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Comparison of the Effectiveness of Short-Term Psychodynamic Therapy and Mentalization on Self-Control in Individuals with Borderline Personality Structure

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ABSTRACT

The present study aimed to compare the effectiveness of short-term psychodynamic therapy and mentalization-based therapy on self-control in individuals with a borderline personality structure. The research employed a quasi-experimental design with a pretest–posttest control group and a 2-month follow-up. The statistical population included all individuals with borderline personality structure who referred to clinics in the western districts of Tehran during the second half of the year 2024 (October to March). From this population, 45 participants were selected using purposive sampling and randomly assigned into three groups (two experimental groups with 15 participants each and one control group with 15 participants). The assessment tools included the Personality Organization Questionnaire developed by Kernberg (2002) and the Self-Control Scale by Tangney et al. (2004). The first experimental group received mentalization-based therapy following the Bateman and Fonagy (2016) protocol, while the second experimental group received intensive short-term dynamic psychotherapy based on Davanloo's (1995) protocol. Both interventions consisted of nine weekly 90-minute sessions. Data analysis was conducted using repeated measures analysis of variance (ANOVA). The results showed that both short-term psychodynamic therapy and mentalization-based therapy had a significant effect on self-control in individuals with borderline personality structure ($p < .01$). Moreover, no significant difference was found between the two therapeutic approaches in terms of effectiveness ($p > .05$). It can be concluded that both short-term psychodynamic therapy and mentalization-based therapy may be applied as effective therapeutic approaches to improve self-control in individuals with borderline personality structure.

Keywords: mentalization-based therapy, short-term psychodynamic therapy, self-control, borderline personality structure

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Introduction

Borderline personality disorder (BPD) represents one of the most challenging psychiatric conditions, characterized by pervasive instability in affect regulation, self-image, interpersonal relationships, and

impulse control (1). This condition has been closely linked to deeper disturbances in personality organization, including identity diffusion and impaired reality testing (2, 3). According to Kernberg's object relations model, individuals with borderline personality organization experience an inseparable interplay of love and aggression, leading to heightened internal conflicts and maladaptive relational patterns (4). These dynamics often result in difficulties with self-regulation and contribute to a heightened vulnerability to emotional dysregulation and self-destructive behaviors (5, 6).

Emotion regulation deficits have been identified as a central feature of BPD, with empirical studies consistently showing that disruptions in the ability to monitor, evaluate, and modify emotional responses play a critical role in the onset and maintenance of the disorder (7). Adolescents and adults with borderline pathology often exhibit heightened impulsivity and impaired self-control, increasing their risk for maladjustment, academic difficulties, and interpersonal conflicts (8). Rumination has also been identified as a mediating factor between personality organization and symptoms of borderline pathology, indicating that maladaptive cognitive processes exacerbate emotional instability and depressive states (9). In this regard, self-control and emotion regulation are considered crucial treatment targets in individuals with borderline traits, as improvement in these domains predicts better adaptation and long-term adjustment.

The clinical understanding of BPD has evolved to emphasize both developmental and relational dimensions. Mentalization-based theory proposes that individuals with BPD struggle with maintaining a stable sense of self and others, especially under conditions of emotional arousal, due to deficits in the capacity to mentalize—that is, to understand behavior in terms of underlying mental states (10, 11). Research demonstrates that weak or disrupted mentalizing is closely associated with impulsivity, self-harm, and heightened sensitivity to rejection (12). Adolescents in particular, given their heightened developmental vulnerability, often exhibit impairments in mentalizing capacities, making them prone to unstable relationships and self-injurious behaviors (13). The ability to restore and strengthen mentalizing capacities is therefore a central goal of contemporary therapeutic approaches.

Among psychotherapeutic interventions for BPD, two evidence-based treatments have gained significant attention: intensive short-term dynamic psychotherapy (ISTDP) and mentalization-based treatment (MBT). ISTDP, pioneered by Davanloo and further developed in contemporary clinical practice, emphasizes rapid access to unconscious feelings and conflicts by challenging maladaptive defenses and resistances (14, 15). Through experiential and affect-focused interventions, ISTDP aims to resolve deep-seated intrapsychic conflicts that underlie maladaptive functioning (16). Meta-analytic evidence indicates that ISTDP is effective in reducing symptom severity and improving emotional regulation across a range of personality disorders, including borderline pathology (15). Its structured, time-limited nature makes it especially suitable for complex patients who present with chronic maladaptive relational patterns (14). Clinical studies have also shown that ISTDP reduces self-harming behaviors and enhances psychological flexibility among borderline patients (17, 18).

In parallel, MBT has emerged as one of the most empirically supported treatments for BPD. Originally developed by Bateman and Fonagy, MBT targets deficits in mentalizing by focusing on improving patients' capacity to understand their own and others' mental states (19, 20). Over the past decade, MBT has been refined to address challenges in implementation and to enhance its effectiveness in both individual and group modalities (21, 22). Clinical trials have consistently demonstrated MBT's efficacy in reducing self-

harm, suicidal behavior, and interpersonal dysfunction in individuals with borderline traits (20, 23). Furthermore, developmental perspectives emphasize that MBT helps restore epistemic trust, facilitating patients' ability to benefit from social learning and therapeutic relationships (11). These findings highlight MBT as a robust framework for addressing core deficits in borderline pathology and promoting long-term recovery.

Both ISTDP and MBT are grounded in psychodynamic principles but differ in their mechanisms of change. ISTDP emphasizes rapid confrontation with defenses and the direct experience of repressed affect (16, 24), whereas MBT prioritizes the gradual restoration of reflective functioning and relational trust (10, 21). Nevertheless, both approaches share the ultimate goal of fostering identity integration, emotional regulation, and healthier interpersonal functioning (25). The comparative study of these interventions is thus essential, not only for advancing theoretical understanding but also for guiding clinical decision-making regarding the most effective therapeutic strategies for BPD.

The clinical literature suggests that the effectiveness of ISTDP and MBT may converge in improving self-control, one of the most critical capacities undermined in borderline personality structure. Self-control is not only linked to emotion regulation but also predicts academic success, interpersonal adjustment, and psychological well-being (8). Individuals with borderline traits frequently exhibit compromised self-control due to their difficulty tolerating distress and regulating impulsive reactions (7). By addressing these deficits, both ISTDP and MBT may contribute to reducing maladaptive behaviors such as self-harm, aggression, and interpersonal instability (6, 26).

The importance of studying the comparative effects of these treatments is further underscored by growing evidence on the heterogeneity of borderline pathology. While ISTDP appears particularly effective in addressing unconscious conflicts and resistance (14, 15), MBT has demonstrated advantages in targeting relational processes and strengthening reflective functioning (11, 22). Studies have also suggested that combining psychodynamic and mentalization-based perspectives may offer complementary benefits for patients with borderline traits (2, 5). However, despite the substantial body of literature supporting both treatments, direct comparative studies remain limited, especially in non-Western contexts. This gap highlights the need for research evaluating their relative effectiveness in improving self-control among individuals with borderline personality structure.

The present study builds on this foundation by comparing the effectiveness of short-term psychodynamic therapy and mentalization-based therapy in enhancing self-control in individuals with borderline personality structure.

Methods and Materials

Study Design and Participants

This study was applied in nature, and the research design, considering its objectives and characteristics, was quasi-experimental with a pretest–posttest control group and a two-month follow-up. The statistical population included all individuals with borderline personality structure who referred to clinics in the western districts of Tehran during the second half of the year 2024 (October to March). The sample size was determined based on the number of groups and variables under investigation. Accordingly, 45 individuals from this population were selected purposively after a preliminary interview and based on inclusion and

exclusion criteria, and were randomly assigned into three groups: short-term psychodynamic therapy group (15 participants), mentalization-based therapy group (15 participants), and control group (15 participants).

The inclusion criteria were: informed consent, a diagnosis of borderline personality structure confirmed by a clinical psychologist or psychiatrist, minimum education level of a high school diploma, age between 20 and 50 years, no regular use of narcotics or alcohol, no concurrent use of psychiatric medications (self-reported), no severe comorbid psychological disorders (self-reported), and no specific environmental or social conditions interfering with participation (such as severe unemployment, family, or social problems). Exclusion criteria included absence from more than two sessions, lack of willingness to continue participation, simultaneous enrollment in other counseling or psychotherapy programs, and non-cooperation in completing questionnaires in the three phases (pretest, posttest, and follow-up).

The study was conducted in western Tehran with the cooperation of several accredited counseling centers. In the initial review, nine officially licensed and active counseling centers in western Tehran were identified. Among them, three centers that met the necessary conditions in terms of facilities, accessibility, staff cooperation, and availability of therapists specialized in psychodynamic and mentalization-based therapies were purposively selected. Subsequently, in agreement with these centers, Nou Psychology Clinic was chosen as the main research site. This clinic had separate therapy rooms, a safe environment, a structured appointment system, and experienced counselors. Given its high volume of clients, it could provide participants meeting the required conditions.

To ensure participants' consistent attendance and control for confounding variables, measures such as precise scheduling, SMS reminders, phone support, and regular follow-ups were implemented. Initially, in collaboration with the clinic's psychologists, a recruitment announcement was distributed via posters in counseling centers and on Nou Clinic's social media channels. From the applicants, an initial screening was conducted using clinical interviews and entry–exit questionnaires. Finally, 45 eligible married women were selected. After confirming eligibility, participants were randomly assigned to three groups of 15: two experimental groups (short-term psychodynamic therapy and mentalization-based therapy) and one control group.

In the first phase, all participants underwent a pretest under fully standardized conditions (same testing room, fixed time, consistent lighting, and silence). The pretest included the questionnaires relevant to the study variables, supervised by the researcher. The first experimental group received short-term psychodynamic therapy, while the second experimental group underwent mentalization-based therapy. Both treatments were delivered at Nou Clinic by licensed specialists with relevant clinical experience. Each program consisted of nine in-person, group-based sessions, each lasting 90 minutes and held weekly. The control group remained on a waiting list and did not receive the target interventions but participated in all evaluation stages simultaneously with the experimental groups.

Immediately after the treatment sessions, all three groups completed the posttest under the same standardized conditions as the pretest, ensuring environmental variables did not influence the outcomes. Sixty days after the final therapy session, participants took part in the follow-up phase and completed the same questionnaires again at Nou Clinic, under consistent standardized conditions. SMS reminders and phone calls were used to maintain participant engagement. At the end of the study, to uphold ethical fairness,

the control group received a free condensed four-session mentalization-based therapy package delivered by the same therapist.

Data Collection

The Personality Organization Questionnaire was developed and validated by Kernberg (2002). This instrument contains 37 closed-ended items rated on a five-point Likert scale. It measures three subscales of personality organization: reality testing, primitive psychological defenses, and identity diffusion. Scores ranging from 37–74 indicate a low level of the variable, scores between 74–148 indicate a moderate level, and scores above 148 indicate a high level. The questionnaire was validated in Iran by Shaker (2018). In Shaker's (2018) preliminary study on a sample of 30 participants, reliability was estimated at 0.81 using Cronbach's alpha. For content validity, expert opinions from academic supervisors and specialists were sought regarding the relevance, clarity, and comprehensibility of the items, which were confirmed. In the present study, reliability of the questionnaire was calculated at 0.85 using Cronbach's alpha.

The Self-Control Scale was developed by Tangney et al. (2004) to measure the tendency toward self-control. The scale consists of 13 items rated on a five-point Likert scale from "not at all" (1) to "very much" (5). Tangney et al. (2004) reported Cronbach's alpha as 0.89 for the long 36-item form and 0.83 for the short 13-item form. Additionally, Reder et al. (2011) reported convergent validity with the Wilkoxon Self-Control Questionnaire (r = .49) and divergent validity with Zuckerman's Sensation Seeking Questionnaire (r = .42). The scale was standardized in Iran by Azadmanesh et al. (2020). Findings from their study identified two coherent factors. Correlation coefficients with the Moral Behavior Questionnaire (r = .462) also confirmed its validity. Internal consistency reliability using Cronbach's alpha ranged between 0.75 and 0.81 (Azadmanesh et al., 2020). In the present study, reliability of the scale was obtained at 0.88 using Cronbach's alpha.

Interventions

The short-term psychodynamic therapy protocol was implemented based on Davanloo's (1995) intensive short-term dynamic psychotherapy model and delivered in nine 90-minute sessions. The first session focused on orientation, introduction of therapeutic rules, and initial assessment through an exploratory psychodynamic interview to raise awareness of experiential findings. The second session targeted tactical defenses by identifying the specific defense mechanisms of participants and confronting them to enhance mindfulness and real-time emotional awareness, with homework encouraging confrontation rather than avoidance of defenses. The third session aimed to identify both positive and negative personality traits by addressing indirect speech, pathological thoughts, and maladaptive defenses, fostering acceptance of emotions without judgment and assigning self-observation tasks. The fourth session concentrated on conflict resolution by addressing rumination and rationalization, applying interventions such as clarification, challenge, and blocking defenses to increase psychological flexibility and disrupt maladaptive interactional patterns. The fifth session targeted intellectualization and overgeneralization, with interventions including clarification and confrontation to enhance flexibility and reduce emotional resistance, supported by restructuring ineffective cognitive patterns as homework. The sixth session emphasized emotion regulation by addressing distraction and suppression tactics, encouraging realistic self-criticism and listing barriers to

emotional expression. The seventh session dealt with resistance to emotional disclosure, particularly denial, using clarification and confrontation strategies, fostering the acceptance of emotions as dynamic constructs, and assigning reflective journaling tasks. The eighth session focused on challenging emotions and nonverbal signs of avoidance through clarification and confrontation, aiming to increase emotional disclosure and reduce negative perspectives toward emotions, with tasks distinguishing thoughts from feelings. The ninth and final session integrated and reviewed all learned strategies, re-administered the questionnaires, and closed the therapeutic process, emphasizing release from negative cognitions and emotions, enhanced flexibility, and continued practice of acquired techniques. The content validity of this protocol has been supported in prior studies by Kashfi et al. (2023) and Shams et al. (2021).

The mentalization-based therapy protocol followed Bateman and Fonagy's (2016) structured model and was administered over nine 90-minute sessions. The first session involved orientation, clarification of goals, participant introductions, and an explanation of mentalization concepts versus misinterpretations, with homework assigned. The second session addressed weak versus strong mentalization, problems in self- and other-mindreading, impulsivity, self-harm, and sensitivity to rejection, clarifying participants' interpretations and assigning reflective homework. The third session focused on core and social emotions, distinguishing primary from secondary emotions, recognizing internal emotional cues, and discussing self-regulation strategies and how others contribute to emotional regulation, alongside relaxation training and homework. The fourth session emphasized the importance of self-control, discussing willpower strategies and assigning related tasks. The fifth session examined self-harming behaviors, identifying antecedent, concurrent, and consequent emotions, and provided reflective assignments. The sixth session dealt with rejection sensitivity, its impact on interpersonal relationships, and emphasized creating secure bonds with therapists and group members, supported by educational material and homework tasks. The seventh session clarified the specific goals and methods of MBT, with training exercises in mentalizing group concerns to facilitate epistemic trust, using empathic validation. The eighth session reviewed prior discussions, applied mentalization to relational dynamics, and clarified or challenged emerging problems while encouraging group exploration and integration of issues. The ninth and final session prepared participants for termination, focusing on processing feelings of loss related to treatment ending, closure, and re-administration of posttest measures. The content validity of this protocol has been confirmed in previous studies by Bromand et al. (2022) and Moradzadeh et al. (2020).

Data Analysis

Data were analyzed using mixed-design repeated measures analysis of variance (ANOVA) with SPSS version 26. Prior to conducting the main analysis, assumptions were tested, including normality of distributions using the Kolmogorov–Smirnov test, homogeneity of variances with Levene's test, and homogeneity of variance–covariance matrices using Box's M test. Since Mauchly's test indicated a violation of sphericity, the Greenhouse–Geisser correction was applied. Effect sizes were reported using partial eta squared, and Bonferroni post hoc tests were conducted to compare group differences across pretest, posttest, and follow-up measurements.

Findings and Results

The analysis of the demographic characteristics of the respondents showed that the three groups were homogeneous in terms of gender, marital status, and education ($p > .05$). The chi-square test results for demographic variables indicated significance levels greater than .05, confirming similarity among the three groups with respect to gender, marital status, and education. In all three groups, most participants were female, single, and held associate or bachelor's degrees. The mean and standard deviation of age in the short-term psychodynamic group were 29.33 and 1.34, respectively; in the mentalization group, 35.53 and 1.69; and in the control group, 34.47 and 1.77. According to the analysis of variance, the groups were also homogeneous in terms of age ($p > .05$).

Table 1. Descriptive Statistics of Self-Control by Group and Time

Variable	Time	Short-Term Psychodynamic	SD	Mentalization	SD	Control	SD
Self-Control	Pretest	40.67	8.37	41.20	8.07	43.00	8.38
	Posttest	46.53	6.15	49.47	6.21	42.13	10.11
	Follow-up	46.20	6.80	48.33	6.61	43.47	10.24

Table 1 shows that the mean self-control score in the short-term psychodynamic group was 40.67 in the pretest, which increased to 46.53 in the posttest and 46.20 in the follow-up, indicating an increase. In the mentalization group, the pretest mean was 41.20, which rose to 49.47 in the posttest and remained elevated in the follow-up, suggesting improvement. In the control group, self-control means showed no notable changes.

To examine the significance of these changes, mixed-design ANOVA was used. Before conducting the test, Kolmogorov–Smirnov analysis confirmed normal distribution of self-control scores across the three measurement stages ($p > .05$). Levene's test confirmed homogeneity of variances across pretest ($F = 0.186$, $p = .20$), posttest ($F = 1.105$, $p = .123$), and follow-up ($F = 1.133$, $p = .263$). M-Box's test indicated homogeneity of variance–covariance matrices for self-control (MBOX = 29.73, $F = 1.04$, $p = .32$). These assumptions were met. However, Mauchly's test of sphericity was violated, so Greenhouse–Geisser correction was applied for interpretation.

Table 2. Results of Repeated Measures ANOVA for Intervention Effectiveness on Self-Control

Variable	Source	SS Mean	df	MS	F	p	Partial Eta²
Self-Control	Group	270.93	2	135.47	0.838	.440	.038
	Time	580.84	1.69	344.46	18.59	<.001	.307
	Time*Group	361.16	3.37	107.09	5.78	<.001	.216

Results in Table 2 indicate that both the main effect of time and the interaction effect of time and group were significant ($p < .05$). This suggests that at least one intervention had a statistically significant effect on self-control. Given the significance of the time*group interaction, further pairwise comparisons were conducted.

Table 3. Bonferroni Post Hoc Test for Self-Control at Posttest

Variable	Group	Adjusted Mean	SE	Reference Group	Compared Group	Mean Difference	p
Self-Control	Short-Term Psychodynamic	47.16	1.43	Short-Term Psychodynamic	Control	5.94	.017
	Mentalization	49.75	1.43	Mentalization	Control	8.52	<.001
	Control	41.22	1.43	Short-Term Psychodynamic	Mentalization	-2.58	.622

The Bonferroni test (Table 3) showed significant differences in posttest self-control means between intervention groups and the control group ($p < .05$). The short-term psychodynamic group had a mean 5.94 points higher than the control group, and the mentalization group had a mean 8.52 points higher than the control group. These findings confirm the effectiveness of both interventions on self-control. However, the difference between the two interventions was not statistically significant ($p > .05$).

Table 4. Pairwise Comparisons of Self-Control by Group and Time

Variable	Group	Reference Time	Comparison Time	Mean Difference	p
Self-Control	Short-Term Psychodynamic	Pretest	Posttest	-5.87	.006
		Pretest	Follow-up	-5.53	.011
		Posttest	Follow-up	0.33	.718
	Mentalization	Pretest	Posttest	-8.27	<.001
		Pretest	Follow-up	-7.13	<.001
		Posttest	Follow-up	1.13	.392
	Control	Pretest	Posttest	0.87	.520
		Pretest	Follow-up	-0.47	.713
		Posttest	Follow-up	-1.33	.223

The pairwise comparison test (Table 4) revealed significant improvements in self-control from pretest to both posttest and follow-up in both intervention groups ($p < .05$). This indicates that self-control levels increased significantly following both short-term psychodynamic therapy and mentalization-based therapy, and the effects were maintained over time. In the control group, no significant differences were observed between pretest, posttest, and follow-up ($p > .05$). The sustained improvements from pretest to follow-up in the intervention groups confirm the long-term effectiveness of both therapeutic approaches on self-control.

Discussion and Conclusion

The results of the present study demonstrated that both short-term psychodynamic therapy (STPT) and mentalization-based therapy (MBT) were effective in enhancing self-control among individuals with borderline personality structure. Participants in both intervention groups showed significant improvement from pretest to posttest and maintained these gains during the follow-up period, while the control group did not exhibit meaningful changes across the three assessment points. These findings suggest that interventions rooted in psychodynamic principles—whether focused on direct confrontation of defenses and affect (STPT) or on strengthening reflective functioning and interpersonal understanding (MBT)—can lead to substantial improvement in one of the core capacities most impaired in borderline pathology, namely self-control. Moreover, the comparative analysis indicated no significant difference between the two approaches in their degree of effectiveness, which implies that both therapies can be considered equally viable treatment options for individuals with borderline traits.

The observed effectiveness of STPT aligns with previous literature emphasizing the efficacy of intensive short-term dynamic psychotherapy in treating personality disorders. Abbass and colleagues (15) provided meta-analytic evidence demonstrating that ISTDP leads to broad improvements in symptom severity, emotional regulation, and interpersonal functioning in patients with personality pathology. Similarly, Town et al. (14) reported that STPT effectively addresses deeply rooted intrapsychic conflicts and defensive patterns, resulting in sustained therapeutic gains for complex patients. The present study extends these findings by highlighting self-control as a specific domain of improvement, reinforcing Andrews' (16) observation that affect-focused psychodynamic interventions help patients confront defenses and enhance their tolerance of emotional distress, thereby reducing impulsive behaviors. Furthermore, consistent with Niknejad et al. (17) and Yousefi and Hosseini (18), who found that STPT reduced self-harm and maladaptive coping among borderline adolescents, our study underscores the potential of psychodynamic approaches to target core features of borderline pathology, including deficits in emotion regulation and impulse control.

The results regarding MBT are also supported by a substantial body of empirical evidence. Bateman and Fonagy's pioneering work (19, 20) established MBT as an evidence-based treatment for borderline personality disorder, with subsequent refinements expanding its applicability across developmental stages and clinical contexts (21). Recent advances confirm its efficacy in enhancing reflective functioning and reducing symptoms associated with BPD (22). In the present study, MBT participants reported significant gains in self-control, echoing findings from Azizi et al. (23), who showed that MBT improved emotion regulation and reduced self-injurious urges in youth with borderline traits. Chabok et al. (13) similarly documented reductions in nonsuicidal self-injury following MBT among adolescents, further reinforcing its utility in mitigating impulsive, dysregulated behaviors. The capacity of MBT to enhance self-control can be understood through Fonagy and colleagues' developmental perspectives (11), which suggest that strengthening mentalization promotes epistemic trust and resilience against emotional dysregulation, both of which are central to borderline pathology.

Notably, the findings also correspond to Sharp and colleagues' (12) emphasis on the role of mentalizing in adolescent borderline pathology, where deficits in understanding self and others exacerbate impulsivity, self-harm, and rejection sensitivity. Improvements in self-control in the MBT group of this study reflect how fostering mentalizing capacities may buffer against maladaptive coping and enhance emotional resilience. This perspective is echoed by Bornstein (25), who argued that mentalization facilitates identity integration and adaptive behavior change, which in turn contribute to greater self-regulatory capacity. The present findings thereby affirm MBT as a treatment that not only reduces symptomatic distress but also fosters developmental capacities underlying self-control.

The absence of significant differences between STPT and MBT in terms of overall effectiveness deserves careful consideration. On one hand, it supports Caligor, Kernberg, and Clarkin's (5) assertion that psychodynamic approaches, whether rooted in intensive confrontation or reflective processes, share common therapeutic mechanisms, such as fostering identity cohesion and resolving intrapsychic conflict. Both therapies aim to restore more adaptive patterns of relating to self and others, which are foundational to self-control. On the other hand, the convergence of outcomes suggests that therapeutic factors such as the therapeutic alliance, emotional engagement, and sustained focus on core personality processes may be more critical determinants of improvement than the specific technical differences between STPT and MBT (24).

This observation resonates with Fonagy et al. (10), who emphasized that psychotherapy effectiveness in BPD often hinges on the restoration of epistemic trust, which can be achieved through multiple therapeutic routes.

Another important implication is that both interventions directly address the deficits in emotion regulation and identity functioning that are central to BPD. Levy and colleagues (2) underscored that identity diffusion and borderline personality organization compromise self-regulatory capacities, rendering individuals vulnerable to impulsive behaviors. By strengthening identity integration through psychodynamic work (4) or enhancing mentalizing capacities (11, 22), both STPT and MBT appear to bolster self-control. Paris (6) noted that personality disorders are characterized by a complex interplay of stability and change, with certain maladaptive traits persisting over time. The findings of this study highlight that targeted interventions can nonetheless facilitate measurable improvements in functional capacities such as self-control, challenging the notion of immutability often associated with BPD.

Moreover, the improvement in self-control observed in both intervention groups aligns with broader psychological theories on the role of self-regulation in adaptive functioning. Tangney and colleagues (8) demonstrated that high self-control predicts better adjustment, reduced pathology, and interpersonal success, while Eisenberg et al. (7) highlighted the link between self-regulation and emotional well-being. The present study confirms that therapies designed for borderline pathology can produce changes in this fundamental capacity, with implications extending beyond symptom reduction to broader psychosocial functioning. Improvements in self-control may thus serve as a marker of therapeutic progress, indicating deeper structural changes in personality organization and mentalizing capacity.

The current findings also corroborate research linking personality organization and cognitive-affective processes to borderline symptomatology. Kovács et al. (9) identified rumination as a mediator between personality organization and borderline/depressive symptoms, showing how maladaptive cognitive patterns perpetuate dysregulation. By disrupting these cycles, STPT and MBT both appear to address underlying vulnerabilities. Eurelings-Bontekoe et al. (3) also highlighted the relationship between personality organization and cognitive models of pathology, suggesting that interventions targeting core organizational deficits are likely to produce broad improvements. This theoretical foundation helps explain why both psychodynamic and mentalization-based approaches, though distinct, converged in their impact on self-control in the present study.

Finally, the study adds to cross-cultural evidence on the applicability of psychodynamic and mentalization-based approaches. While much of the evidence base originates from Western contexts, research in non-Western populations, including Chabok et al. (13) and Azizi et al. (23), has confirmed the efficacy of MBT, while Niknejad et al. (17) and Yousefi (18) demonstrated the effectiveness of STPT. The present findings reinforce these outcomes and suggest that the mechanisms of change identified in Western literature may be generalized to different cultural settings, albeit with attention to contextual and systemic factors.

Despite the promising findings, several limitations should be acknowledged. First, the sample size was relatively small, with only 45 participants divided into three groups, which limits the statistical power and generalizability of the results. Future studies with larger and more diverse samples are necessary to strengthen the external validity of the findings. Second, the study relied on self-report measures, which may

be subject to biases such as social desirability and limited self-awareness, particularly in individuals with borderline traits. Incorporating clinician-rated assessments and behavioral measures of self-control would provide a more comprehensive evaluation. Third, the intervention period consisted of only nine sessions, which, although consistent with structured protocols, may not fully capture the long-term trajectory of therapeutic change. Finally, while the study included a two-month follow-up, longer-term follow-ups are needed to determine the durability of treatment effects and the potential for relapse over time.

Future research should aim to replicate these findings with larger and more heterogeneous samples, including both genders, different age groups, and participants from varied cultural and socioeconomic backgrounds. Comparative studies examining STPT and MBT across different personality disorder subtypes could further clarify their differential effectiveness. Longitudinal studies with extended follow-up periods are recommended to evaluate the sustainability of treatment outcomes and to explore whether gains in self-control translate into improvements in broader life domains such as occupational functioning and relationship stability. Additionally, studies employing multimodal assessment methods, including neurobiological and behavioral indicators, could provide deeper insights into the mechanisms of change underlying improvements in self-control. Finally, exploring integrative approaches that combine elements of psychodynamic confrontation and mentalization training may yield promising avenues for treatment innovation.

From a clinical standpoint, the findings of this study highlight the value of both STPT and MBT as effective interventions for improving self-control in individuals with borderline personality structure. Mental health practitioners may select between these approaches based on patient preferences, therapist expertise, and contextual considerations, with confidence that both offer robust benefits. Training programs should ensure that clinicians are equipped with skills in both modalities, thereby broadening access to evidence-based care. Furthermore, incorporating self-control as a specific treatment target may help therapists track therapeutic progress and motivate patients by emphasizing tangible improvements in everyday functioning. Finally, policymakers and mental health systems should consider integrating both psychodynamic and mentalization-based interventions into treatment programs for borderline pathology, ensuring that patients have access to diverse yet effective therapeutic options.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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