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Empathic Reflection

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Abstract

Therapist *empathic reflections* are used to communicate understanding of client communications and experiences. Originally associated with person-centered and experiential psychotherapies, they have been adopted by psychotherapists from a range of approaches. We begin with definitions and subtypes of empathic reflection, drawing on relevant research and theory, including conversation analysis. We distinguish between the response mode empathic reflection, reviewed here, and the relational quality of empathy (reviewed in previous meta-analyses). We look at how empathic reflections are assessed and present examples of successful and unsuccessful empathic reflections, also providing a framework of the different criteria used to assess their effectiveness. In our meta-analysis of 43 samples, we found virtually no relation between empathic reflection and effectiveness, both overall and separately for each of six effectiveness criteria. Although not statistically significant, we did find weak support for reflections of change talk and summary reflections. We hypothesize that good and poor reflections routinely cancel each other within studies, indicating the need to look more carefully at the quality of *empathy sequences* in which empathic reflections are ideally calibrated in response to *empathic opportunities* offered by clients and sensitively adjusted in response to client *confirmation/disconfirmation*. We conclude with diversity considerations, research limitations, training implications, and therapeutic practices.

Keywords: empathic reflections, reflections, psychotherapy, psychotherapy process, psychotherapy outcome, meta-analysis, conversation analysis

Empathic Reflection

Therapist empathic reflections are a class of therapist response modes whose primary expressed intention is to "reflect back" or share the therapist's understanding of the client's communications and underlying experiences. They are the primary tool of person-centered and experiential approaches to psychotherapy (Elliott et al., 2004; Goodman & Esterly, 1988; Murphy, 2019), but have been widely adopted and are a core part of basic communication skills training programs (e.g., Hill, 2020; Ivey et al., 2022; Miller & Rollnick, 2013).

Although the word *skill* is used in the title of this book, we regard empathic reflection as a type of therapist *response mode* (or speech act) rather than a *skill* in the ordinary language sense of expertise or ability to do something well (Oxford English Dictionary, Simpson et al., 1989). In fact, Carl Rogers (1975) did not like the idea of empathic responding as a "skill," famously claiming that he was never trying to reflect feelings. Instead, he saw himself as checking his understanding of the client. It was only in the 1960s and 1970s that writers such as Carkhuff and Berenson (1977), Goodman and Dooley (1976), and others began to describe empathic reflection as a "skill" that could be taught. Since then the teaching of empathic reflection as a skill has grown and is typically a core part of curricula for the training of counselors, as well as for a wide range of other helpers.

In our review, we examine the effectiveness of empathic reflection as a response mode without regard to how well or poorly it is carried out. In any case, there is almost no research on the skillful or unskillful delivery of empathic reflections. Instead, it is our view that the quality of skillful empathic reflection is best described as *empathy*, which has already been evaluated in a series of reviews (Bohart et al., 2002; Elliott et al., 2011, 2019).

In this chapter, we begin with definitions and subtypes of empathic reflections and provide clinical examples. We report an original meta-analysis of quantitative research, along with narrative reviews of qualitative and conversation analysis research. We also examine the limitations of the research reviewed, before concluding with diversity considerations, training implications, and recommended therapeutic practices.

Definitions

At the outset, we note that the term *reflection* is somewhat misleading. The term connotes a simple mirroring or paraphrasing of what the other person says; however, many empathic reflections are more complex than this. Accordingly, proponents of the person-centered tradition (e.g., Brodley, 2006; Mearns et al., 2013; Rogers, 1975) prefer *empathic understanding* responses or *empathic following responses*. Following Goodman and Dooley (1976) and others, we define empathic reflections primarily in terms of their expressed intent. Carl Rogers (1951) saw reflections as having the purpose of "trying to understand from the client's point of view and to communicate that understanding" (p. 452). This response mode is distinguished from, for instance, interpretations, whose primary expressed intent is to "bring news" to the client (Goodman & Esterley, 1988, p. 71). Empathic reflections are also distinct from advice aimed at offering guiding information to the client, and questions focused on eliciting information from the client. Furthermore, *expressed intention* (communicating understanding) can be distinguished from the *form* (reflection or paraphrase) of a therapist's response (Goodman & Dooley, 1976; see also Stiles, 1986).

By calling them *empathic reflections* we highlight the connection of this form of response with *empathy*, while still distinguishing between the two concepts. That is, empathic reflections refer to responses primarily intended to convey the therapist's empathic understanding of the client (Goodman & Esterley, 1988).

On the other hand, we use *empathy* to denote the quality or skillfulness of empathic reflections and related therapist empathic responses (e.g., claims of understanding such as "mhm" responses or nonverbal expressions of understanding). Similarly, Hill (2020) noted, "Empathy is not a specific response type or skill; rather, it is an attitude or manner of responding with genuine caring and a lack of judgment" (p. 434). The classic definition of empathy is that of Carl Rogers (1957, p. 99): "To sense the client's private world as if it were your own, but without ever losing the "as if" quality." Relatedly, Hill (2020) defined empathy as "understanding clients at both a cognitive level (their thoughts and expressions) and an affective level (their feelings)" (p. 434). In fact, we see empathy as a complex cognitive-affective-perceptual-somatic process of trying to enter or sense the phenomenological world of another person in order to get in touch with how they see and experience the world. Furthermore, empathy cannot be reduced to saying back or paraphrasing what the client has said, or simply noting that the client is feeling a certain feeling. Instead, it is trying to *understand* what the client is getting at, which often goes beyond the spoken words to capture implicit meanings. For Brodley (2001), "The therapist's sole goal in acceptant empathic understanding is to *understand* the client in a manner that is likely to result in the client having *the experience of being understood*" (p. 18).

In any case, as used in contemporary practice, empathic reflections are not necessarily either simple mirroring or paraphrasing responses, although they may be. They often involve trying to *infer* what the client is getting at; and they also involve resonating (emotionally and bodily) with the client's often implicit experience (Elliott & Greenberg, 2021). Therefore, empathic reflections may have a *depth* dimension (Gendlin, 1968) and may be "additive" (Hammond et al., 1977). However, the degree of inference does not go beyond what the client presumably has available to conscious awareness.

From the point of view of conversational analysis (CA; Sacks, 1995; Sidnell & Stivers, 2013), empathic reflections would be considered one form of *empathic response* (Muntigl et al., 2014). (CA researchers don't use the term "empathic reflection.") Empathic responses reveal the recipient's (i.e., therapist's) understanding and appreciation of the teller's (i.e., client's) troubles and emotional experience (Weiste & Peräkylä, 2014), and may be distinguished from non-empathic responses that do not address clients' perspectives or substantially depart from and alter clients' understandings of their experience (e.g., Ruusuvuori, 2005, 2007; Voutilainen et al., 2010). Prior CA studies identified various conversational methods used to convey empathy. According to Hepburn and Potter (2007), empathic responses are speaking turns that (a) formulate or describe/reference the other's perspective or experience, and (b) acknowledge the client's 'expert' authority to know and describe their experience. In CA, *formulations* overlap substantially with what we are referring to as empathic reflections, displaying understanding by summarizing or providing an upshot of prior talk (e.g., Antaki, 2008; Heritage & Watson, 1979).

Consistent with this CA perspective, empathy and empathic responses do not occur in isolation but are part of larger "empathy sequences" (Muntigl et al., 2014) in which clients attempt to make themselves understood, therapists offer understandings (commonly via empathic responses or formulations), and clients provide feedback about the accuracy or appropriateness of those understandings. The focus is on the sequential organization of jointly accomplished and negotiated *displays* of affect and understanding, critiquing a more conventional view of empathy as a one-way therapist intervention or discrete speech act (e.g., Heritage, 2011; Ruusuvuori, 2007).

Finally, although the intent of empathic reflections is to convey empathy to clients, it is not the case that empathic reflections are the only therapist responses that result in clients feeling understood. For example, Elliott et al. (1982) studied two samples of clients: in the first sample they found that in single-session interventions there was a medium effect size relation between empathic reflections and clients feeling understood. However, in the second sample, from ongoing therapy, there was no relation. That is, clients could feel understood from any response form that displayed or revealed therapist understanding, including questions and advice.

Types of empathic reflection. Contemporary psychotherapists have identified various kinds of empathic reflection. We briefly summarize some of their distinctions. Hill's (2020) helping skills system includes two types of empathic reflection responses, primarily based on their target or content: *Reflections of feeling* can repeat, rephrase or identify the client's feelings, or may be more inferentially arrived at from nonverbal behavior or other aspects of the client's situation or verbal communication. *Restatements* paraphrase content and meaning, and can reference material in the moment, earlier in a session, or even earlier in therapy. Ivey's (1978) microskill taxonomy includes several types of empathic reflections: *encouraging* **(**repeating what the client said**)**, *paraphrasing*, *summarizing*, *reflection of feelings*, *reflection of meaning*, and *empathic self-disclosure* (where the therapist demonstrates understanding by sharing a relevant personal experience). To these Larson (2020) adds *first-person* responses. In a *first-person* response, the therapist speaks from the point of view of the client, using the first-person (e.g., "So I hear a part of you saying, 'I can't stand this job anymore!'").

Within motivational interviewing (MI; Miller & Rollnick, 2013) many kinds of reflection have been described and studied (Amrhein et al., 2008, Moyers et al., 2014). Broadly, reflections can be either *simple* (restating what the person has just said with little or no added meaning) or *complex* (where a guess is made about previously implicit meaning, or meaning or emphasis is added). MI then distinguishes among content of reflections: *change talk* (e.g., desire or reasons to change), *sustain talk* (difficulties in changing or reasons not to change), *commitment language,* and *other* (everything else). Beyond this, MI specifies an ever-expanding range of reflections, for example, c*ontinuing the paragraph (*a complex reflection where the therapist says what might follow from what the client said), *double-sided (*where the interviewer states both sides of a client's ambivalence), and *summary (*which brings together multiple contents the client has expressed).

In their study of client-centered therapy drawing on a CA perspective, Muntigl, Knight, and Watkins (2014) identified varying types of empathic responses, providing a useful perspective on the types of empathic reflection described above: *gist formulations* summarize the client's prior talk; *upshot formulations* deliver the implications of the client's talk; *naming another's feelings* formulates the client's emotional state; and *co-completions* complete the client's prior incomplete utterance. Formulations have also been found to vary in the extent to which they convey empathy. Further, in comparing CBT and psychoanalysis, Weiste and Peräkylä (2013) found that *highlighting* and *rephrasing* formulations remain closest to clients' talk (i.e., most empathic and consistent with what we are calling empathic reflections), while *relocating* and *exaggerating* significantly transform or challenge clients' prior talk and are therefore unlikely to function as empathic reflections.

Finally, in order to help therapists broaden the range of their empathic reflections, Elliott and Greenberg (2021, pp. 53-56) identified nine types of empathic reflections, based on different client micro-markers and corresponding aspects or tracks of client experience. Table 1 describes and contains examples of each type: *empathic repetition*; *empathic reflection* (of the main

content or feeling the client is communicating), *empathic affirmation* (gentle reflections of emotional pain), *empathic formulation* (used in a narrower sense than in the CA literature, here referring to translating client communication or experience into psychological terms or a useful narrative); *empathic refocusing* (reflecting back toward avoided experiences); *evocative reflection* (heightening emotion by vivid imagery or first person presentation); *exploratory reflection* (tentative and aimed at unclear experiences), *process reflection* (nonconfrontational description of client verbal or nonverbal action); and *empathic conjecture* (tentative guesses about client unspoken experience).

Clinical Description and Indications

Therapeutic Functions of Empathic Reflections

Although the most obvious function of empathic reflections is to convey empathic understanding, a variety of other functions have been proposed. Broadly, reflections are affiliative responses that act to support, validate, or help clients feel that they make sense (Heritage, 2011). In addition, a wide range of more specific functions have been proposed to: (a) help clients access feelings and experience (Martin, 2016); (b) foster emotion regulation (Watson, 2002); (c) help clients reflect on their experience (Rennie, 1998); (d) help clients articulate, symbolize, and carry forward their experiencing (Gendlin, 1968); (e) help clients differentiate and integrate information (Wexler, 1974); (f) help clients deconstruct old ideas (Watson, 2002); (g) foster higher order thinking and to facilitate client creativity (Bohart, 2021); (h) orient clients towards present feelings or towards future possibilities (Bohart et al., 1993); (i) strengthen the self and foster positive introjects (Watson, 2002); (j) help clients access and work through ambivalence by fostering change talk (Miller & Rollnick, 2013); and (k) draw attention to therapeutically relevant meanings in what the client has said (Antaki, 2008).

General Indications for Empathic Reflection

Clients' displays of emotion offer opportunities, what Suchmann et al. (1997) call *empathic opportunities*, for therapists to respond with empathy. These typically take the form of a client's report of a distressing experience or situation, referred to colorfully as *troubles telling* (Jefferson 1988). Empathic opportunities also encompass client talk that often extends beyond factual reporting of events to disclosures of feelings or thoughts about events and people in their lives (e.g., becoming surprised or disappointed). Through these affective descriptions, clients display a *stance* (Stivers, 2008) towards these events. CA distinctly focuses on the client's frame of reference as displayed or made recognizable for the recipient (therapist). An affective stance can be achieved lexically (through words) and grammatically but also kinetically (through body movement) and prosodically (through speech intonation and rhythm; Muntigl et al., 2012; Suchman et al., 1997). A stance may evolve (rather than being static) throughout a troubles' telling, providing a moving target for the therapist to respond to (Muntigl et al., 2012).

Indications for Types of Empathic Reflection

The different forms and functions of empathic reflection raise the issue of when and how to offer them. What are the indicators or micro-markers that point to particular types of reflection? For example, in motivational interviewing, reflections are generally seen as most helpful when capturing *change talk*, that is, client speech favoring client movement toward a specific goal (Miller & Rollnick, 2013). For the most part, however, there is little differential information about when and how to use empathic reflections. It may be that the lack of consensus on how to operationalize and use empathic reflections in clinical practice plays a role in the empirical conclusions we draw later. As an example of what might be possible, Table 1 provides, for each of a set of types of empathic reflections, a recommended target micro-marker

that the therapist is listening for and which is hypothesized to be the optimal context for the corresponding reflection response.

Assessment

Assessment of Empathic Reflections

There are several systems for classifying therapist response modes that include empathic reflections. Hill's system (in its various versions: e.g., Hill, 1978, 1986, 2020) has probably been used over the longest time period. However, over the past 20 years, the most frequently-used approach has been based on motivational interviewing, including the *Motivational Interviewing Skill Code* (MISC; Amrhein et al., 2008) and the *Motivational Interviewing Treatment Integrity Coding Manual* (MITI; e.g., Moyers et al., 2005, 2014). Empathic reflections are also included in the coding systems of Stiles (1992) and Elliott (1985). Beyond this, psychodynamic therapy researchers have sometimes assessed empathic reflection, although commonly referred to as *clarification* (e.g., McCullough et al., 1991).

An especially important but tricky issue is distinguishing between empathic reflection and interpretation. Thus, reflections can pick up client experiences that are at the edges of awareness, but which have not yet been put into words. This means that it is not always easy to tell the difference between a "deep" empathic reflection and an interpretation, leading to disagreements among researchers.

The confusion with interpretation underscores the broader question of how reliably one can identify empathic reflections. Identifying reflections *within* different coding systems can be done reliably (e.g., Elliott et al, 1987; Hill, 1986; Lietaer & Gundrum, 2018; Stiles, 1986). However, there are problems with identifying reflections *across* coding systems. This is most likely in part due to the varying ways that empathic reflections are defined. For example, Ivey's et al. (1987) system scores deeper empathic reflections as interpretations (e.g., Weinrach, 1990), whereas Hill's (1986) coding definition (as well as the system developed by Brodley; see Moon, 2018) sticks closer to the person-centered/experiential tradition, which has a more expansive definition of reflections, including deeper, more exploratory empathic responses (e.g., referred to in Table 1 as evocative, exploratory and process reflections, plus empathic conjectures, empathic formulations and empathic refocusing). In spite of these differences, Elliott et al. (1987) found convergence between six response mode scoring systems used to rate a common set of sessions with seven psychotherapists. Depending on how one interprets this, one can conclude that there is some relation across systems as to what a reflection is, but there is also some disagreement.

Assessment of the Effects of Empathic Reflections

Different research approaches point to different ways of assessing the effects or effectiveness of empathic reflections. Therefore, we briefly review them here.

The most widely-used of these is the *process-outcome* criterion, in which researchers measure both a within-session process (e.g., a particular type of empathic reflection, typically aggregated as a total or proportion across a whole session) and a post-session or post-treatment outcome. At the post-session level, measures might include relationship quality (e.g., the Working Alliance Inventory, cf. Boardman et al., 2006) or client continuation of therapy vs dropping out (e.g., Huang et al., 2013). At the treatment level, measures might include client post-therapy abstinence from substance misuse (e.g., Palfai et al., 2016) or amount of pre-post symptom reduction (e.g., Brief Symptom Inventory; Milbrath et al., 1999). Such studies are intuitively appealing but suffer from causal inference problems, such as reverse- or third-variable causation (e.g., Stiles & Shapiro, 1994).

Another, increasingly popular, approach to change process research is the *sequential process* paradigm (Elliott, 2010). In these studies, researchers identify examples of a particular therapy process, such as empathic reflection, and then look at what the client does next in the session, using measures of productive (e.g., client experiencing; Hill et al., 1983) or unproductive (e.g., counterchange talk in motivational interviewing; Moyers et al., 2009) process. The chief strength of this design is that it comes closer to warranting causal inference because we can directly see whether what the client says next is ostensibly a response to what the therapist just said, as opposed to an evasion or change of topic.

A less robust version of the sequential process paradigm throws out the sequential information. In *process-process correlational* research, the client process variable (e.g., observer ratings of client engagement) is aggregated over a time period, most often the whole session (e.g., Boardman et al. 2006), and correlated with the therapist process measure aggregated over the same time period.

A less often used approach, *sequential experiential* research, has clients review recordings of sessions and rate the immediate within-session impact of particular empathic reflections using Interpersonal Process Recall (Elliott, 1986). Immediate impacts are most often helpfulness, e.g., Elliott et al., 1982), but sometimes involve particular immediate reactions such as feeling understood (e.g., Elliott, 1985).

In addition, qualitative researchers (e.g., Bachelor, 1988) have interviewed clients about their experiences of therapy, and these clients sometimes talk about therapist empathic reflections. Finally, conversation analysis (CA) has provided a rich account of how clients affiliate or disaffiliate with therapist empathic reflections (Muntigl et al., 2013; Muntigl & Horvath, 2014).

Clinical Examples

We present two contrasting segments of emotion-focused therapy taken from Muntigl et al.'s (2012, 2013) CA studies, one successful, the other unsuccessful. Each of these examples includes the sequential structures within which empathic reflections are located (discussed in more detail later in this chapter). In order to convey important details about these interactions, CA uses special transcription conventions (Table 2; see also Jefferson, 2004; Hepburn & Bolden, 2017), similar to a musical score. We invite the reader to study these transcripts for the valuable level of relevant detail about the verbal and nonverbal means used by client and therapist to construct each of the two empathy sequences. (Key expressions of judgment and affect are in bold; annotations of important nonverbals are in italics.)

The first extract portrays a standard, successful empathic reflection: Near the end of therapy, the client Paula is reporting on how she has acted in ways that are contrary to her prior patterns of behavior by taking more control of her actions: rather than withdrawing from certain uncomfortable situations, she has confronted others and stood up for herself:

[Copy editor: Kindly place all transcript currently in blue as grayscale in the printed version. If possible, please retain the blue color in the digital version.]

(1) 312.16(03) [13:28]/ *Muntigl et al. 2013, p. 4*

1) Client's troubles telling + affective stance display

01	Paula:	I: think at one point in time I was saying, like (0.7) u:m,
02		(1.3)
03	Paula:	i- it's kind of like starting to- (.) to change and like first
	p	*hands circling over each other in front of body*
04		it was kind of like **a little bit on the aggressive side**
05		**of things** .hh=
06	Ther:	=↑mm:.

```
07          (0.7)
08  Paula:  and that I ↑really wanted like (.) you know like to get into
    p       taps hands down/                          holds hands up
09          this:, (1.0) well I guess what you would call assertiv:e (.)
    p       chops hands forward
10          behaviour , (.) [ mode.]
11  Ther:                   [mm hm ] mm hm
    p       pulses hands forward
13          (0.4)
14  Paula:  a:n- (0.9) yea:h, (0.9) u- and for some time I was ↑kind of a
15          little bit worried .hh that I wouldn't be able like
16          to:, (.) to find that balance but, (0.4)
17          it's comin:g (0.4) alo:ng (0.7) alright (h)e he he.=
    p                          slow shallow multiple nods
    t                       shallow nod
```

2) Therapist's empathic reflection [gist formulation]

```
18  Ther:   =so you're finding a way (.) to do it but also not to do it
19          too aggressive[ly, ]
20  Paula:                [.hh ]
21  Ther:   to do it in a way that's, (0.4) works socially, works for
    p       multiple nods ------------------------------>       fast...
22          you, works for them.
    p       multiple nods----->
```

3) Client's response [confirmation]

```
23  Paula:  ((lip smack))) ↑yeah.
    p       fast deep multiple nods
    t       multiple shallow nods
24          (       0.3       )
    p       fast multiple nods
25  Ther:   and isn't, (0.3) you know turning off everyone you
    p       fast multiple nods---------------------------------->
    t                                  Smiling
26  Paula:  [thet's-]
27  Ther:   [meet,  ]kind of
    p       nods---------->
28  Paula:  that's right. [that's] right,=
29  Ther:                 [yeah, ]
    t       double nod
    p       multiple nods
```

The second extract, shows a short sequence with the same client but from an earlier session. Here, the therapist's effort at recasting Paula's stance is rejected, resulting in a disaffiliative sequence. The transcript not only shows how the therapist's attempt at connecting with the client's expressed stance seems to miss the mark, resulting in *failed empathy*, but also how the therapist secures re-affiliation with Paula by mobilizing a number of key interactional resources: producing nods in direct response to Paula's stance displays and later by showing understanding of Paula's alternative position:

(2) 312.09(08)/ taken from *Muntigl et al. 2012, p.126*

1) Client's affective stance display

```
01  Paula:  and it's just really hard, (0.8) to say oka:y (1.3)
02           this person (2.0) doesn't make me feel good,
03           (3.4)
04           a:n- (.) like jus- (.) just to leave it like just to sa::y,
05           like f::- (.) ↑f:orget it. like just drop it an- and move o:n.
06           like it doesn't work.
07           (2.5)
```

2) Therapist's empathic reflection/conjecture

```
08  Ther:   and is there (.) a feeling of somehow,
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09          (0.9)
10          I fa:iled if tha- I do that or I-
            3) Client's response [disconfirmation]
11          (1.1)
12  Paula:  .hhh::: hhh:::
13          (8.8)
14  Paula:  I- euh no:. like-
15          (.)
            4) Re-affiliation/ Mutual consensus
16  Paula:  w- what ↑I'm wondering about like wis this- (0.8) particular man.
17          like why: (.) am I so: hung up on him. (0.3)
    t       shallow multiple nods.
18          like why do I have to try:, (1.2) ↑so hard, (0.5)
    t       slow double nod---------->              shallow nod
19          and at the same time like it's almost like he doesn't ca:re.
20          (1.5)
    t       deep nod. slow nod.
21  Paula:  and why do, (0.4) why do I keep, (3.9) ↑running.
    t                                      slow nod
22          (     1.6     )
    t       multiple nods→
23  Paula:  uh(hh) (.) and why does he say certain things, (0.3) which kind of me
    t       ------------------------------------------->
24          make ↑thi:nk (.) that he cares, but then (0.8) in his behavior
    p           double nod
25          he doesn't really- (.) live up to it. uh(hh)
    p                                          Smiles
    t                                          Nod
26  Ther:   so you feel very confused by his behavior
27          (1.0)
28  Paula:  oh ↑yeah. (h)he he he!
    p              rolls eyes to side
    t             shallow nod
```

We are aware that it can take some effort to fully appreciate transcripts as complex as these, but we believe the standard simplified transcripts omit important interactional detail and, as a result, grossly underestimate the interpersonal complexity and collaborative nature of the empathic reflection process. In particular, lines 11-15 of extract 2 provide a classic example of how clients signal that a reflection has failed to capture their experience. (Later on we provide a targeted elaboration of what is going on in these examples.)

Landmark Studies and Previous Reviews

Landmark Studies

In this section we briefly describe four studies that illustrate the main types of evidence to be reviewed in our meta-analysis. These studies correspond to the different criteria for assessing the effectiveness of empathic reflections introduced earlier.

Process-outcome. In a study of psychodynamic therapy for bereavement, Milbrath et al. (1999) examined two kinds of empathic reflection, corresponding to what are referred to more commonly as reflections of content (referred to by these authors as *clarification*) or emotion (*reflection*). Their effectiveness variables included client improvement on three outcome measures (e.g., Brief Symptom Inventory), generating a total of six process-outcome correlations. Four were reported as not statistically significant and therefore estimated as zero; the other two correlations (both involving reflection of feeling) were large (r = .61 and .48),

yielding a study-level average process-outcome correlation for reflection of feeling of .39 (calculated using the Fisher r-to-z transformation), while the process-outcome correlation for reflection of content was estimated at zero (based on being reported as statistically nonsignificant).

Sequential Process. In a study of the change process in motivational interviewing with alcohol misuse, Moyers et al. (2009) studied three kinds of reflection: *Reflection of client change talk* (e.g., talking about reasons to change), *reflection of client counterchange talk* (e.g., difficulty of changing), and *reflection of other change talk* (or neutral or balanced change/counterchange talk). They evaluated how often these three kinds of reflections were followed by client change talk (previously found to lead to posttherapy client change and therefore considered to be a productive client in-session process) or client counterchange talk (considered to be an unproductive client process likely to interfere with client change). As they expected, the researchers found that reflections of client change talk appeared to lead to client change talk (phi = .215) but did not suppress client counterchange talk. On the other hand, reflections of counterchange talk did not affect client change talk but did enhance client counterchange talk (phi = .175, reversed to -.175 to reflect this as a negative effect). Reflections of neutral or balanced change talk had no effect on either client change or counterchange talk. These results support the MI change process model but were small. Furthermore, the picture was complicated by the presence of reverse causation (i.e., client change talk led to therapist reflections of change talk) and third variable causation (i.e., chains of client self-generated change talk).

Process-process correlational research. In a study of MI for smoking cessation, Boardman et al. (2006) evaluated two kinds of reflections: *simple reflections* (defined as briefer responses paraphrasing or rephrasing of either content or emotion) and *summaries* (longer, more complex reflections referring to two or more client responses). Rates of these for whole sessions were calculated and correlated with observer session ratings on the Working Alliance Inventory and the Client Engagement subscale of the Vanderbilt Psychotherapy Process Scale. Summary reflections were slightly better at predicting the two measures of good process (mean r = .19) than simple reflections (mean r = .05). However, the causal relation between average reflection ratings and good process measures could as easily run in reverse or even be circular.

Sequential Experiential. Elliott et al. (1982) reported on two studies of empathic reflections evaluated by raters, clients or therapists: one study of brief, laboratory-based therapy sessions, the other involving clients in ongoing therapy. After each session, clients reviewed the recordings of their sessions and rated the helpfulness of therapist responses. None of the correlations between perceived empathic reflection and client-rated helpfulness were statistically significant (range: -.05 to .09). Exploratory analyses pointed to the possibility that "for each mode, significantly helpful and nonhelpful instances can be found, so that the overall effect is that the ratings cancel each other out" (p. 360).

Previous Reviews

Orlinsky et al. (2004) summarized the results of 14 previous process-outcome studies of therapist reflection using the old-fashioned box score method: Eight of these studies reported no association between reflections and outcome, five reported negative correlations, whereas only one reported a positive correlation. We are not aware of any previous quantitative meta-analyses of research on the effectiveness of empathic reflections.

In contrast, a cumulative series of meta-analyses of process-outcome research on therapist *empathy* have been published (Bohart et al., 2002; Elliott et al., 2011, 2019). These reviews are consistent in finding a moderate association between therapist empathy and client

post-therapy outcome (r = .28; equivalent to d = .58). There is, however, little or no overlap between the studies in these previous meta-analyses and the following research review on empathic reflection.

Research Review

Meta-analysis of Quantitative Research

In this section, we report the results of an original meta-analysis of available research relating therapist empathic reflections to measures of their effectiveness. We started with a general question: How effective are therapist empathic reflections? We operationalized this by looking for studies that provided evidence of empathic reflections having had helpful or hindering effects. This search yielded a more refined question: What associations are there between empathic reflections and measures of their effectiveness? We were also interested in a range of potential moderators of the effectiveness of empathic reflection, which generated further research questions: (a) Do different *effectiveness criteria* (as described earlier, e.g., process-outcome) produce similar or different sized effects? (b) Are some *types of reflection* (e.g., complex vs. simple) more effective than others? (c) Does the *content of reflections* (e.g., feeling vs. content) make a difference for their effectiveness? Importantly, our review deals with the presence or absence of reflections (including their quantity) rather than *quality* of reflections.

Search Strategy

Because of the multiple meanings of the word *reflection* in the psychological literature and because most measures of empathic reflection are embedded in broader systems of therapist response modes, we started with a recent systematic review of measures of therapist verbal response modes (Gumz et al., 2015). From this, we identified the major approaches to measuring therapist response modes, including those described earlier. For each we identified one or two original or key references; for MI we used Amrhein et al. (2008) and Moyers et al. (2005); for general response mode rating systems we used Hill (1978, Hill et al., 1981), Stiles (1979, 1992), and Elliott et al. (1982; Elliott, 1985); for psychodynamic response rating systems we used Gumz et al. (2015). Using the cited source function in PsycInfo, this gave us a starter set of 1075 sources; after screening these via their abstracts we were left with 60 possible sources to retrieve. From here, we checked reference lists to identify more studies; this resulted in a further 32 sources to check. After retrieval and analysis of these additional studies, we added 12 more, for a total of 45 studies involving 49 samples of clients (four studies each contained two samples). However, six experimental process studies (e.g., Waskow, 1962) were judged to be outside the parameters of this review, resulting in 39 studies involving 43 samples of clients. Table 3 provides PRISMA information.

Characteristics of the Studies

Table 4 summarizes the 43 samples (from 39 studies) and 214 effects (n = 2710 clients, 573+ therapists) used in the meta-analysis. Research on the effectiveness of empathic reflections has burgeoned over the past 20 years, driven largely by research on MI for substance misuse, which is now the most-studied treatment approach and client presenting problem in this literature. Client ethnicity was reported for only 18 (42%) of the 43 samples; only 5 studies reported therapist ethnicity. Of studies that reported client ethnicity (most of which were on MI), mean non-European ethnicity was 60% (range: 0 to 100%). Reflection was overwhelmingly assessed by nonparticipant observers; most often raters did not distinguish between different types and contents of reflections. Reflections were most frequently coded at the therapist speaking turn level, but often then aggregated to the session level (e.g., proportion of reflections out of the total number of speaking turns). Effectiveness evaluation most often involved observer

ratings of good client process or client ratings (e.g., of outcome or helpfulness). The most common index of effectiveness was client next speaking turn good process (e.g., client change talk), but client post-therapy outcome measure scores were also common. Sequential process and post-therapy process-outcome effectiveness criteria were most common in our dataset.

Estimation of Effect Size

We used Pearson correlations as our main metric of effect size. Our strategy was to extract all possible effects. Therefore, we used the following conventions to estimate *r*: First, if the result was nonsignificant, but we had enough information to calculate a *t* and then convert, we did so. If we had no other information than that the effect was nonsignificant, we set *r* at 0. We converted standardized difference and odds ratio effect sizes to correlations using standard formulas. For transition probabilities in sequential process design studies, we calculated phi coefficients, which are equivalent to correlation coefficients for 2X2 tables. We also report results as standardized differences (Cohen's *d*).

Coding Procedure and Analyses

As summarized in Table 4 and in keeping with the exploratory nature of this meta-analysis, we coded multiple features of each study: therapy approach/orientation, format/modality, setting, client presenting problem, treatment length, sample size, and experience level of therapists. For reflection measures, we coded rater perspective (e.g., observer), target/content of reflection (e.g., feeling, change talk), type of reflection (e.g., simple, complex), and reflection measurement unit (e.g., speaking turn, 2-5 min segment). For effectiveness measures, we coded perspective (therapist, client), variable type (e.g., client next turn good process; client post-therapy outcome), and measure timing (e.g., client next turn good/poor process). Finally, we coded effect size calculation method and change process effectiveness criterion.

We conducted two sets of analyses: First, we analyzed the 214 separate effects to examine the impact of reflection and effectiveness criterion parameters, with and without inverse weighting for the number of effects within studies to control for nonindependence of effects from the same sample. Second, study-level analyses averaged individual effects within client samples before further analysis, thus avoiding problems of nonindependence and eliminating bias due to variable numbers of effects reported in different studies (Lipsey & Wilson, 2001).

For analyses across studies, including overall effects, effectiveness criteria, and moderator variable analyses, we used Fisher's r-to-z transformation, weighted studies by inverse error (n-3), analyzed for heterogeneity of effects using Cochrane's *Q*, and used a restricted maximum likelihood random effects model (calculated using Wilson's 2021 updated macros for SPSS). We also calculated I^2, an estimate of the proportion of variation due to true variability as opposed to random error (Higgins et al., 2003) and generated a funnel plot. (We were unable to calculate a fail-safe number.) In subgroup and moderator analyses, given the overall baseline of zero effect size, we have interpreted small effects (mean $r_w \geq |.1|$) as potentially meaningful or promising, even when because of small sample size, these were not statistically significant.

Results

Overall Effectiveness. We calculated the overall effectiveness for empathic reflections in three ways (see Table 5), all with virtually identical findings of around zero (the largest was model 2, with mean $r_w = .02$, equivalent to $d = .04$). Overall, we found *no* relation between therapist empathic reflections and effectiveness with clients. Furthermore, these effects were relatively homogeneous: Higgins I^2 values were generally low (where they could be calculated at

all), and only the effects level model 1 analysis had a significant Cochrane's *Q*, no doubt because degrees of freedom were inflated using multiple effects from each study.

The null effect here obviates the usual bias checks, such as funnel plots and fail-safe numbers, although we did find some evidence of bias in the form of a medium-sized correlation of .33 ($p < .05$) between effect size (r) and standard error of r (see funnel plot in Figure 1). This might mean that our estimate of mean weighted $r = .02$ is, if anything, overly optimistic. As the lower part of Table 5 shows, our null results were remarkably consistent across all three levels of effectiveness: within-session, postsession, and posttherapy.

Immediate Within-session Effectiveness. Within-session effectiveness included results using three criteria (sequential process, sequential experiential, and process-process correlational); because studies often included measures using different criteria, only effects-level data could be analyzed (k =136 effects), although analyses controlled for number of effects per study. Empathic reflections did not predict within-session effectiveness; Table 5 presents additional details.

Breaking down within-session effectiveness further, we looked separately at sequential process, sequential experiential, and process-process correlational designs. These results are summarized in Table 6. For sequential process ($k = 82$) and sequential experiential ($k = 42$) effects, mean r_w was -.01 ($d = -.03$) and .04 ($d = .08$) respectively, again indicating no relation between empathic reflections and immediate within-session effectiveness. On the other hand, *process-process correlation* designs ($k = 12$ effects) produced variable ($I^2 = 53\%$) but slightly favorable results marginally supporting the effectiveness of empathic reflections (mean r_w =.14; CI: -.08, .35; $d = .28$. This result suggests that therapist empathic reflections show a small tendency to be associated within sessions with higher rates of client productive process (e.g., proportion of client change talk; Catley et al., 2006). However, the direction of causal influence is not clear in these studies, so this effect might be inflated by unmeasured reverse or circular causal processes.

Postsession Effectiveness. We found no effect for postsession effectiveness measures (Tables 5 & 6; $k = 11$ effects; $r_w = .01$; CI: -.22, .19; $d = .02$; $Q = 2.1$, NS). Although the sample was small, the effects are consistent, suggesting that rates of empathic reflection are generally unrelated to global measures of good session outcome or process, including client ratings of session or relational quality (e.g., Barkham & Shapiro, 1986), observer ratings of client insight gain over the course of the session (Baumann et al., 2008), composite ratings of good vs. bad sessions (Friedlander et al., 1985), and client postsession engagement in treatment (e.g., Huang et al., 2013).

Posttherapy Effectiveness. Similarly, we found no effect for empathic reflections on measures of posttherapy outcome ($k = 67$ effects), in spite of the more robust sample and high consistency. The model 2 mean r_w was .03 ($d = .06$; $Q = 29.6$, NS). Thus, frequency of empathic reflections appears to be unrelated to treatment outcome. As with immediate within-session effectiveness, these effects were significantly and consistently smaller than $r = .1$, generally considered to be a small effect; this justifies an inference of a null or no-difference effect.

Moderator Analyses

The lack of heterogeneity made it unlikely that we would find substantial effects for moderator variables, while at the same time raising the question of what might make reflections helpful or unhelpful. For this reason, we carried out exploratory analyses on a range of potential moderators.

Type of Reflection. The most common distinction we encountered in the literature was simple, brief reflections vs. more complex, ambitious reflections, a distinction described variously as additive (Hammond, 1977), change-focused, deeper or complex (e.g., Amrhein et al., 2008), and exploratory (e.g., Barkham & Shapiro, 1986). However, as Table 7 indicates, we found no overall difference in effects between (a) undifferentiated general reflections, (b) simple reflections, and (c) more complex reflections, with all effects hovering around zero. Perhaps complexity or ambitiousness of reflections is still too undifferentiated a concept; further, adding more of a speculative element to a reflection may simply mean that the therapist is more likely to get it wrong.

Target/Content of Reflection. A more fine-grained and potentially promising approach has been to examine the specific contents of reflections, that is, what they refer to. This is certainly the rationale behind the common distinction between reflections of content and feeling (e.g., Hill, 1978), as well as the proliferation of the different types of change-related reflections in MI (e.g., Amrhein et al., 2008). As Table 8 shows, we found two small, statistically nonsignificant but intriguing effects favoring change talk reflections (k = 13; mean r_w = .12; CI: -.08, .31; ns; d = .24) and session summary reflections (k = 5; mean r_w = .15; CI: -.22, .48; ns; d = .30). These effects also help explain the general null effect, which may be the result of watering down slightly helpful reflection contents with contents that have no relation to effectiveness.

Other Moderators. Looking at sample level effects (k = 43), we found no differences or significant effects for type of therapy (MI, psychodynamic, mixed/unspecified), therapist experience, client presenting difficulty, client ethnicity (non-European origin) or decade in which the study was conducted. Similarly, for effect level effects (k = 214), we found highly consistent null results across a wide range of effectiveness variables, including client IPR turn-ratings, client next-turn productive process, client or observer post session ratings, client posttherapy outcome or status, and therapist turn-level or post session ratings.

Review of Qualitative Research

We located only four qualitative studies specifically examining the effectiveness of psychotherapist empathic reflections. Bohart and Boyd (1997) found evidence that clients interpreted empathic reflections in terms of what they were looking for. One client, looking for support, interpreted her therapist's empathic reflections in terms of providing support. Another client, looking for insight, interpreted her therapist's empathic reflections as offering insight. Myers (2000) interviewed five female clients after their experiences with two therapists. Clients mentioned that paraphrasing, clarifying, and summarizing helped them feel understood; they specifically mentioned the value of the therapist summing up and saying back some of what they had said, and they valued hearing their own words fed back to them in a different way. In Bachelor (1988), 27 clients described a situation in which their therapist had been empathic. She found that empathy was not tied to a particular response form or therapist behavior. Finally, in a grounded theory analysis of clients' reports on experiences of empathy in therapy (MacFarlane et al., 2017), simple reflections were associated with client experiences of cognitive empathy, which appeared to lead to improved client self-understanding. Emotional empathy was communicated through therapist nonverbals and self-disclosures.

To sum up, a common theme across the four studies was that empathic reflections were not uniquely associated with specific client effects. They can be interpreted by clients in different ways, and they are not the only responses that lead to clients' experiences of empathy. However, three of the four studies did find that reflections are one response form associated with an increase in client self-understanding.

Review of Conversation Analysis Studies

The key premise of conversation analysis (CA) is that social interaction is sequentially organized and accomplished through speakers' shared methods of action and reasoning (Stivers & Sidnell, 2013). One key line of CA investigation is identifying and describing commonly occurring sequences of responsive actions (e.g., question-answer, storytelling-response) for how they are 'done' or accomplished in interaction both vocally (e.g., lexico-grammar, prosody) and non-vocally (e.g., gesture, gaze). There is a growing body of CA work on empathic responses in psychotherapy, most of which address empathic reflection (e.g., Elliott et al., 2000; Muntigl et al., 2014; additional CA studies marked with "+" in reference list).

Muntigl and colleagues (2014) observed a three-part sequence in psychotherapy in which therapist empathic responses (i.e., reflections) are regularly used to display empathy: (a) the client reports a distressing experience or situation, (b) the therapist provides an empathic reflection or displays understanding of the client's experience, and (c) the client responds (e.g., confirmation, disconfirmation) to the therapist's empathic reflection. We refer back to the two CA transcripts with the client Paula presented earlier under the Clinical Examples to illustrate how CA research has shed light on how empathic reflections feature in accomplishing and negotiating empathy sequences in therapy.

Successful Empathy (Example 1)

(1) Empathic opportunities: Client Troubles telling + Affective Stance Displays. CA research indicates that empathy sequences begin with clients providing the therapist with detailed, incremental access to their troubles and their progress in dealing with those troubles, as well as their affective stance toward those troubles (i.e., how they feel about them). This offers an empathic opportunity for therapists to show their understanding and support (e.g., Kupetz, 2014; Muntigl, Knight, & Watkins, 2014). In example 1, lines 01-10 illustrate how clients can develop an affective stance, first through descriptions of being "a little bit on the aggressive side of things" and adopting an "assertiv:e behaviour , mode.", and then by stating a 'worry' in which she is unsure as to whether she will be able to find a balance of taking control while not exceeding boundaries (lines 14-17). In line 17, Paula conveys some tentative self-reassurance via a positive assessment "it's comin:g (0.4) alo:ng (0.7) alright" and a series of slow successive nods. The therapist, in turn, nods in unison, thus displaying token affiliation (=the minimum required) with Paula's assessment. Paula's stance is also built up through a number of non-vocal, mainly gestural, resources. For example, in line 03, her circular hand movement reinforces her claim that her behavior is "starting to- (.) to change", making this visually accessible to the therapist. Paula's tapping hand movements in line 08 further emphasize her desire to change her ways ("I ↑really wanted") and her chopping/tapping hand movements provide further visual access into her having taken on a more assertive behavioral mode. The affective stance components of Paula's turn include descriptions of having been aggressive/assertive, claims of desiring change, worry, positive assessment that she will find a balance and gestural resources to accompany and strengthen Paula's stance.

(2) Therapist formulation response. CA research shows how therapists respond to empathic opportunities with formulation responses (empathic reflections; e.g., Davis, 1986; Voutilainen et al., 2019). In lines 18-22, we see the therapist offering a summary formulation (=reflection) that captures the gist of the client's prior talk. The formulation is produced without any intervening pauses (i.e., contiguous to Paula's prior turn, which often conveys affiliation or 'being in agreement') and highlights how Paula is able to achieve a 'healthy' balance between competing needs: 'taking control/ standing up for herself' vs. 'not imposing on others ("do it

too aggressively"). Then, in lines 25-27, the therapist continues her turn by downplaying the possible negative effects of Paula taking control and being assertive ("isn't, … turning off everyone you meet"). In common with other CA studies (e.g., Weiste, Voutilainen & Peräkylä, 2016), the therapist's formulation here works empathically in the following ways: (a) it demonstrates their understanding of the client's dilemma by summarizing her affective stance and thus by staying close to the client's own descriptions of her personal experience; (b) it invites confirmation from the client, thus allowing her to maintain 'ownership of experience' and to validate her expert role by confirming or disagreeing with the therapist's response; (c) it supports and thus affiliates with the client's emotional meanings, but without identifying with or intruding on the client's feelings as, for example, through sympathy. Such subtleties are difficult to capture in standardized measures of therapist empathic reflection such as used in the research reviewed earlier.

(3) Client Confirmation. Responses to therapist formulations/empathic reflections, which constitute the third position of empathy sequences, have been shown to be either affiliative or disaffiliative (e.g., Muntigl & Horvath, 2014). Whereas affiliative responses display varying degrees of agreement with the therapist's proffered empathy, disaffiliative responses convey disagreement (e.g., Elliott et al., 2000), often as either a form of direct opposition or as communicating disengagement such as refraining from answering (cf., Eubanks et al., 2018 on 'confrontation' vs. 'withdrawal' in alliance ruptures). Strong forms of client affiliation have been noted to co-accomplish what has been termed *empathic moments* in the CA literature (Heritage, 2011). During these moments, therapists and clients display interactional synchrony at both the vocal and non-vocal (e.g., synchronous nodding) levels and display (prosodically) upgraded, overlapping confirmation, as seen in Example 1, lines 21-29.

Failed Empathy and Re-affiliation (Example 2)

Moments of disaffiliation occur when clients do not communicate agreement with the prior therapist formulation (e.g., Guxholli et al., 2021; Muntigl et al., 2013). Example 2 shows a short sequence with the same client in which the therapist's effort at recasting Paula's stance is rejected, resulting in a disaffiliative sequence. The transcript not only shows how the therapist's attempt seems to miss the mark, resulting in *failed empathy*, but also how the therapist secures re-affiliation with Paula by producing nods in direct response to Paula's stance displays and later by showing understanding of Paula's alternative position.

(a) Missed Empathic opportunity. Lines 01-07 provide an illustration of a missed empathic opportunity that the therapist's reflection fails to pick up (Wynn & Wynn, 2006 offers another example of failed empathy). Paula's initial troubles telling highlights her dissatisfaction and frustration with her current boyfriend and the relationship. Her unhappiness is conveyed through negative assessments such as "it's just really hard," and "this person (2.0) doesn't make me feel good," and a sense of hopelessness for and frustration of the relationship situation as communicated via expressions such as "like f::- (.) ↑f:orget it. like just drop it an- and move o:n." Various prosodic features (i.e., stress, rise/falling intonation, syllable lengthening) also consistently work to upgrade her feelings of frustration and stuckness.

(b) Therapist failed attempt at empathic response. CA studies have described how empathic responses that rephrase or transform are inherently risky, in the sense that they are more likely to be disconfirmed by the client (e.g., Antaki, 2008; Weiste & Peräkylä, 2013). In Example 2, *lines 08-10,* rather than summarizing or highlighting the client's frustration, the therapist's empathic response (draws attention to a possible reason (feelings of failure) that could explain why the client finds it difficult to move on. Thus, it is not the client's displayed affect as

such that the therapist orients to (negative affect towards the boyfriend and relationship), but rather the possibility that the client might blame herself if the relationship fails. This inferential leap, going significantly beyond what the client had said, is certainly a plausible (and perhaps even insightful) display of understanding of the client's troubles. But it is offered without making an explicit connection, or show of support/affiliation, with what the client had said, which increases the risk of disconfimation (e.g., Voutilainen et al.,, 2010). The client might not, in turn, recognize this new understanding as her own.

(c) Client Disconfirmation. The defining feature of a failed empathy sequence is client disaffiliation (disconfirmation; e.g., Muntigl, 2020; Weiste, 2015). Lines 11-15 provide a graphic illustration of client disaffiliation/ disconfirmation/disagreement. Perhaps for the reasons mentioned above, the client disaffiliates with what the therapist had put forward and instead works to clarify her original position. Her disaffiliation at lines 12 onwards can be immediately inferred from the transcript: First, there is a significant silence following the therapist's turn completion (line 11), which implicates that confirmation may not be provided (see Pomerantz, 1984). Second, she utters a pronounced sigh, as expressed via a deep in- and out-breath ("`.hhh::: hhh:::`"), which also signals potential disagreement in this sequential position (Hoey, 2014). Third, following another lengthy pause of 8.8-sec., she expresses explicit disagreement, "`no:`" in line 14. After having rejected the therapist's attempt at focusing on 'feelings of failure' as an explanatory construct for her frustration, the client continues by critically questioning her excessive feelings for the boyfriend and her effort in keeping the relationship going (`I so: hung up on him; I have to try:, ↑so hard; I keep, ↑running`) with the boyfriend's lack of interest (`he doesn't ca:re`).

(d) Therapist re-affiliation. CA researchers have long documented how dispreferred responses as illustrated by Example 2 lead to attempts to repair the disaffiliation (e.g., Muntigl & Horvath, 2014). For instance, in lines 16-28, during the client's next speaking turn (in which she criticizes herself and her boyfriend), the therapist nods at strategic places within Paula's turn that involve criticism. These nods communicate the therapist's affiliation with the client's new divergent position and, by indicating support, encourages her to continue developing her position until they reach the point where the therapist can offer a suitable formulation/empathic reflection to secure their re-affiliation. This empathic display seems to resonate well with Paula, as it results in a successful re-affiliative episode: Paula offers strong confirmation in line 28 (`oh ↑yeah.`).

To sum up, this interaction in Example 2 may be interpreted as at best a mixed success: Re-affiliation between therapist and client was achieved and maintained, preventing a worse in-session outcome, but the therapist's possible immediate agenda of developing the client's stance in a different, potentially relevant direction (e.g., through two-chair work on a self-critical process), was not. Thus, the two examples illustrate how empathic reflections appear to succeed or fail through the operation of multiple complex and nuanced moment by moment processes. The chief value of this CA literature is to document the existence of some of these processes, something that is not currently reflected in the quantitative research literature or measures.

Summary and Implications of Research Review

In our meta-analysis of the quantitative literature, we found empathic reflections in general appear to have no relation to a wide range of measures of effectiveness. At the same time, we found a few small, non statistically significant positive effects for: (a) reflections of client desire or reasons for change ("change talk"; Moyers et al., 2009), possibly because they encourage the client or offer a direction forward for the client; and (b) summary reflections (e.g.,

Boardman et al., 2006), possibly because they begin to offer the client a narrative for their process or provide closure for the session and a direction forward.

We can make sense of this reliably null effect (that is, statistically significantly less than a small effect < |.1|) with four, probably overlapping, theories. The first (*Filler theory*) suggests that empathic reflections are therapeutically inert filler. The second (*Nudge theory*) suggests that empathic reflections are "nudges" (Thaler & Sunstein, 2008), that is, small opportunities for clients to explore further, generally imperceptible in their effects, which are likely to indirect and contextual. The third (*Cancellation theory*) suggests that some reflections are likely to be helpful, but these are rare and probably cancelled out by unhelpful or even hindering reflections. Finally, there is *Quality theory*, which suggests that the empathy, timing, and manner of reflections are essential for them to be effective.

The small set of qualitative studies reviewed points to two main conclusions: First, that empathic reflections are not uniquely associated with specific effects, and, second, that reflections do appear to be regularly associated with enhanced client self-understanding.

The CA research begins to highlight the intricacy and complexity of what goes into empathic reflections in the joint achievement of both "empathic moments" (as in Example 1) and instances of "failed empathy" (as in Example 2). More specifically, CA research points to the importance of therapists recognizing and responding to empathic opportunities (referred to as "markers" in EFT; Elliott et al., 2004) afforded by troubles telling. Further, CA highlights the importance of the form and delivery of responses for them to be heard as empathic (versus less empathic or non-empathic). It also directs the attention to the third part of the empathic sequence—the client's response (i.e., how the client receives the therapist's response) as offering opportunities for stronger empathic responses or to repair failed empathy by reaffiliating.

Possible Negative Effects and Harm

Based on the CA literature, illustrated by the example 2, empathic reflections are likely to have negative effects under the following conditions: (a) When reflections deviate too far from client experience, especially when not expressed tentatively enough or with enough empathy or affiliation from the therapist (e.g., Muntigl et al., 2020); (b) when reflections fail to adequately represent clients' affective stance, including the intensity or strength of their feelings ("under-reflecting") (e.g., Jefferson, 1988); or (c) when therapists fail to take back or repair reflections after clients subtly signal disagreement (e.g., Example 2)

At the same time, Miller and Rollnick (2013) wrote that it is unlikely that an empathic reflection will cause any harm. We understand this statement to mean that the capacity for harm is substantially less than for more directive responses such as challenge, criticism, or advice-giving (Miller et al., 1993).

Diversity Considerations

Client ethnicity was reported for only 18 (42%) of the samples in our meta-analysis and then mostly for studies on MI, which often involved Black or Hispanic populations (itself a reflection of cultural bias; cf. Substance Abuse and Mental Health Services Administration, 2019). Some MI research explicitly addressed socio-cultural dimensions of people's experiences and identities (e.g., Carcone et al., 2013; Felstein Ewing et al., 2015; Jacques-Tiura et al., 2017), suggesting the overall null effects we found for empathic reflections is likely to hold across several dimensions of diversity (e.g., gender, race/ethnicity, sexual orientation, SES). In fact, we found no relation between the proportion of non-European clients in the studies reporting ethnicity and the effectiveness of empathic reflections. None of the small number of qualitative studies included non-European-origin clients, but we are unaware of any studies that

systematically studied differences in response to empathic reflection across different cultural identities.

Nevertheless, Rimal et al. (2021) discussed the translation of MI concepts like reflective listening into Nepali, noting that Indigenous trainees felt it would be impolite to offer empathic reflections as statements, preferring instead to add tag-questions to make them more tentative (cf. exploratory reflection, Table 1). Miller and others in the MI community have argued that reflections are useful for working with clients from various social positionalities (e.g., Miller & Rollnick, 2013). On the other hand, we are also aware that in some cultures, attitudes toward authority lead clients (e.g., in east Asia) to expect therapists to take the lead and give advice (e.g., Sue et al., 2022). A "pure" nondirective style of a steady diet of empathic reflections might backfire with such clients, along with many in Western cultures. Obviously, more reporting of ethnicity data and research on empathic reflections in diverse populations is needed.

Limitations of the Research

Although empathy is considered a critical change process in psychotherapy (e.g., Bohart & Greenberg, 1997; Elliott et al., 2019), little work has been done to show how empathy is achieved within sessions at an interactional level (Wynn & Wynn, 2006), for example, via therapist empathic reflections and the client and therapist actions that precede and follow them. Historically, research on empathy and empathic reflections has focused largely on its cognitive components and relied primarily on retrospective self-report or behavioral coding systems. These methods lack the specificity and contextual sensitivity needed for clarifying when and how (i.e., using which communicative resources) empathic reflections and the empathy sequences in which they are embedded are most likely to succeed or fail. Existing measures and methods for studying empathy and empathic reflections are also limited in their potential for clarifying how empathy can be interactionally brought off and jointly achieved by therapists and clients (Pudlinski, 2005). CA research focuses on empathy as process and *inter-action* and extends the therapy literature by locating abstract concepts (e.g., empathy, emotion, understanding, frame of reference) in concrete practices. It challenges the notion of therapists as the sole and unilateral empathy providers and of clients as passive empathy recipients, highlighting the interconnectedness and sequential nature of therapy participants' inter-actions. Note also CA researchers have evaluated the success or failure of the therapist's empathic reflections based on the commonsense criteria of client affiliation/disaffiliation and progress on therapeutic work, evaluative standards that were not used in *any* of the 37 studies in our meta-analysis.

It seems premature to dwell too much on the causal status of these tentative findings. However, we do want to note that different change process research designs vary in the kinds of causal claims they support. For example, as appealing as process-outcome studies are, they do not address the complex mediational process needed to explain how empathy sequences unfold within sessions to link therapy process to outcome. These causal gaps are a major limitation of these designs. The gap is narrowed in process-process correlational designs but because these ignore the sequential nature of therapy process, they lose any reasonable basis for untangling the direction of causality when correlations are found. This leaves us with sequential process and sequential experiential designs, which capitalize on direct sequential links between client and therapist process. In these designs, we can look at specific therapist responses and see what the client does next (sequential process, using observer coding systems like MITI) or what they experience next (sequential experiential, using IPR to ask clients). Furthermore, these designs allow us to separate out competing causal processes, such as client self => self and client =>

therapist influences (e.g., Moyers et al., 2009), and thus lend themselves to demonstrating precedence, plausibility, and internal validity (cf. Elliott et al., 2019).

These sequential designs sound promising; however, our results make clear that we do not as of yet have a clear account of what kinds of reflections, in what kinds of within-session contexts, have what kinds of helpful and hindering effects. The preliminary work needed for a fuller understanding of how and when empathic reflections work has not been addressed by any of the six change process research designs included in our meta-analysis. This suggests that psychotherapy researchers have attempted to quantify empathic reflections before fully understanding how and when they work, which we refer to as "premature quantification."

We are critical of most of the existing research on therapist empathic reflections, on multiple grounds. For example, each of different change research designs has significant flaws that seriously compromise the validity of findings. Furthermore, as the CA literature highlights, the existing rating systems for therapist empathic reflections are blunt instruments that ignore important aspects of client context (e.g., empathic opportunities), fail to account for nonverbal and paralinguistic factors, and do not assess client next turn affiliation/disaffiliation and therapist ability to attend to and use this kind of client feedback.

It strikes us that we can begin to remedy this problem of premature quantification by carrying out the missing careful observational and descriptive research on empathic reflections and empathy sequences. A long time ago, the first author of this chapter told the first editor of this book a parable about how to study the silver fox, a rare, shy creature, who lives in the forest. It went something like this:

> If we go crashing through the bushes with our usual methods, like quantitative rating scales and rigidly fixed category systems, we will scare her and we will never see her because she will hide from us. Instead, we must go quietly and respectfully through the forest, there to settle down amid the weeds and wildflowers of a sunny meadow. In that meadow we must wait quietly, patiently, and in a humble, nonthreatening manner. Then, if we are lucky, she will eventually emerge. And when she does come into that meadow we will watch carefully, observe what we can see, and learn from her. (Update: If we are technologically sophisticated, we might set up a camera to take pictures automatically and nonintrusively when she happens by.)

We are saying is that researchers now need to go back to that preliminary step. We believe that one important method for coming to know the silver fox of empathic reflections is CA, particularly if it is applied with a significant events approach focusing on empathic moments or failed empathy. To complement the observational perspective of CA, a phenomenological perspective focused on clients' subjective experiences of empathic reflections is also needed (Myers, 2000).

Most critically, in our meta-analysis we did not set out here to review research on the *quality* of empathic reflections. Instead, our focus was on the response mode itself, that is, its presence or absence in a given speaking turn, or its frequency or proportion within a session. We also explored types and contents of empathic reflection. In general, "empathy" is our best candidate for describing the quality of empathic reflections and is clearly related to outcome (Elliott et al., 2019); however, it obviously covers a broader range of responses. We are missing a clear account of what makes some reflections more or less skillful than others. In this review, we have seen attempts to address this in terms of specific types or contents of reflections (e.g., reflections of change talk or summary reflections), but ignoring client context and therapist manner is unlikely to produce anything more than the small effects we have seen here. The

specification of markers for different reflection responses (cf. Table 1), is a consistent with a broader trend in contemporary therapy theory and practice (Watson & Wiseman, 2021). For empathic reflections, quality probably includes such things as how attuned the reflection is to the client's experience (Bohart & Greenberg, 1997), how responsive it is to the empathic opportunity and affective stance offered by the client (as the CA literature shows), how emotionally and experientially engaging it is (Gendlin, 1968), and so on.

Another suggestion for further research includes studying what makes *unhelpful reflections* counter-productive: Are they too obvious, too slow, too intrusive, too awkward, cliched ("wooden"), distracting, attention-seeking, or just plain wrong? Reflections look easy, but in our experience they are hard to do well; people often think they are already good at them when they are not. Thus, we need to study unhelpful reflections to be able to identify them and the contexts in which they are more likely to occur, and to teach therapists to avoid or repair them. We could also study *significant reflection events:* Some reflections (e.g., at particular *empathic moments)* might be important, useful, or even transformative, enabling clients to feel deeply understood, accepted, validated, or accompanied. Learning from such moments can tell us how to better facilitate them.

Training Implications

Training programs that teach empathy and empathic reflection go back to Carl Rogers' training courses in the 1940's (documented in Kirschenbaum, 2008); however, they expanded rapidly in the 1970's with the work of Ivey, Goodman, and others. Meta-analyses (e.g., Teding van Berkout & Malouff, 2016; Ngo, 2022) suggest that such training programs are generally effective in imparting empathy and empathic reflection skills, and that both didactic and skill practice components contribute to this effectiveness. Unfortunately, the impact of such trainings on client outcome is unknown; further, their curricula have often promulgated simplistic ideas about empathic reflections and frequently led to their indiscriminate use. We suspect that this is largely due to a kind of fetishization of therapist empathic reflections at the expense of attention to their optimal contexts, common client responses, and alternate modes of expression.

In fact, CA studies of empathy sequences and empathic reflection/formulation can inform therapy practice and training. First, therapists informed by CA work can be taught to better recognize *opportunities for empathy* and discern the client's affective stance toward described events. An affective stance can be developed to varying degrees. Supervisors can help students attend to opportunities for clients to further develop their stance and unpack or detail their experiences before producing more conjectural empathic responses. This would help therapists improve the timing and accuracy of their empathic reflections by clarifying the relevant micro-markers and subtle nuances in client talk.

Second, in teaching about *empathic reflections*, trainers can draw on use existing CA work to help their supervisees to learn about multiple, multimodal ways to display an understanding of clients' troubles, including both empathic reflections and other interactional resources for expressing empathy. For example, supervisors can point out prosodic continuity and discontinuity (e.g., matching or nonmatching the client in speech rhythm or pitch) and how these may play a role in whether an utterance is heard by the client as more or less empathic (Weiste & Peräkylä, 2014). CA studies can also highlight that therapists' responses may convey different degrees of empathic strength or intensity (Jefferson, 1988). For example, a nod at the end of the trouble telling may convey insufficient empathy (Stivers, 2008), whereas the therapist's disclosure of second stories (e.g., *The same thing also happened to me*) may indicate too much personal involvement on the part of the therapist (Ruusuvuori, 2005, 2007).

Supervisors can also help therapists recognize that the more their empathic responses depart from clients' original descriptions, the more caution or tentativeness they may want to adopt in delivering them (Muntigl, 2020; Weiste et al., 2016).

Finally, in evaluating *empathic receipts*, trainers and supervisors can direct supervisees' attention to clients' responses and recognize when empathic reflections are not (strongly) confirmed by clients and make efforts to reaffiliate or adjust their responses in order elicit a stronger endorsement from clients. For example, a CA-trained therapist in Example 2 would probably have recognized Paula's, expressive sigh and silence as signaling disagreement, that is, disaffiliation with her therapist's empathic conjecture. Similarly, as trainers we must confess that we have generally downplayed clients' immediate affiliation or disaffiliation to reflections, robbing ourselves and our students of the opportunity to learn from clients on a response-by-response level. In the process, we have ignored the most important form of deliberate practice: learning how to learn from our clients' immediate reactions to what we have offered them.

Therapeutic Practices

Based on our research review, as well as clinical experience, we suggest that therapists:

- Listen for and reflect client change talk (e.g., desire for change), especially with clients struggling with ambivalence about self-damaging activities. [Source: reflection meta-analysis]
- Offer summary reflections that pull together what you and the client have talked about, where possible formulating client experience into narratives about how their difficulties unfold. [Source: reflection meta-analysis]
- Base empathic reflections on genuine empathy and positive regard for the client and allow yourself convey this to them. [Source: empathy meta-analysis]
- Offer empathic reflections when clients offer empathic opportunities, for instance, when they express emotion in the context of telling about their troubles (or other important experiences). [Source: CA review]
- Offer empathic reflections particularly when patients are confused or uncertain about their feelings; such reflections seem to regularly enhance their self-understanding [Source: review of qualitative research]
- Reflect not only what the client is saying and feeling but also how intensely they are saying or feeling it, and try to match this intensity in the manner of your reflection. [Source: CA review]
- Match the delivery of your reflections to their distance from your client's main message: The further away a reflection is from the client's expressed experience, the more careful, tentative or humble you will want to be in offering it. [Source: CA review]
- Pay close attention to how clients immediately respond to your reflections; reflect hesitation and lukewarm agreement nondefensively as signs you have missed the client's meaning [Source: CA review]
- Correct your empathic reflections when this happens and perhaps acknowledge that you initially missed the client's meaning or experience. [Source: CA review]

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Table 1
Nine Types of Empathic Reflection Responses

Type	Content/Target/Micro-marker (What the therapist is listening for)	Examples
Empathic Repetition (repeats a word or phrase verbatim)	*Key words:* Potentially important word or phrase	C: "Sometimes I feel like I'm too sensitive." T: "Too sensitive."
Empathic Reflection (feeds back main points or content to make it has been heard correctly)	*Central content*: The gist or main point; central idea; essence; substance; crux	"OK, so the point is that the whole family was there for once. Is that what you're saying?"
Evocative Reflection (uses vivid words or images to open up experience; includes speaking in the first person as if they were the client)	*Emerging emotion*: Poignant, touching emotionally alive experiencing (present or absent)	"Sort of feeling like, 'I'm just trying to stay afloat through all this!'"
Empathic Affirmation (offers empathy and support; often delivered with gentle, compassionate voice)	*Vulnerable emotion*: What is tender, fragile or painful	"I guess it just hurts to see that."
Exploratory Reflection (tentatively leaves an open edge to model self-exploration)	*Edge of awareness*: Important, emerging, unclear experiencing	"So the feeling is a bit like bitterness, but that's not quite it?"
Process Reflection (describes what client is doing right now in the session, including nonverbals)	*Client process*: Immediate client experience, task, action, manner, including different aspects of the person	"There's a tear there." "Right now you've maybe just remembering what happened with your partner."
Empathic Formulation (collaborates with client to identify their experience and to translate it into a useful narrative about their process)	*Person*: General shared understandings of person or how their process works	"So from what you've said, it sounds like, first you start feeling sad, then you get scared of the sadness."
Empathic Conjecture (makes an empathy-based guess about what client may be experiencing but has not yet said out loud)	*Implicit experience*: Unspoken but possibly present experiencing	"As you speak, I'm getting a heavy feeling, almost sadness, in my stomach. Does that fit for you?"
Empathic Refocusing (offers client opportunity to return uncomfortable experience the client has introduced, then moved away from)	*Bypassed experience*: Avoided, minimized, ignored, side-tracked experiencing	"So it seems to you that you drink less than your friends, but I guess I also hear that a part of you is still worried that you might be drinking more than you really want to be."

Table 2
Conversation Analysis Transcription Notation

Symbol	Meaning
[	starting point of overlapping talk
]	endpoint of overlapping talk
(1.5)	silence measured in tenths of seconds
(.)	hearable untimed pause <.2 sec
.	falling intonation at end of utterance
,	continuing intonation at end of utterance
wor-	truncated, cut-off speech
wo:rd	prolongation of sound
word=word	latching (no audible break between words)
↑word	markedly upward shift in pitch
.hhh	audible inhalation, # of h's indicate length
hhh	audible exhalation, # of h's indicate length
heh/huh/hah/hih	laugh particles
((cough))	audible non-speech sounds
italics (blue)	non-verbal behavior (actor indicated by initial)
bold	examples of key activities

Table 3
PRISMA Information for Meta-analysis

Stage	N of Sources included	N of Sources excluded	Notes
1. Search Result:	1075		Date of search: January 2022
2. Abstract screening stage: Possible Empathic Reflection effectiveness studies	60	1015	
3. Original search full text retrieval, review & analysis	33	27	• Unable to retrieve full text • Failed exclusion criteria • Combined with another study at full text review or analysis
4. Sources added via branching bibliographies	12	20	• Combined • Failed exclusion criteria
5. Final sample	• 39 (27 + 12) studies • 43 samples in main study	6	• 4 studies contained 2 samples each • 6 experimental process samples/studies dropped

Table 4
Selected Study Characteristics

Parametric Characteristics:	*N*	*M*	*SD*	*Range*
Sample size: Studies/Samples	43 samples			
	39 studies	63.0	68.0	
Clients (fror 43 samples):	2710	(median: 37)		1 – 327
Therapists (for 39 samples):	573	(median: 8)		1 – 131
Length of therapy (sessions)	40	6.6 (median: 2)	10.2	1 – 47
Effects per study	43	5.0	4.3	1 – 18
Categorical Characteristics		*Selected Categories*		*n*
Year of publication	43	1981-2000		12
		2001 - 2021		31
Theoretical orientation	43	Motivational Interviewing		21
		Psychodynamic		8
		Humanistic-Experiential		2
		Mixed, eclectic or unknown		13
Treatment format	43	Individual in person		41
Client presenting problem	43	Substance misuse		17
		Normal/minor disturbance		7
		Mixed clinical		16
		Physical health problems		3
Client ethnicity	18	Non-European origin (mean %)		60%
Therapist experience level	42	Paraprof/early grad student		6
		Masters level/advance grad student		22
		Recent/experienced PhD		14
Reflection assessment	***214***			
Perspective		Observer		211
		Client/therapist		3
Target/content		General/broad		146
		Content/meaning		12
		Feeling/emotion		6
		Change-related		40
		Summary		5
Type of reflection		General/broad		131
		Simple/basic		22
		Complex/deeper/feeling/summary		61
Effectiveness assessment	***214***			
Perspective		Observer		95
		Client		108
Effectiveness criterion	***214***	Process-outcome: Post-therapy		67 (14)[a]
		Process-outcome: Post-session		11 (7)
		Sequential process		82 (17)
		Process-process correlational		12 (5)
		Sequential experiential		42 (4)

[a]Numbers in parentheses refer to number of samples using each change process effectiveness criterion; some samples used multiple criteria.

Table 5
Empathic Reflection-Effectiveness Correlations: Overall and Three-level Summary Statistics

	Effects Level, model 1 (k = 214) M (95% CI)	Effects Level, model 2 (k = 214) M (95% CI)	Sample level (k = 43) M (95% CI)
	Overall (excluding Experimental)		
Weighted Mean r [d]	.019 (-.004, .042) [.04]	.020 (-.024, .065) [.04]	.014 (-.025, .052) [.03]
Cochrane's Q	290.7*	74.3 (ns)	23.8 (ns)
I^2	27%	--	--
	Within-Session Effectiveness (k = 136)		
Weighted Mean r [d]	.020 (-.013, .053) [.04]	.024 (-.044, .093) [.05]	--
Cochrane's Q	157.3	42.2 (ns)	
I^2	14%	--	
	Postsession Effectiveness (k = 11)		
Weighted Mean r [d]	.003 (-.150, .157) [.01]	.019 (-.221, .185) [-.04]	--
Cochrane's Q	3.0	2.1 (ns)	
I^2	--	--	
	Posttherapy Effectiveness (k = 67)		
Weighted Mean r [d]	.019 (-.0143, .053) [.04]	.020 (-.040, .079) [.04]	--
Cochrane's Q	129.2	29.6 (ns)	
I^2	49%	--	
Between groups Q	.4 (df = 2, 211)	.2 (df = 2. 211)	--

* $p < .001$

Note. 95% CI: 95% confidence interval. Random effects model, restricted maximum likelihood with Fisher r-to-Z transformations; inverse variance weights except where noted. Effects Level, model 1: ignores number of effects calculated per study (violates nonindependence assumption). Effects level, model 2: uses additional weighting by number of effects per study (weight = [n clients – 3]/number of effects per study). Fail-safe numbers could not be calculated.

Table 6
Effect-Level Effects Across Change Process Criteria

Research Design	*n*	Mean Weighted *r [d]*	Within Group Q	I^2
Within-Session:				
Sequential process	82	-.01 (-.13, .10) [-.03]	14.7	--
Sequential experiential	42	.04 (-.19, .27) [.08]	.8	--
Process-process correlational	12	.14 (-.08, .35) [.28]	23.4*	53%
Post-session (Process-outcome)	11	*.01 (-.27, .29) [.02]*[a]	2.1	--
Post-therapy (Process-outcome)	67	*.03 (-.06, .13) [.06]*[a]	29.6	--
Experimental (Process-process)	21	-.17 (-.37, .05) [-.34]	35.7*	--
Between groups Q		4.37 (df = 5, 229) (ns)		

*$p < .05$

Note. Mean correlations and significance tests (vs. null hypothesis $r = 0$) for subgroups calculated using Fisher's z scores and a restricted maximum likelihood random effects model using Wilson's (2021) macros for SPSS and weighting by inverse error and number of effects per study (=Effects level model 2). Italics indicates results for postsession and posttherapy effects that differ slightly from those reported in Table 5; this is because of the differing number of groups.

Table 7
Effect-Level Effects Across Reflection Type

Reflection Type	*N*	Mean Weighted *r [d]*	Within Group Q	I^2
General/broad	131	.02 (-.05, .09) [.04]	49.2	0%
Simple/basic	22	-.00 (-.12, .12) [.04]	15.2	0%
"Reflection-plus" (Complex/deeper/etc)	61	.03 (-.04, .11) [.06]	9.4	0%
Between groups Q		.04 (df = 2, 211) (ns)		

Note. See note for Table 6. No mean weighted r values were statistically significant.

Table 8
Effect-Level Effects Across Reflection Target/Content

Reflection Target/ Content	*n*	Mean Weighted *r* *[d]*	Within Group Q	I^2
General/broad	146	.02 (-.02, .07) [.05]	42.4	0%
Content/meaning	12	-.05 (-.18, .07) [-.11]	10.8	75%
Feeling/emotion	6	.08 (-.36, .49) [.16]	.2	0%
Change talk	13	.12 (-.08, .31) [.24]	1.53	0%
Counterchange talk	12	-.03 (-.16, .10) [-.06]	14.52	24%
Neutral/balanced talk	9	-.01 (-.22, .20) [-.02]	.67	0%
Commitment language	6	.03 (-.42, .47) [.07]	.07	0%
Unrelated to change	5	-.08 (-.50, .36) [-.18]	.01	0%
Summary	5	.15 (-.22, .48) [.30]	.31	0%
Between groups Q		3.78 (df = 8, 205) (ns)		

***p<.01*
Note. See note for Table 6. No mean weighted r values were statistically significant.

Figure 1
Funnel Plot of Empathic Reflection-Effectiveness Effects by Standard Error: Study Level Effects