




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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1. Round 1

1.1. Reviewer 1

Reviewer:

The paragraph stating “Among the central features of BPD, impulsivity has received extensive empirical and clinical attention” would benefit from a more nuanced discussion of the multidimensional structure of impulsivity assessed by the BIS-11. Specifically, the manuscript should explain why cognitive impulsivity and non-planning impulsivity were more responsive to treatment than motor impulsivity, preferably before the Results section, by linking these dimensions to psychodynamic theory and treatment mechanisms.

The section discussing cognitive emotion regulation introduces adaptive and maladaptive strategies effectively; however, the manuscript does not adequately explain why the authors selected the CERQ instead of broader emotion regulation measures such as the DERS. The paragraph beginning “Emotion regulation is another core dimension of BPD...” should justify the theoretical preference for cognitive emotion regulation strategies over behavioral or physiological emotion regulation domains.

The paragraph beginning “The relationship between impulsivity and emotion regulation in BPD is reciprocal and clinically significant” includes several broad claims regarding reflective functioning and cognitive biases, yet no explicit theoretical model is presented linking these constructs to the expected mechanisms of change in TFP and ISTDP. The manuscript would be substantially improved by presenting a conceptual mediation framework illustrating how psychodynamic interventions are hypothesized to alter impulsivity through changes in emotion regulation or reflective functioning.

The paragraph introducing psychotherapeutic interventions discusses DBT and MBT before focusing on TFP and ISTDP. However, the rationale for excluding comparison with established first-line treatments for BPD remains underdeveloped. The authors should explicitly justify why ISTDP and TFP were selected as the comparative interventions instead of including DBT or MBT as active comparators, especially given the strong empirical status of those treatments.

The paragraph beginning “Transference-Focused Psychotherapy is a structured psychodynamic treatment...” provides a theoretically rich explanation of TFP, but the actual treatment protocol used in the study is insufficiently detailed. The authors should specify whether the intervention followed an established TFP manual, whether therapist adherence was monitored, and whether any supervision procedures were implemented to ensure treatment fidelity.

Similarly, the paragraph beginning “Intensive Short-Term Dynamic Psychotherapy is another psychodynamic intervention...” requires greater procedural transparency. The article does not specify which ISTDP model was implemented (e.g., Davanloo-based standard ISTDP or an adapted version), nor does it clarify whether pressure, challenge, and head-on collision techniques were systematically used. Greater procedural precision is necessary for replication and treatment integrity evaluation.

The final paragraph of the Introduction states that the study aims to compare TFP and ISTDP on impulsivity and cognitive emotion regulation; however, no explicit hypotheses are presented. The manuscript would be methodologically stronger if the authors articulated directional hypotheses, particularly regarding the expectation that TFP would outperform ISTDP in cognitive emotion regulation domains.

In the Methods section, the statement “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” raises concerns regarding sampling bias and representativeness. The authors should clarify the socioeconomic and clinical characteristics of District 3 clinics and discuss how referral patterns may limit external validity.

The manuscript states that diagnosis was established using “structured clinical interviews and the diagnostic criteria of the DSM-5-TR,” but the specific diagnostic interview instrument is not identified. The authors must specify whether instruments such as SCID-5-PD or another standardized diagnostic protocol were used, including information about interviewer training and inter-rater reliability.

The inclusion criterion requiring “at least a high school diploma” may unintentionally exclude lower-functioning individuals with BPD who are clinically important. The authors should provide a rationale for this educational threshold and discuss its implications for generalizability.

The interpretation of motor impulsivity findings is theoretically interesting but insufficiently supported empirically. The paragraph beginning “The limited effect of both interventions on motor impulsivity deserves further consideration” speculates about neurobiological vulnerability and ADHD-related executive dysfunction without measuring these constructs. The authors should frame these interpretations more cautiously and acknowledge their speculative nature.

The manuscript repeatedly refers to “reflective functioning” as a mechanism of change, yet no reflective functioning measure was administered. This creates a discrepancy between the theoretical framework and the empirical methodology. The authors should either moderate these claims or acknowledge the absence of direct measurement as a limitation.

The Conclusion section appropriately summarizes the implications of psychodynamic interventions for BPD; however, it overstates the empirical support for “process-based and personality-focused treatments” without comparing them to established non-psychodynamic approaches. The conclusion should avoid implying superiority of psychodynamic interventions beyond the data presented in this study.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

The Measures section reports Cronbach's alpha values derived from a pilot sample of only 15 participants. Such a small pilot sample may produce unstable reliability estimates. The authors should either report reliability coefficients calculated from the full study sample or justify the methodological appropriateness of estimating internal consistency using such a limited pilot group.

The description of the CERQ includes psychometric information from prior Iranian studies; however, no confirmatory factor analysis or construct validation was conducted within the current sample. Given the complexity of BPD-related cognitive distortions, the authors should discuss whether the factor structure of the CERQ remained stable in this clinical population.

The intervention descriptions are overly generalized and read more like theoretical summaries than replicable treatment protocols. For example, the sentence "The therapist consistently worked to integrate fragmented emotional experiences and facilitate reflective functioning and emotional awareness" requires operational clarification. The manuscript should include session objectives, therapist interventions, homework expectations (if any), and specific therapeutic techniques used during each treatment phase.

The ISTDP intervention description states that "therapeutic pressure and clarification techniques were used," but there is no mention of anxiety pathway monitoring, resistance restructuring, or unlocking of the unconscious, all of which are central components of ISTDP theory. The authors should clarify whether these elements were absent or simply omitted from reporting.

The Data Analysis section reports the use of repeated-measures MANCOVA; however, no covariates are identified despite the use of covariance terminology. The authors should specify which variables, if any, were statistically controlled. If no covariates were included, the analysis should be described as repeated-measures MANOVA or ANOVA rather than MANCOVA.

In the Findings section, the demographic paragraph reports differences in age distribution across groups, yet no inferential statistics are presented to confirm baseline equivalence. The manuscript should include chi-square and one-way ANOVA results for demographic comparisons to support the claim of homogeneity.

Table 1 reports total impulsivity and total cognitive emotion regulation scores, whereas Table 2 analyzes impulsivity subdimensions and cognitive emotion regulation components. This inconsistency creates interpretive ambiguity. The authors should either report all subscale descriptive statistics in Table 1 or justify why only total scores are presented descriptively while subscales are analyzed inferentially.

The paragraph discussing assumption testing reports Box's M and Mauchly's tests appropriately; however, the manuscript does not report effect size interpretation standards or statistical power estimates. Including observed power values or confidence intervals for major effects would improve the statistical rigor of the findings.

Table 2 combines multiple repeated-measures outcomes into a single table, which reduces readability and interpretive clarity. The manuscript would benefit from separating impulsivity analyses and cognitive emotion regulation analyses into distinct tables, especially because the CERQ includes multiple subcomponents with potentially distinct clinical implications.

The Discussion section appropriately integrates prior literature, but several interpretations appear overly causal given the quasi-experimental design. For example, the sentence "TFP may therefore reduce impulsivity by promoting psychological integration and more stable self-regulatory capacities" should be revised to reflect correlational rather than causal inference unless mediating mechanisms were directly measured.

Authors revised the manuscript and uploaded the document.

2. Revised

Editor's decision: Accepted.

Editor in Chief's decision: Accepted.

