Therapeutic modalities at a glance

Nine approaches side by side: the core idea, typical techniques and the evidence, each with one peer-reviewed source, and what CRPO asks of you before you use one.

Study aid, not legal advice. Last verified against the official sources linked below on 11 November 2026.

1 Before the table

- Exam options **rarely name a theory**: they reward the option that fits this client, this moment and their consent.
- Know the limits of the modalities you use (CRPO **2.1.1**) and practise only within your competence (2.1.2).
- Before adding a modality: verifiable training, and supervision or consultation (**2.1.4**).
- Consent covers the process of therapy, its benefits and risks, and other options (**3.2.3**): explain the approach and what it will ask of the client.
- Each evidence line names one peer-reviewed source: it shows the kind of support, not a ranking.

2 Cognitive and behavioural

Approach	Core idea	Typical techniques	Evidence (one source)
CBT (cognitive behavioural therapy)	How we interpret events shapes what we feel and do; changing unhelpful thoughts and behaviours relieves symptoms.	Shared formulation, thought records and cognitive restructuring, behavioural activation, graded exposure, homework, an agenda each session.	Hofmann et al. (2012), a review of 106 meta-analyses: strongest support for anxiety disorders, somatoform disorders, bulimia, anger and general stress. Cognit Ther Res 36(5):427-440.
DBT (dialectical behaviour therapy)	Acceptance and change held together; emotion dysregulation at the heart of self-harm and borderline personality disorder.	Validation; skills groups in mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness; diary cards, chain analysis, phone coaching, a consultation team.	Linehan et al. (2006), a two-year trial with 101 women with recent suicidal behaviour: half as likely to attempt suicide as with treatment by community experts. Arch Gen Psychiatry 63(7):757-766.
ACT (acceptance and commitment therapy)	Psychological flexibility: make room for hard thoughts and feelings and act on chosen values, instead of fighting to control them.	Acceptance, cognitive defusion, contact with the present moment, self-as-context, values, committed action.	A-Tjak et al. (2015), a meta-analysis of randomized trials: better than waitlist, placebo and usual care (g = 0.57); no significant difference from CBT. Psychother Psychosom 84(1):30-36.

3 Emotion, relationship and depth

Approach	Core idea	Typical techniques	Evidence (one source)
EFT (emotionally focused therapy, couples)	Distress is a negative cycle driven by attachment fears; reaching and sharing the emotions beneath it builds new, safer bonds.	Tracking and naming the cycle, accessing primary emotions and attachment needs, enactments; three stages: de-escalate, restructure, consolidate.	Rathgeber et al. (2019), a meta-analysis of 33 randomized trials of couple therapy: EFT g = 0.73 after treatment, 0.66 at six months; read with caution for publication bias. J Marital Fam Ther 45(3):447-463.
Psychodynamic	Unconscious processes, early relationships and recurring patterns shape present difficulties; understanding them, lived in the relationship, brings change.	Open exploration, attention to feeling and avoidance, recurring themes, links between past and present, transference and countertransference, interpretation.	Shedler (2010), a review: effect sizes as large as other evidence-based therapies, with gains kept and often growing after treatment ends. Am Psychol 65(2):98-109.
Person-centred	Offered empathy, unconditional positive regard and congruence, a person moves toward growth; the client leads.	Empathic reflection, acceptance and genuineness more than techniques; staying within the client's frame of reference.	Elliott et al. (2018), a meta-analysis of 82 samples (6,138 clients): therapist empathy, one of its conditions, predicts outcome (r = .28) across orientations. Psychotherapy 55(4):399-410.

4 Meaning, strengths and parts

Approach	Core idea	Typical techniques	Evidence (one source)
Narrative	People live by the stories they tell about themselves; the problem is the problem, not the person.	Externalizing the problem, mapping its effects, finding unique outcomes, re-authoring, outsider witnesses, therapeutic letters.	Still limited. Vromans and Schweitzer (2011), 47 adults with major depression, eight sessions, no control group: symptom gains comparable to benchmarks and kept at three months. Psychother Res 21(1):4-15.
Solution-focused (SFBT)	Build solutions rather than analyse problems, from the client's strengths, exceptions and preferred future.	The miracle question, scaling questions, finding exceptions, compliments, small next steps, few sessions.	Zhang et al. (2018), a meta-analysis of nine randomized trials in medical settings: a small effect on psychosocial outcomes (d = 0.34). J Behav Med 41(2):139-151.
IFS (internal family systems)	The mind holds parts, protectors and exiles, and a core Self; healing comes as the Self meets each part with curiosity and compassion.	Identifying parts, unblending, befriending protectors, witnessing and unburdening exiles, asking parts for permission.	Early. Shadick et al. (2013), a trial with 79 adults with rheumatoid arthritis: less pain and better function after treatment, some gains at one year; a proof-of-concept study. J Rheumatol 40(11):1831-1841.

Fit, timing and consent before the name of the approach; practise only what you are trained in.

Official sources: CRPO Standard 2.1: Seeking Consultation, Clinical Supervision, & Referral and CRPO Standard 3.2: Consent. Condensed from Foundations and Therapeutic Process. Independent study aid, not legal advice, not affiliated with CRPO or COMPASS.