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Comparison of the Effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Transference-Focused Psychotherapy (TFP) on Impulsivity and Cognitive Emotion Regulation in Patients with Borderline Personality Disorder

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A B S T R A C T

Objective: The present study aimed to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Transference-Focused Psychotherapy (TFP) on impulsivity and cognitive emotion regulation in patients diagnosed with Borderline Personality Disorder.

Methods and Materials: This study employed a quasi-experimental design with a pretest–posttest control group and a three-month follow-up phase. The statistical population consisted of female patients diagnosed with Borderline Personality Disorder who were referred to psychiatric and psychological clinics in District 3 of Tehran during the first quarter of 2026. Forty-five participants were selected using purposive sampling and randomly assigned into three groups, including ISTDP, TFP, and a control group. The research instruments included the Cognitive Emotion Regulation Questionnaire (CERQ) and the Barratt Impulsiveness Scale (BIS-11), which were administered at the pretest, posttest, and follow-up stages. The TFP intervention was implemented in twelve weekly 60-minute sessions, whereas the ISTDP intervention was conducted in ten weekly 60-minute sessions. Data were analyzed using repeated-measures multivariate analysis of variance in IBM SPSS Statistics Version 26.

Findings: The findings demonstrated that both ISTDP and TFP significantly reduced impulsivity and improved cognitive emotion regulation compared to the control group ($p < 0.001$). Significant interaction effects between time and group membership were observed for non-planning impulsivity and cognitive impulsivity, while no significant interaction effect was found for motor impulsivity. Moreover, significant improvements were observed in most components of cognitive emotion regulation, including self-blame, rumination, positive refocusing, planning-focused refocusing, positive reappraisal, and perspective taking. Bonferroni post-hoc comparisons indicated that TFP was more effective than ISTDP in improving adaptive cognitive emotion regulation strategies

and reducing cognitive dimensions of impulsivity. The treatment effects remained relatively stable during the three-month follow-up period.

Conclusion: The findings suggest that both Intensive Short-Term Dynamic Psychotherapy and Transference-Focused Psychotherapy are effective interventions for reducing impulsivity and improving cognitive emotion regulation in patients with Borderline Personality Disorder. However, TFP demonstrated superior effectiveness in enhancing reflective and cognitive aspects of emotional regulation. These results highlight the importance of psychodynamic interventions that focus on emotional processing, personality organization, and reflective functioning in the treatment of Borderline Personality Disorder.

Keywords: *Borderline Personality Disorder, impulsivity, cognitive emotion regulation, Intensive Short-Term Dynamic Psychotherapy, Transference-Focused Psychotherapy, psychodynamic psychotherapy*

1. Introduction

Borderline Personality Disorder (BPD) is one of the most clinically complex personality disorders and is characterized by persistent instability in affect regulation, interpersonal relationships, self-image, impulse control, and behavioral functioning. Contemporary clinical literature conceptualizes BPD not merely as a diagnostic category defined by symptomatic instability, but as a multidimensional disorder involving disturbances in personality organization, identity integration, attachment functioning, affect tolerance, and reflective capacity (Alfieri et al., 2025; Skodol, 2023). Patients with BPD often experience rapidly fluctuating emotional states, heightened interpersonal sensitivity, chronic fear of abandonment, unstable representations of self and others, and recurrent maladaptive behaviors that may include impulsive decision-making, self-damaging actions, anger outbursts, substance misuse, unstable relationships, and suicidal or self-injurious tendencies (Linehan, 2024; Rossberg et al., 2024). These clinical manifestations impose a substantial burden on patients, families, and mental health systems, particularly because the disorder is frequently associated with recurrent crises, high service utilization, treatment dropout, and comorbidity with mood, anxiety, trauma-related, and substance-related disorders (Ditrich et al., 2021; Gabbard et al., 2023).

Among the central features of BPD, impulsivity has received extensive empirical and clinical attention. Impulsivity in BPD is not limited to rapid action without forethought; rather, it includes cognitive impulsivity, motor impulsivity, emotional urgency, reward sensitivity, poor planning, and difficulty inhibiting behavior under conditions of intense affective arousal (Mahmoudaliloo et al., 2018; Skodol, 2023). Patients with BPD may engage in impulsive behaviors as attempts to regulate intolerable emotional states, reduce abandonment anxiety, escape shame or guilt, or externalize internal conflict. In this regard, impulsivity is closely linked to the affective instability and interpersonal reactivity that define the disorder (Koenigsberg et al., 2023; Rossberg et al., 2024). Recent evidence also indicates that neurobehavioral systems such as behavioral activation and inhibition systems may contribute to impulsive tendencies through the mediating role of emotion regulation difficulties, especially in vulnerable female populations with borderline personality features (Sam et al., 2025). Therefore, impulsivity in BPD should be understood as both a behavioral dyscontrol problem and a manifestation of deeper emotional and personality-level dysregulation.

Emotion regulation is another core dimension of BPD and represents a major target of psychological intervention. Individuals with BPD typically show heightened emotional sensitivity, intense emotional responses, slow return to baseline after emotional activation, and limited access to adaptive emotion regulation strategies (Liu et al., 2024; Miller et al., 2023). Cognitive emotion regulation refers specifically to the cognitive strategies used to process, reinterpret, manage, or maintain emotional responses after stressful experiences. Adaptive strategies such as positive reappraisal, planning, positive refocusing, acceptance, and putting events into perspective can buffer emotional distress, whereas maladaptive strategies such as rumination, catastrophizing, self-blame, and blaming others may intensify emotional dysregulation and increase vulnerability to impulsive behaviors (Liu et al., 2024; Miller et al., 2023). In BPD, dysfunctional cognitive emotion regulation strategies often maintain cycles of interpersonal conflict, shame, anger, rejection sensitivity, and unstable behavioral responses. Rejection sensitivity, in particular, has been identified as a key cognitive-affective mechanism in BPD,

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linking interpersonal threat perception to emotional escalation and maladaptive action tendencies (Cavicchioli & Maffei, 2020).

The relationship between impulsivity and emotion regulation in BPD is reciprocal and clinically significant. Emotional dysregulation can increase impulsive behaviors by narrowing cognitive control, intensifying urgency, and reducing reflective processing, while impulsive behaviors may further aggravate emotional instability through interpersonal consequences, guilt, shame, and loss of self-coherence (Koenigsberg et al., 2023; Rossberg et al., 2024). Neuropsychological and clinical studies suggest that cognitive biases, maladaptive appraisal patterns, and deficits in reflective functioning contribute to the persistence of this cycle (Bateman & Fonagy, 2016; Miller et al., 2023). Furthermore, shame and guilt are particularly relevant to borderline pathology, as these self-conscious emotions can both motivate reparative reflection and trigger defensive, impulsive, or dissociative responses when poorly regulated (Diamond, 2024; Gottlich et al., 2020). For this reason, effective treatment of BPD should not focus solely on symptom reduction; it must also address the underlying mechanisms that connect affective arousal, cognitive appraisal, self-other representations, and behavioral dyscontrol.

Psychotherapeutic interventions remain the primary evidence-based approach for treating BPD. Dialectical Behavior Therapy emphasizes skills training, mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness, and has contributed substantially to the structured treatment of chronic emotional and behavioral dysregulation (Linehan, 2024). Mentalization-Based Treatment focuses on enhancing patients' capacity to understand their own and others' mental states, especially under conditions of attachment activation and interpersonal stress (Bateman & Fonagy, 2016). Within psychodynamic and personality-focused approaches, Transference-Focused Psychotherapy (TFP) and Intensive Short-Term Dynamic Psychotherapy (ISTDP) offer clinically rich and theoretically distinct models for addressing the emotional, interpersonal, and intrapsychic mechanisms underlying BPD symptoms (Gabbard et al., 2023; Thoma & Abbass, 2022). Comparing these two treatments can clarify which mechanisms of change are most relevant for improving impulsivity and cognitive emotion regulation in patients with BPD.

Transference-Focused Psychotherapy is a structured psychodynamic treatment originally developed for severe personality pathology, particularly BPD. TFP is grounded in object relations theory and focuses on the integration of split and polarized representations of self and others through systematic clarification, confrontation, and interpretation within the therapeutic relationship (Clarkin et al., 2023; Gabbard et al., 2023). In BPD, patients often shift between idealized and persecutory perceptions of self and others, and these unstable internal representations are enacted in the transference relationship. TFP uses these enactments as clinically meaningful material through which primitive defenses, identity diffusion, affective instability, and interpersonal distortions can be examined and integrated (Diamond et al., 2021). By increasing awareness of contradictory internal states and linking emotional experience to interpersonal patterns, TFP may reduce impulsive action and strengthen reflective functioning.

Recent studies suggest that TFP may be particularly relevant to emotion regulation and impulsivity in BPD. Research on TFP has shown its potential to improve reflective functioning, reduce borderline symptoms, and enhance emotional regulation capacities in patients with borderline pathology (Fakhraei Nejad et al., 2023; Khouryanian et al., 2018). Comparative findings also indicate that transference-focused analytic psychotherapy can reduce neuroticism and impulsivity in patients with BPD, supporting the assumption that working through internalized relational patterns may influence behavioral dyscontrol (Fathi et al., 2023). The clinical utility of TFP may also extend beyond classical BPD presentations to broader personality pathology, as recent formulations conceptualize it as a transdiagnostic treatment for personality dysfunction (Clarkin et al., 2023). Moreover, contemporary discussions have emphasized the integration of cognitive-behavioral elements within TFP when working with borderline symptoms, suggesting that structured psychodynamic interpretation can be complemented by attention to cognition, behavioral patterns, and emotion regulation processes (Otto et al., 2024).

The relevance of guilt, shame, and self-evaluation in TFP is also important for understanding its potential effects on cognitive emotion regulation. Patients with BPD often oscillate between self-blame, other-blame, guilt, and anger, and these emotional shifts can intensify impulsive reactions. TFP provides a framework for examining these affective states as they emerge in the therapeutic relationship, thereby helping patients differentiate between realistic guilt, persecutory guilt, shame-based self-attack, and defensive externalization (Diamond, 2024). Evidence on shame and

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guilt experiences in women with BPD shows that these emotions have distinctive neural and clinical correlates and may play a central role in emotional dysregulation (Gottlich et al., 2020). Therefore, TFP may improve cognitive emotion regulation by helping patients identify, tolerate, and integrate painful self-conscious emotions rather than discharging them through impulsive or maladaptive behaviors.

Intensive Short-Term Dynamic Psychotherapy is another psychodynamic intervention that directly targets emotional avoidance, defensive processes, and unconscious conflicts. ISTDP is based on the assumption that many psychological symptoms arise when patients defend against complex feelings, particularly those associated with attachment trauma, anger, guilt, grief, and anxiety (Thoma & Abbass, 2022). Through techniques such as clarification of defenses, pressure toward emotional experience, anxiety monitoring, and challenge to resistance, ISTDP helps patients recognize and experience previously avoided emotions in an adaptive and regulated manner. This model may be especially relevant for patients whose impulsivity and emotional dysregulation are maintained by defensive avoidance, somatization, affect phobia, or unresolved attachment-related conflict (Kleinknecht et al., 2023; Shapiro et al., 2024). In this sense, ISTDP may reduce impulsivity not only by increasing awareness but also by transforming the patient's relationship with avoided emotional states.

Empirical findings increasingly support the effectiveness of ISTDP for emotion regulation and related psychological outcomes. Studies have reported the effectiveness of ISTDP in improving emotion regulation, self-esteem, and defense mechanisms in clinical populations, suggesting that dynamic work on defenses and emotional experience can produce meaningful regulatory change (Mahboudi et al., 2022). ISTDP has also been shown to improve emotion regulation, anger, anxiety, and symptom severity in patients with tension-type headache, indicating its capacity to influence both psychological and psychosomatic manifestations of dysregulated affect (Ahmadvand Shahverdi et al., 2024). Similarly, comparative evidence has supported the effectiveness of ISTDP and acceptance and commitment therapy in improving personality organization and emotion regulation, further highlighting the relevance of intensive dynamic interventions for conditions involving emotional and personality-level dysfunction (Abolpour et al., 2024). Recent clinical discussions have specifically emphasized the role of ISTDP in treating emotion dysregulation and impulsivity in BPD, proposing that its focus on defense restructuring and affective experiencing may be useful for patients with borderline features (Shapiro et al., 2024).

Despite shared psychodynamic foundations, ISTDP and TFP differ in their mechanisms of action. TFP primarily focuses on the transference relationship, identity integration, split object relations, and the interpretation of relational patterns as they appear in therapy (Clarkin et al., 2023; Gabbard et al., 2023). ISTDP, by contrast, emphasizes the rapid identification of defenses, regulation of anxiety, and direct experience of previously avoided affective states (Shapiro et al., 2024; Thoma & Abbass, 2022). From a clinical perspective, TFP may be more directly aligned with improving reflective functioning, interpersonal understanding, and cognitive regulation of affect, whereas ISTDP may be particularly effective in reducing defensive avoidance and increasing emotional tolerance. Attachment patterns may also influence treatment responsiveness, as patients with borderline pathology often display insecure and disorganized attachment configurations that affect emotional expression, therapeutic alliance, and defensive functioning (Kleinknecht et al., 2023). Therefore, comparing these treatments in the same clinical population can provide valuable insight into their relative effectiveness on impulsivity and cognitive emotion regulation.

The need for comparative treatment research is especially important because BPD is heterogeneous. Some patients primarily present with emotional lability and interpersonal instability, while others display prominent impulsivity, dissociation, identity disturbance, or maladaptive cognitive strategies (Alfieri et al., 2025; Ditrich et al., 2021). Dissociation and dysfunctional personality traits may complicate treatment by impairing emotional awareness and continuity of self-experience, while comorbid attention-deficit/hyperactivity features may further intensify impulsivity and executive dysfunction (Alfieri et al., 2025; Ditrich et al., 2021). These complexities suggest that no single treatment mechanism may be sufficient for all patients. Treatments that enhance reflective functioning, regulate affective arousal, restructure defensive patterns, and improve cognitive appraisal strategies may be particularly useful for patients whose impulsivity is maintained by emotion dysregulation and unstable self-other representations.

In the Iranian clinical context, research on psychodynamic treatments for BPD has grown, yet comparative evidence remains limited. Studies have supported the relevance of impulsivity, reward sensitivity, and emotional dysfunction in differentiating individuals

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with borderline symptoms from nonclinical populations (Mahmoudaliloo et al., 2018). Other findings have indicated that TFP can improve emotion regulation and reduce borderline-related symptoms, while ISTDP has shown effectiveness in improving emotion regulation and personality-related outcomes across clinical groups (Fakhraei Nejad et al., 2023; Khouryanian et al., 2018; Mahboudi et al., 2022). However, fewer studies have directly compared ISTDP and TFP in patients with BPD using both impulsivity and cognitive emotion regulation as outcome variables. Such comparison is clinically meaningful because it allows researchers to determine whether a treatment focused on transference and self-other integration or a treatment focused on emotional experiencing and defense restructuring produces stronger effects on different aspects of borderline dysfunction.

Taken together, the literature indicates that impulsivity and cognitive emotion regulation are central mechanisms in BPD and that both TFP and ISTDP may address these mechanisms through different but potentially complementary therapeutic pathways. TFP may help patients integrate fragmented self-other representations, increase reflective functioning, and reinterpret interpersonal emotions, while ISTDP may help patients identify defenses, tolerate anxiety, and experience avoided emotions more adaptively (Diamond et al., 2021; Thoma & Abbass, 2022). Given the clinical importance of reducing impulsive behaviors and strengthening adaptive cognitive emotion regulation strategies in BPD, evaluating and comparing these two interventions can contribute to treatment planning, clinical decision-making, and the development of more mechanism-based psychotherapy protocols. Therefore, the aim of the present study was to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy and Transference-Focused Psychotherapy on impulsivity and cognitive emotion regulation in patients with Borderline Personality Disorder.

2. Methods and Materials

2.1. Study design and Participant

The present study employed a quasi-experimental design using a pretest–posttest format with experimental and control groups and a three-month follow-up phase. The aim of the study was to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Transference-Focused Psychotherapy (TFP) on impulsivity and cognitive emotion regulation in patients diagnosed with Borderline Personality Disorder (BPD). The statistical population consisted of female patients with Borderline Personality Disorder who were referred to psychiatric and psychological clinics located in District 3 of Tehran during the first quarter of 2026. Diagnosis of Borderline Personality Disorder was established based on structured clinical interviews and the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). The sample was selected using purposive sampling, and after meeting the inclusion criteria, participants were randomly assigned to one of three groups, including the ISTDP group, the TFP group, and the control group. A total of 45 participants were included in the study, with 15 participants allocated to each group. The inclusion criteria consisted of a confirmed diagnosis of Borderline Personality Disorder, age range between 18 and 45 years, at least a high school diploma, and willingness to participate in the study through informed consent. The exclusion criteria included the presence of psychotic disorders, severe substance dependence, absence from more than two therapeutic sessions, and simultaneous participation in another psychotherapy program during the study period.

2.2. Measures

The Cognitive Emotion Regulation Questionnaire (CERQ) was developed by Nadia Garnefski and colleagues in 2002 to assess the multidimensional cognitive coping strategies individuals use following the experience of negative or stressful events. The questionnaire is a self-report instrument consisting of 36 items rated on a five-point Likert scale ranging from “never” to “always.” The CERQ evaluates nine cognitive emotion regulation strategies, including self-blame, acceptance, rumination, positive refocusing, refocus on planning, positive reappraisal, putting into perspective, catastrophizing, and other-blame. The Persian version of the questionnaire was adapted and validated by Hasani in 2010, and previous studies reported satisfactory psychometric properties for the instrument. Internal consistency coefficients for the subscales ranged from 0.76 to 0.92, while test–retest reliability coefficients ranged from 0.51 to 0.77. In addition, acceptable construct and criterion validity indices were reported for the Persian version. External reliability coefficients were reported as 0.91 for positive strategies, 0.87 for negative strategies, and 0.93 for the total questionnaire score. In the present study, the validity of the instrument was confirmed through expert review by psychology specialists, and a pilot study

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conducted on 15 participants yielded a Cronbach's alpha coefficient of 0.81, indicating appropriate internal consistency.

The Barratt Impulsiveness Scale, Eleventh Version (BIS-11), originally developed by Ernest S. Barratt in 1959, was used to assess impulsivity. The BIS-11 is one of the most widely used self-report measures of impulsive personality traits and consists of 30 items assessing three major dimensions of impulsivity, including cognitive impulsivity, motor impulsivity, and non-planning impulsivity. Responses are rated on a Likert-type scale, and higher scores indicate greater impulsivity. Previous Iranian studies have reported acceptable psychometric properties for the Persian version of the scale, with total reliability coefficients ranging from 0.77 to 0.83 and subscale reliability coefficients ranging from 0.47 to 0.78. International studies have also reported Cronbach's alpha coefficients of approximately 0.83 for the total scale and between 0.73 and 0.74 for the subscales. In the current study, content validity was confirmed through consultation with university faculty members and clinical psychology experts. Prior to the main implementation, the questionnaire was administered to a pilot sample of 15 participants, and the obtained Cronbach's alpha coefficient was 0.85, demonstrating satisfactory reliability for the research sample.

2.3. Interventions

The Transference-Focused Psychotherapy (TFP) intervention was implemented in twelve weekly sessions, each lasting approximately 60 minutes. The first session focused on establishing the therapeutic contract, clarifying treatment goals, discussing session rules, and defining the boundaries and responsibilities of both therapist and patient. During the second through fourth sessions, the therapist concentrated on identifying and clarifying the patient's dominant transference patterns within the therapeutic relationship, with particular attention given to contradictory emotional states, unstable interpersonal perceptions, and split object representations characteristic of Borderline Personality Disorder. Sessions five through nine emphasized the interpretation and analysis of unconscious conflicts, primitive defense mechanisms, identity diffusion, and polarized self-other representations. The therapist consistently worked to integrate fragmented emotional experiences and facilitate reflective functioning and emotional awareness. The final sessions, from the tenth through twelfth sessions, were devoted to consolidating therapeutic gains, strengthening more integrated personality functioning, promoting emotional stability, and generalizing treatment-related changes to everyday interpersonal and emotional situations outside the therapy environment.

The Intensive Short-Term Dynamic Psychotherapy (ISTDP) intervention was conducted in ten weekly sessions of approximately 60 minutes each. The treatment process emphasized the identification of maladaptive defensive patterns and unconscious emotional conflicts underlying impulsive and dysregulated behaviors. Early sessions focused on monitoring anxiety responses and recognizing the patient's habitual defensive operations that interfered with emotional awareness and interpersonal functioning. As treatment progressed, the therapist encouraged patients to directly experience previously repressed or avoided emotions within the therapeutic setting while simultaneously reducing resistance and defensive avoidance. Particular emphasis was placed on facilitating emotional processing, identifying the origins of unresolved emotional conflicts, and enhancing insight into unconscious emotional dynamics associated with impulsivity and maladaptive emotional regulation. Throughout the intervention, therapeutic pressure and clarification techniques were used to increase emotional experiencing and promote adaptive coping capacities. The final sessions focused on stabilizing therapeutic changes, reinforcing emotional insight, and increasing patients' ability to regulate emotional experiences and interpersonal reactions more effectively in daily life.

2.4. Data Analysis

The collected data were analyzed using both descriptive and inferential statistical methods. Descriptive statistics, including means and standard deviations, were calculated to summarize participants' demographic characteristics and study variables. The chi-square test was used to evaluate the homogeneity of the groups regarding demographic variables at baseline. To examine the effectiveness of the interventions over time, repeated-measures multivariate analysis of covariance (MANCOVA) was employed. Prior to conducting the primary analyses, the assumptions underlying repeated-measures analysis were examined and reported, including Box's M test for equality of covariance matrices, Mauchly's test of sphericity, and Levene's test for homogeneity of variances. All statistical analyses were conducted using IBM SPSS Statistics software, Version 26, and the significance level for all analyses was set at 0.05.

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3. Findings and Results

The present study included 45 participants who were equally assigned to the Intensive Short-Term Dynamic Psychotherapy (ISTDP), Transference-Focused Psychotherapy (TFP), and control groups, with 15 participants in each group. The age range of participants in the ISTDP group was between 23 and 43 years, with the highest frequency observed in the 23–30-year age range. In the TFP group, most participants were between 37 and 43 years old, whereas participants in the control group were primarily concentrated within the 31–36-year age range. Regarding educational status, most participants in the ISTDP group held a bachelor's degree, whereas the fewest participants had postgraduate education. In the TFP group, the majority of participants possessed a diploma or associate degree, while only a limited number had postgraduate education. Similarly, in the control group, most participants had a diploma or associate degree, and the smallest proportion had postgraduate education. Overall, the demographic distribution indicated an acceptable level of diversity in terms of age and educational attainment, and the groups demonstrated relative homogeneity across demographic characteristics, thereby supporting the internal validity of the study findings.

Table 1

Descriptive Statistics for Impulsivity and Cognitive Emotion Regulation Across Study Groups

Variable	Group	Pretest Mean ± SD	Posttest Mean ± SD	Follow-Up Mean ± SD
Impulsivity	ISTDP	68.13 ± 2.83	60.87 ± 3.25	59.67 ± 2.61
	TFP	66.53 ± 3.96	54.47 ± 4.24	55.20 ± 3.32
	Control	67.67 ± 3.68	69.33 ± 3.75	66.80 ± 4.90
Cognitive Emotion Regulation	ISTDP	69.33 ± 4.08	92.33 ± 3.83	92.07 ± 3.04
	TFP	69.33 ± 3.18	111.60 ± 5.37	108.40 ± 4.50
	Control	66.53 ± 2.64	68.80 ± 4.93	67.73 ± 3.71

The descriptive findings demonstrated that the mean scores of impulsivity decreased from pretest to posttest in both intervention groups, and this reduction remained relatively stable during the three-month follow-up assessment. In contrast, the control group showed no substantial changes across the measurement stages. Furthermore, the mean scores of cognitive emotion regulation increased considerably in both treatment groups during the posttest stage, and these improvements persisted at follow-up. The TFP group exhibited greater improvement in cognitive emotion regulation compared to the ISTDP group. Overall, these descriptive findings suggest that both therapeutic interventions were effective in reducing impulsivity and improving cognitive emotion regulation compared to the control condition.

The assumption of normality for impulsivity and cognitive emotion regulation variables was examined using the Shapiro–Wilk test. The findings indicated that the significance values for all variables were greater than 0.05, confirming the normal distribution of the data and supporting the use of parametric statistical analyses. In addition, Box's M test demonstrated that the equality of covariance matrices assumption was satisfied for impulsivity variables (Box's M = 222.169, F = 1.284, p = 0.068) as well as for cognitive emotion regulation variables (F = 1.812, p = 0.135). Mauchly's test of sphericity further indicated that the assumption of sphericity was met for the cognitive and motor dimensions of impulsivity, whereas the assumption was violated for the non-planning impulsivity component; therefore, the Huynh–Feldt correction was applied for this dimension. For cognitive emotion regulation components, all Mauchly's test significance values exceeded 0.05, indicating that the sphericity assumption was satisfied for all subscales. Multivariate repeated-measures analyses demonstrated significant effects of time and significant interaction effects between time and group membership for both impulsivity and cognitive emotion regulation variables, indicating that changes over time differed significantly across the three study groups.

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Table 2

Results of Repeated-Measures Analysis of Variance for Study Variables

Source of Variation	Variable	df	F	p	Partial Eta Squared
Time	Non-Planning Impulsivity	1.593	67.872	0.001	0.618
	Motor Impulsivity	2	9.444	0.001	0.184
	Cognitive Impulsivity	2	83.482	0.001	0.665
Time × Group	Non-Planning Impulsivity	3.186	18.857	0.001	0.473
	Motor Impulsivity	4	1.071	0.376	0.049
	Cognitive Impulsivity	4	37.857	0.001	0.643
Time	Cognitive Emotion Regulation Components	18	12.291	0.001	0.590
Time × Group	Cognitive Emotion Regulation Components	36	5.112	0.001	0.368

The repeated-measures analysis of variance revealed that the effect of time was statistically significant for all impulsivity dimensions, including non-planning impulsivity, motor impulsivity, and cognitive impulsivity ($p < 0.001$). Significant interaction effects between time and group membership were also observed for non-planning and cognitive impulsivity, indicating that changes across the assessment stages differed significantly among the groups. However, the interaction effect for motor impulsivity was not statistically significant ($p = 0.376$), suggesting that the changes in this component were relatively similar across groups. Furthermore, significant multivariate effects were found for cognitive emotion regulation variables, demonstrating that both interventions improved emotional regulation strategies over time. The strongest effect sizes were observed for self-blame, positive refocusing, refocus on planning, and positive reappraisal components, whereas acceptance and catastrophizing demonstrated smaller effect sizes.

Table 3

Bonferroni Post-Hoc Comparisons for Impulsivity and Cognitive Emotion Regulation Variables

Variable/Component	Group Comparison	Mean Difference	p
Non-Planning Impulsivity	ISTDP vs. TFP	2.044	0.016
	ISTDP vs. Control	-1.978	0.021
	TFP vs. Control	-4.022	0.001
Motor Impulsivity	ISTDP vs. TFP	0.644	1.000
	ISTDP vs. Control	-0.333	1.000
	TFP vs. Control	-0.978	0.513
Cognitive Impulsivity	ISTDP vs. TFP	1.467	0.004
	ISTDP vs. Control	-2.733	0.001
	TFP vs. Control	-4.200	0.001
Self-Blame	ISTDP vs. TFP	1.422	0.003
Positive Refocusing	ISTDP vs. TFP	-2.067	0.001
Refocus on Planning	ISTDP vs. TFP	-1.800	0.001
Positive Reappraisal	ISTDP vs. TFP	-1.511	0.001
Perspective Taking	ISTDP vs. TFP	-2.133	0.001

The Bonferroni post-hoc comparisons demonstrated significant differences between the intervention groups and the control group for the non-planning and cognitive dimensions of impulsivity. Both ISTDP and TFP significantly reduced impulsivity scores compared to the control condition, although TFP showed stronger effects, particularly in the cognitive dimension of impulsivity. No statistically significant differences were observed for motor impulsivity, indicating that this component was less responsive to therapeutic intervention. Regarding cognitive emotion regulation, both therapeutic approaches significantly improved adaptive emotion regulation strategies compared to the control group. However, TFP demonstrated greater effectiveness than ISTDP in reducing maladaptive strategies such as self-blame and rumination and in enhancing adaptive strategies including positive refocusing, planning-focused refocusing, positive reappraisal, and perspective taking. Comparisons across measurement stages further indicated that the largest changes occurred between pretest and posttest as well as between pretest and follow-up, whereas differences between posttest and follow-up were nonsignificant for several

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components, suggesting relative stability of treatment effects over time.

4. Discussion

The present study aimed to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Transference-Focused Psychotherapy (TFP) on impulsivity and cognitive emotion regulation in patients with Borderline Personality Disorder (BPD). The findings demonstrated that both therapeutic interventions significantly reduced impulsivity and improved cognitive emotion regulation compared to the control group. However, TFP showed greater effectiveness in improving cognitive dimensions of impulsivity and adaptive cognitive emotion regulation strategies, while the effects of both interventions on motor impulsivity were comparatively limited. In addition, the therapeutic gains remained relatively stable during the three-month follow-up period, suggesting that both interventions produced enduring psychological changes rather than temporary symptom reduction.

One of the major findings of the present study was the reduction of impulsivity in both treatment groups. This finding is consistent with previous literature emphasizing impulsivity as a central feature of BPD that can be modified through psychotherapeutic interventions targeting emotional processing, reflective functioning, and personality organization (Rossberg et al., 2024; Skodol, 2023). The reduction in impulsive behaviors observed in the present study may be explained by the capacity of both TFP and ISTDP to increase emotional awareness and decrease automatic affect-driven reactions. Individuals with BPD often respond impulsively when confronted with intense affective states, interpersonal rejection, or internal experiences of shame, anger, or emptiness. These reactions are frequently associated with deficits in emotional containment, reflective thinking, and inhibitory control (Koenigsberg et al., 2023; Sam et al., 2025). Therefore, interventions that strengthen emotional processing and self-observation may reduce the urgency underlying impulsive action.

The significant reduction in non-planning impulsivity and cognitive impulsivity in the treatment groups supports the assumption that psychodynamic therapies can influence cognitive-affective processes involved in behavioral dyscontrol. Patients with BPD often exhibit polarized thinking, impaired future orientation, and rapid emotionally driven decision-making. Through interpretation, clarification, and emotional exploration, psychodynamic therapies help patients pause before acting, reconsider emotional meanings, and develop more coherent internal representations (Clarkin et al., 2023; Gabbard et al., 2023). In TFP, the therapeutic relationship serves as a direct context for identifying impulsive relational reactions and linking them to unconscious interpersonal expectations and split self-other representations. This process may enhance the patient's reflective functioning and increase awareness of the psychological antecedents of impulsive behavior (Diamond et al., 2021; Khouryanian et al., 2018). Similarly, ISTDP reduces impulsivity by confronting defensive avoidance and helping patients tolerate emotions that would otherwise be discharged behaviorally through impulsive actions (Shapiro et al., 2024; Thoma & Abbass, 2022).

The present findings are aligned with prior research demonstrating the effectiveness of TFP in reducing impulsivity and emotional dysregulation among individuals with BPD (Fathi et al., 2023; Koenigsberg et al., 2023). Koenigsberg and colleagues emphasized that improvements in impulsivity following TFP are associated with enhanced affect regulation and increased integration of cognitive and emotional experiences (Koenigsberg et al., 2023). Likewise, Fathi and colleagues reported that transference-focused analytic psychotherapy significantly reduced impulsivity and neuroticism in patients with BPD (Fathi et al., 2023). The findings are also consistent with studies suggesting that TFP improves reflective functioning and symptom reduction by facilitating integration of fragmented identity structures (Khouryanian et al., 2018). In patients with BPD, impulsive behaviors are often attempts to manage internal chaos, unstable attachment experiences, or unprocessed affective conflict. TFP may therefore reduce impulsivity by promoting psychological integration and more stable self-regulatory capacities.

The effectiveness of ISTDP in reducing impulsivity and improving emotional regulation is also consistent with previous findings (Ahmadvand Shahverdi et al., 2024; Mahboudi et al., 2022; Shapiro et al., 2024). ISTDP conceptualizes impulsive and dysregulated behaviors as manifestations of unconscious anxiety, unresolved attachment conflicts, and maladaptive defenses. Through direct emotional experiencing and the restructuring of defensive processes, patients gradually become more capable of tolerating emotional intensity without resorting to impulsive discharge (Thoma & Abbass, 2022). The reduction in impulsivity observed in the ISTDP group may therefore reflect improved emotional tolerance and

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decreased reliance on defensive avoidance. The findings of Ahmadvand Shahverdi and colleagues, who reported improvements in emotion regulation and emotional symptoms following ISTDP, further support this interpretation (Ahmadvand Shahverdi et al., 2024). Similarly, Mahboudi and colleagues demonstrated that ISTDP can improve emotion regulation and adaptive psychological functioning by modifying maladaptive defenses and increasing emotional awareness (Mahboudi et al., 2022).

Another important finding of the present study was the improvement in cognitive emotion regulation among participants in both intervention groups. Patients with BPD commonly rely on maladaptive cognitive strategies such as rumination, catastrophizing, self-blame, and blaming others, all of which contribute to emotional instability and interpersonal dysfunction (Liu et al., 2024; Miller et al., 2023). The observed increase in adaptive cognitive emotion regulation strategies and reduction in maladaptive strategies suggests that both interventions enhanced patients' ability to cognitively process emotional experiences in a more balanced and reflective manner. Improvements in positive refocusing, planning-focused coping, positive reappraisal, and perspective taking indicate increased cognitive flexibility and emotional integration. These changes are clinically meaningful because maladaptive cognitive processing often maintains cycles of shame, anger, rejection sensitivity, and impulsive interpersonal reactions in BPD (Cavicchioli & Maffei, 2020).

The greater effectiveness of TFP in improving cognitive emotion regulation strategies may be explained by its explicit focus on mental representation, reflective functioning, and interpretation of relational experiences within the transference relationship. TFP encourages patients to examine contradictory emotional states, differentiate self from others, and understand the psychological meaning of their interpersonal reactions (Clarkin et al., 2023; Gabbard et al., 2023). This process may directly strengthen higher-order cognitive regulation processes, especially those involving self-reflection, perspective taking, and emotional interpretation. The findings are consistent with studies reporting improvements in emotion regulation and reflective function following TFP in patients with BPD (Fakhraei Nejad et al., 2023; Khouryanian et al., 2018). Since many patients with BPD experience cognitive distortions during emotionally charged situations, interventions that facilitate interpretation and integration of affective experience may produce stronger changes in cognitive emotion regulation than interventions primarily focused on emotional experiencing alone.

The present results may also be interpreted through attachment and personality organization theories. Individuals with BPD frequently exhibit insecure or disorganized attachment patterns associated with fear of abandonment, unstable interpersonal expectations, and hypersensitivity to rejection (Kleinknecht et al., 2023). These attachment-related vulnerabilities intensify emotional reactivity and impair the development of stable regulatory capacities. TFP addresses these dynamics by working directly with attachment activation within the therapeutic relationship, thereby helping patients develop more integrated representations of self and others. ISTDP, although less explicitly attachment-focused, also addresses unresolved attachment emotions through intensive emotional processing and confrontation of defensive avoidance (Shapiro et al., 2024). Thus, both therapies may improve emotional regulation by reducing fear-based defensive responding and increasing tolerance for attachment-related affective experiences.

The limited effect of both interventions on motor impulsivity deserves further consideration. Unlike cognitive or non-planning impulsivity, motor impulsivity may involve more automatic and behaviorally conditioned response tendencies that are less directly influenced by insight-oriented psychodynamic interventions. Behavioral impulsivity may also be more closely associated with neurobiological vulnerability, executive dysfunction, or attentional dysregulation, all of which have been linked to borderline pathology and related conditions such as ADHD (Ditrich et al., 2021). Consequently, although psychodynamic treatments can reduce emotionally driven impulsivity through improved emotional awareness and reflective functioning, they may exert weaker effects on automatic behavioral activation patterns. This finding is consistent with the nonsignificant interaction effect observed for motor impulsivity and suggests that additional behavioral or skills-based interventions may be necessary to target this dimension more effectively.

The persistence of treatment gains at follow-up is another important aspect of the findings. The relative stability of improvements in impulsivity and cognitive emotion regulation suggests that both interventions produced enduring structural or functional psychological changes. Psychodynamic interventions often aim not only to reduce symptoms but also to modify underlying personality structures, defensive processes, and emotional processing

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patterns (Gabbard et al., 2023; Thoma & Abbass, 2022). Therefore, sustained improvements at follow-up may indicate that participants internalized more adaptive regulatory capacities and developed greater emotional insight. The stability of therapeutic effects also supports contemporary perspectives emphasizing the importance of process-based and personality-focused treatments for chronic emotional disorders (Thoma & Abbass, 2022).

5. Conclusion

The findings support broader theoretical models conceptualizing BPD as a disorder of affect integration and personality organization rather than merely a behavioral syndrome. Emotional dysregulation, shame sensitivity, identity diffusion, rejection sensitivity, and impulsive behavior appear to function as interconnected dimensions maintained through maladaptive cognitive-affective processing (Alfieri et al., 2025; Cavicchioli & Maffei, 2020). TFP and ISTDP may influence these dimensions through different therapeutic pathways, yet both appear capable of enhancing emotional integration and reducing maladaptive regulation strategies. The present findings therefore contribute to the growing literature supporting psychodynamic approaches as empirically relevant interventions for BPD (Bateman & Fonagy, 2016; Otto et al., 2024).

6. Limitations and Suggestions

Several limitations should be considered when interpreting the findings of the present study. First, the sample consisted exclusively of female patients from psychiatric and psychological clinics in one district of Tehran, which limits the generalizability of the findings to males, nonclinical populations, or culturally diverse groups. Second, the relatively small sample size may have reduced statistical power and limited the ability to detect subtle differences between treatment approaches. Third, the use of self-report questionnaires may have increased the possibility of response bias and subjective reporting inaccuracies. Fourth, the follow-up period was limited to three months, and longer-term follow-up assessments are needed to determine the durability of treatment effects over extended periods. Finally, variables such as attachment style, trauma history, medication use, and comorbid disorders were not controlled in the present study and may have influenced treatment outcomes.

Future research should examine the comparative effectiveness of psychodynamic interventions in larger and more diverse samples, including male participants and individuals from different cultural and socioeconomic backgrounds. Longitudinal studies with extended follow-up periods are also recommended to evaluate the long-term stability of changes in impulsivity and cognitive emotion regulation. Future studies may benefit from integrating neuropsychological, neurobiological, and observational measures alongside self-report instruments to obtain a more comprehensive understanding of treatment-related change. In addition, examining mediating variables such as reflective functioning, attachment security, shame tolerance, and defense mechanisms may help clarify the mechanisms through which TFP and ISTDP influence borderline pathology. Comparative studies involving other evidence-based interventions such as DBT and Mentalization-Based Treatment may also provide valuable insight into the relative strengths of different therapeutic approaches for BPD.

From a clinical perspective, the findings suggest that both TFP and ISTDP can be considered effective interventions for reducing impulsivity and improving cognitive emotion regulation in patients with Borderline Personality Disorder. Mental health professionals working with BPD populations may benefit from incorporating psychodynamic approaches that address emotional processing, personality organization, and maladaptive defensive patterns. TFP may be particularly useful for patients with severe identity diffusion, unstable interpersonal representations, and difficulties in reflective functioning, whereas ISTDP may be especially appropriate for patients whose symptoms are strongly associated with emotional suppression and defensive avoidance. Treatment planning for BPD may therefore benefit from individualized assessment of personality structure, emotional functioning, and attachment dynamics in order to match patients with the most suitable therapeutic approach.

Authors' Contributions

Authors equally contributed to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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Data are available for research purposes upon reasonable request to the corresponding author.

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Ethical Considerations

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