the other side again. . ." Although this experience still could be wearisome for the participant to this very day, she described it as a formative event, making her more sensitive and authentic in her meetings with patients:

> Making such assessments today. . . I recognize that there is still baggage there, there are still emotions there. The way I thought about it, since I was going to talk to you now, so I thought about it, because I made such an assessment only a few days ago. And. And that's when I feel it. The healthy side of regret. That. . . It's. . . It's really important for me to have that. And that. . . Ehm. What can I say. That. . . That I can go all in. To understand the person sitting there, actually sat in the chair you are sitting in now. Be present, and stay connected, make contact. And. . . And ask questions. Be completely open and. . . Yes. It's a bit like that. . . Ehm. That's the good side, making contact and being real. All in, sort of (interview 12).

Working to accept and model fallibility

The participants stated that they had become more mindful of the complexity that characterizes the psychotherapeutic context. There were often no clear answers to the situations therapists found themselves in, but, despite this uncertainty, they still had to make decisions within a limited period of time. Accordingly, regrets were an unavoidable part of their clinical encounters, necessitating a sense of humility and acceptance both in relation to the situation they were in and to themselves. One of the participants said:

> At the same time, you have to accept that you . . . That you didn't know . . . I didn't know any better at that time. I did it with the best of intentions. And I had to sort of learn . . . By trying this here. That this wasn't the way to go. And I couldn't have known that without experience, I think. So, I can feel a kind of acceptance as well (interview 1).

Some of the participants highlighted how they not only recognized their regrets, but also actively made use of them in their clinical work. One, for example, could give examples of her own parental missteps to some of her patients:

> So that's partly why, not to be preachy, but to. . . show that I'm fallible, and that there's a lot of things I did that I'm ashamed of. Yes. [. . .] We're in the same boat and. . . I'm fallible just like them (interview 8).

Another participant similarly argued that his supervisees needed to know his flaws and imperfections. In this way, he said, they could see him as a whole person, which he felt was important in order to get the most out of their relationship:

> I always start by telling them about all the mistakes I have made [. . .] I feel somehow that proper therapy [supervision] cannot start until they have lost respect for me, and see me as a real person, and a person who makes mistakes. Ehm . . . I think it's not until they see that, that they . . . I mean . . . I think they learn in a different way, in a much better way*(interview 2)*.

Several participants apprehended the power that was implicit in their position as a therapist. One reported, for example, experiences of regret in relation to discussing the pros and cons of an abortion with a patient suffering from a severe substance use disorder. In the interview, she emphasized how such a question does not have an obvious answer and how her reflections at the time were thoughtful and deliberate. Yet, she kept coming back to the fact that she had provided the patient with concrete advice on this matter. She said:

> That this child maybe . . . Knows that someone . . . A person in a position of power or, a professional, felt that you should not have been born. Ehm. Yes. I've thought that it's . . . Must be bad. Knowing . . . Or can be . . . Difficult to live with (interview 9).

The participant did not get opportunity to follow-up on her counselling with the patient who was discharged shortly after. She described how this became an important lesson about the value of exploring situations without taking position, especially when patients are struggling with existential dilemmas. At the same time, she said in the interview, there was something ambiguous about this feeling of regret because it also provided the participant with some sense of acceptance about the therapist role:

> I'm not sure if I can put this into words, but . . . But . . . There is something . . . There is . . . It is like I feel I have more leeway [now], a more nuanced [understanding] how one as a therapist in situations [like these] can do both one thing and the other (interview 9).

Another participant correspondingly articulated a strong sense of shame related to his position and power in describing his work-related regret. At a conference dinner, where everyone had had a few drinks, the person sitting next to the participant had shared with him the most difficult experience she had had to live through, in response to which he intended to offer comfort and support. Instead, what came out, the participant explained, was experienced by the person as almost taunting. The person immediately stopped eating and left the table with an abrupt movement, leaving everyone noticing that something had happened. The participant described how he later approached her, but was angrily rejected: "You should never have said that. And you're a psychologist." To the participant, this was an important reminder on his role, and he emphasized that he had learned a lot from this situation about being humble when it came to the effect of his position on others. He said in the interview:" I felt really ashamed, because it means something to me. Ehm. Being, being a psychologist, that, that title, it's . . . yes, it, it means something" (interview 10).

The process of making changes based on regret experiences

The participants typically described how their work-related regrets sparked them into stepping in and responding to the situation they found themself in. One of the participants emphasized this process in the following way:

> When something is wrong, you have to act there and then. And quickly. And then you again feel that you actually have to trust, and listen to your inner moral compass, in a way (interview 2).

To the participants, these processes could play out in a variety of ways. In addition, participants identified different phases of this change process. Several of the participants, for example, noted how they had come to realize the necessity of self-care in their line of work to ensure constructive development. Accordingly, they committed to making changes in their lives in order to better attend to themselves. One participant was currently in a pre-contemplative phase in which she could take cognitive responsibility, but had not yet managed to bring about the changes that she wanted to commit to:

> Why have I not had more faith that what I'm doing is at least good enough? Why have I always been sort of looking for things I do wrong. [. . .] Why have I not been more relaxed, why have I not been more flexible and proud that what I . . . Think and evaluate and feel is good enough (interview 4).

Other participants expressed development toward becoming less self-sufficient and making use of their social support and professional networks. Although some talked about the importance of their family and friends, and others highlighted supplementary strategies such as reading literature or working out, the importance of co-workers was regularly addressed in the interviews. This could be discussed in the broader context of the workplace; as described by the following participant:" We had this understanding that… It's not, it's not my case, it's our case. I mean, it's ours, it's our responsibility, together" (interview 12). However, participants most often emphasized the support they found in supervision or in seeing a therapist. This relationship seemed to allow for experiences of regret to be relationally shared, thereby facilitating processes toward making changes. The following quote exemplifies this phenomenon:

> But it's probably been an important, important place to be able to somehow … Process some of this. And not be completely alone with it. […] Yes. Try to maybe rationalize these feelings, both of anger and having a bad conscience and, and, yes, that heavy feeling of doing something that you don't really feel you can fully face up to. That too, yes. Being able to share it. With an experienced colleague (interview 16).

Moreover, participants valued how their experiences of work-related regret had helped them to take explicit action in their ongoing therapies. One of them described how she had initiated experiential work with a patient who was not ready for it. The patient had confronted her about how these demanding exercises were unhelpful, and the therapist took full responsibility. This shifted the therapy into a more constructive direction. In the interview, she said:" So that's why I sometimes think that taking the radical responsibility is so incredibly useful, because… It strengthens the relationship. Between the therapist and patient" (interview 8).

Another participant similarly highlighted the need to take responsibility. Like the many therapists before her, she had not been able to treat a new patient in line with this person's hopes and expectations. This led the patient to abruptly leave their session. As a result, the participant decided to write her a letter: "But then I think with that letter, she experienced something new, namely that someone expressed regret and apologized. Because she probably hadn't experienced that before, and that she could get a little justice." Later in the interview, the participant discussed how this reflected an important role of regret, leading to the act of making amends:

> It's now a, you get a need, in a way. Ehm … But if I don't do it, if I don't … […] It gnawed at me for a long time. And that's perhaps what regret is supposed to do. That it forces us to make amends, is what I think (interview 14).

Discussion

In this article, we explore how therapists' work-related regret impacted on their clinical practice. Our study findings suggest that experiences of regret are emotionally intense and viewed as holding potential for development. Three subthemes summarize how these experiences could impact participants' clinical practice: (a) increased awareness; (b) working to accept and model fallibility; and (c) the process of making changes based on regret experiences. While Von Arx et al. (2018) and other studies investigating the

consequences of regrets on healthcare workers (see for example Courvoisier et al., 2011; Cullati et al., 2017; Schmidt et al., 2015) articulate the adverse effects that experiences of regret may have, the participants in the present study also emphasized the benefits of regret. As such, our study may add important knowledge about constructive effects following regrets through descriptions of processes of growth.

How can we understand these results? By describing the lessons participants learned through their regret and the changes that resulted, participants' narratives emphasize how reflecting on and working with their regrets benefited their vocational development. As such, the situations leading to regret can be seen as epiphanies in the therapist's professional life, according to Denzin's (1989) terminology. He describes epiphanies as interactional moments that leave marks on a person's life. They are existential turning points that often result from challenging or problematic interactions with others. Epiphanies are experiences of crisis which alter the fundamental meaning structure in a person's life, transforming how one understands oneself and one's relationship to the world (Denzin, 1989).

The crises experienced by our participants resonate with what Lucas (2004) termed existential regret. She argued that this is a phenomenon in which a deep existential anxiety coexists with existential guilt. Here, we face one of the givens in life – the finitude of our past choices – and, in relation to accepting or failing to accept this, we encounter existential anxiety (Yalom, 2020). In existential regret, this anxiety is coupled with ontological guilt, an experience of having abandoned ourselves and failing to fulfill the potential in our own as well as in other people's lives (May, 1958). One of the participant's descriptions in our first subtheme – increased awareness – vividly illustrates this point. This participant was suddenly confronted with not being the person he thought he was, and needed to find ways to integrate this experience into his journey forward. As such, existential regret is the crossroads at which failing to respond in accordance with our inner values and knowledge is confronted with the inability to go back and restore that very moment when we could have made other choices (Lucas, 2004).

According to Denzin's (1989), epiphanies are not typically perceived as moments of change when they initially occur. But retrospectively, upon reflection of the situation, told and retold, it becomes clearer how these were in fact, transformative events. Overcoming experiences of regret has been understood to involve releasing oneself from rumination about other choices and different outcomes through processes of self-forgiveness (Fisher & Exline, 2010), as well as shifting one's focus toward a determination to live more deliberately in the future (Lucas, 2004). This means that it calls us toward responsibility, both personally and socially (May, 1958). Reflecting upon regrets has moreover been argued to have potential for promoting a richer and more complex form of well-being (King & Hicks, 2007). The specific outcome of our participants' regrets – increased awareness; working to accept and model fallibility; and the process of making changes based on regret experiences – can be seen as results of such processes. Because the participants could not make the situation better by changing the past, they turned to something they could change, such as their present and future actions. As such, their experiences of regret paved the way for important changes in participants' attitudes and their interactions with patients.

The feelings and reflection rising out of regret in our study seems to lead the therapist into a process of professional humility, guiding new ways of orienting towards their

practice. During this process, they also refine their values and ethos, giving more weight to the virtues emphasized in our three subthemes: increased awareness; working to accept and model fallibility; and the process of making changes based on regret experiences. These virtues are also, and to an increasing degree, regarded as essential therapist characteristics in light of empirical studies of constructive psychotherapeutic processes and psychotherapist effectiveness. Elliott, Bohart, Watson, and Murphy (2018) demonstrated, for example, how interpersonal sensitivity is central for good outcomes, and Davis, Cuthbert, Worthington, Davis, and Hook (2017) and Nissen-lie et al. (2017) highlighted the importance of therapist humility.

Our findings also relate to an expanding scholarly knowledge base on psychotherapists' personal and professional development. Rønnestad and Skovholt (2013) summarized practitioners' development through the organization of five phases: the novice student phase, the experienced student phase, the novice professional phase, the experienced professional phase, and the senior professional phase. In this model of therapists development, it is suggested that individuals move through different phases of development based on how they resolve inherent crises in maturing professionality (Rønnestad, Orlinsky, Schröder, Skovholt, & Willutzki, 2019). Facing and integrating personal and professional selves while coping with experiences of disillusionment, inefficacy, and inconsistency is an imperative part of a therapist's maturation to experienced phases (Rønnestad, Orlinsky, Schröder, Skovholt, & Willutzki, 2019; Řiháček & Danelova, 2018). These processes also include finding ways to handle experiences of regret in the role as a psychotherapist.

Similarly, Rousmaniere (2016) highlighted the importance of learning from mistakes as a key element in deliberate practice for psychotherapists. This concept rests on a premise that the therapist cultivates an openness toward, and an interest for, areas of improvement. In turn, these areas form the basis for a deliberate practice toward development of mastery (Goldberg et al., 2016). As suggested by the findings of this study, regret is one phenomenon involved in making changes from situations in which one believes one should have acted differently. It takes the structure of a junction, in which both acceptance and willingness to learn and act, and, conversely, closing down, are available options. As such, when handled well, it appears that regret can play an important role in becoming and developing as a therapist (Bugental, 1992).

Study strengths and limitations

The in-depth, semi-structured and open-ended individual interviews we conducted captured rich and nuanced data reflecting participants' experiences with work-related regrets. A major strength in our study is this ability to encompass and describe themes that are close to psychotherapists' first-hand experiences, as it offers a deeper understanding on a topic in which knowledge is scarce and necessary. Another important advantage of our study is our research team's diverse clinical experience, allowing multiple perspectives and different understandings regarding participants' descriptions of regret.

However, weaknesses must also be noted. Firstly, our study was limited by both sample size and scope. The 17 participants were experienced therapists and, on average, had worked as psychologists for 19 years. This means that we have primarily interviewed

people in the ultimate phase of professional development, according to the model described by Rønnestad and Skovholt (2013). As such, participants were therapists who had been able to stay in their jobs; stories of work-related regret from people who stop being therapists or from therapists with less experience may have provided us with other nuances. The inclusion of novice therapists could have offered more variation in our data. Moreover, it must be noted that the study was conducted within a Norwegian context. Care needs to be taken in transferring findings to other settings.

Reflexivity refers to the researchers' self-awareness at all stages in the process of conducting a study (Finlay, 2011). Because we view research as a dynamic enterprise in which meaning is constructed in the interplay between researchers and participants, making this interplay explicit and transparent is essential to safeguarding the quality of the research (Veseth, Binder, Borg, & Davidson, 2017). However, the task of seeing and thinking about oneself in relation to a study can be a strenuous undertaking. One interesting point to discuss may be that participants' autobiographical accounts consisted mainly of moments of change for the good, what McAdams and Bowman (2001) describe from a narrative viewpoint as a "redemption story." Following this line of thinking, we must consider why our data did not comprise of more contamination stories, that is, narratives where the outcome of participants' regrets were turning points for the bad instead of learning and growth. This may be a result of the recruitment method in our study; the snowball strategy can give a higher likelihood of recruiting therapists with similar experiences because, as Noy (2008) argued, snowball sampling necessarily involves people's social networks. It is also conceivable that therapists who had experienced growth rather than stagnation following regret were easier to recruit. Alternatively, perhaps these stories were more accessible in the interviews. Because one of the interviewers (second author) was conducting interviews as part of her main thesis in clinical psychology, it is possible that participants chose redemption stories rather than contamination stories so as not to dishearten her at the start of her career. However, there was no clear difference in content between the material collected by the two interviewers, indicating that such effects were not particularly salient. Furthermore, research also demonstrates that people value regret above other negative emotions (Saffrey, Summerville, & Roese, 2008). As such, it can be seen as reasonable that redemption stories were at the center of our data material. It is also possible that our focus on experiences of regret, rather than, for example, acts of making mistakes, may have influenced the data we collected. Participants who found resonance in this concept and therefore wanted to participate may already have been in a process in which regrets were something they reflected upon.

Implications

Our results point to work-related regret experiences being common for psychotherapists. Moreover, these experiences are described as emotionally intense and potentially draining. One implication of regret's universality is a need to include regret as an expected experience in training of psychotherapists. In this regard, our findings suggest that framing and discussing regret experiences as a potential for development is constructive and should be addressed in clinical supervision, as well as in more informal meeting points for collegial support. Qualitative studies of common phenomena in therapy can

contribute to this cause by developing language that is useful for clinicians in making meaning out of their experiences. For future research, our findings point to the importance of clarifying the different constructs relevant to regret and development. Regret related to personal and relational missteps might be fundamentally different from experiences attributed to making technical errors. Moreover, the development potential that participants experienced related to their regret could be studied as part of more general therapist development studies.

Conclusion

Qualitative research concerns the systematical exploration of people's lived experiences. Examining 17 participants' experiences of work-related regrets, we found that participants notably viewed these regrets as emotionally intense experiences with potential for development. To communicate how these experiences were understood to impact on their clinical practice, we formulated an overarching theme called "holding on to regret as a kind of enrichment." Different aspects of this process are summarized through three subthemes: (a) increased awareness; (b) working to accept and model fallibility; and (c) the process of making changes based on regret experiences. We have discussed these findings in relation to theory and research, and have explored methodological strengths and limitations of the study.

Disclosure statement

No potential conflict of interest was reported by the authors.

ORCID

Marius Veseth http://orcid.org/0000-0002-5881-5451
Per-Einar Binder http://orcid.org/0000-0003-0867-0386
Christian Moltu http://orcid.org/0000-0003-3269-6383

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