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The Effect of Brief Supportive–Expressive Psychotherapy on Defense Mechanisms and the Quality of Object Relations in Patients with Borderline Personality Disorder and a History of Interpersonal Trauma

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ABSTRACT

Objective: This study investigated the effects of brief supportive–expressive psychotherapy on defense mechanisms and the quality of object relations in patients with borderline personality disorder (BPD) and a history of interpersonal trauma.

Methods: Using a quasi-experimental pretest–posttest control group design, the study sampled 60 patients from psychological and psychiatric centers in Tehran in 2026, randomly assigned to an intervention or control group. The intervention group received 16 sessions of therapy, while the control group remained on a waiting list. Multivariate analysis of covariance revealed that, after controlling for pretest scores, group membership significantly impacted the dependent variables.

Results: Univariate analyses demonstrated that the intervention significantly reduced maladaptive defense mechanisms and improved the quality of object relations, with moderate-to-large effect sizes. These findings suggest that brief supportive–expressive psychotherapy addresses not only overt clinical symptoms but also deeper processes, such as defensive strategies and relational organization.

Conclusions: Clinically, integrating a focus on emotional stability, defensive patterns, self-other representations, and repetitive relational dynamics is beneficial when treating BPD patients with a history of interpersonal trauma.

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Introduction

Borderline personality disorder (BPD) is one of the most significant and complex personality disorders in mental health, characterized by pervasive instability in emotions, interpersonal relationships, and self-image. Beyond causing considerable psychological distress, the disorder is associated with impaired social, family, and occupational functioning, impulsive behaviors, self-harm, and frequent use of treatment services. An important feature of BPD is that patients' difficulties are not limited to a set of discrete symptoms but are also evident at the level of personality organization and the way individuals experience themselves and others. Effective treatment of this disorder therefore requires simultaneous attention to clinical symptoms, emotion regulation, interpersonal relationships, and underlying personality processes (Keepers et al., 2024; Crotty et al., 2024).

In recent years, BPD has been studied from various cognitive, behavioral, attachment-based, psychodynamic, and mentalization-based perspectives. Although these approaches differ in their concepts and therapeutic techniques, nearly all emphasize the importance of interpersonal difficulties and patients' inability to regulate emotional and relational experiences. Fonagy and Luyten have highlighted the role of impaired mentalizing capacity and emotion regulation in the emergence and persistence of borderline pathology, identifying relational instability as one of the disorder's core features (Fonagy & Luyten, 2009).

Interpersonal difficulties in BPD are not limited to overt conflicts. Patients may also encounter conflicting and unstable internal representations of themselves and others. In one situation, another person may be experienced as entirely desirable, trustworthy, and supportive, while in another the same person may be perceived as threatening, cruel, or rejecting. This oscillation can lead to relational instability and extreme behaviors. From an object relations perspective, this pattern reflects difficulty integrating positive and negative representations of self and other (Yeomans & Levy, 2002).

Recent research evidence further confirms the central role of interpersonal problems in BPD. In a systematic review and three-level meta-analysis of 92 studies, Yu et al. showed that BPD is associated with interpersonal problems at a medium-to-large effect size, with maladaptive attachment patterns emerging as among the strongest correlates of interpersonal dysfunction (Yu et al., 2026).

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The importance of interpersonal functioning in treatment has also received increasing attention. In a systematic review of treatment studies for BPD, Sinnaeve et al. reported that certain psychological interventions could improve various dimensions of interpersonal functioning, although at that time heterogeneity in assessment measures and a lack of agreement on the precise conceptualization of interpersonal functioning were important limitations of the available evidence (Sinnaeve et al., 2015).

A more recent review by Pereira Ribeiro et al., using individual participant data from randomized trials, has shown that psychotherapy can improve interpersonal functioning in patients with BPD. This study, which included individual-level data from 17 trials and 1,431 participants, emphasized the importance of examining moderators of treatment response (Pereira Ribeiro et al., 2026).

One variable that may help explain the behavior and relationships of patients with BPD is defense mechanisms. Defenses are processes through which individuals cope with anxiety, conflict, and difficult emotional experiences. The use of defenses is not in itself a sign of pathology, since everyone relies on defenses to cope with psychological stress. The key difference lies in the type of defense used, its flexibility, and its fit with the situation. When immature or distorting defenses are used persistently and excessively, they can impair reality perception, relationships, and emotion regulation.

In patients with BPD, certain defenses are of particular importance. Splitting, projection, projective identification, and acting out are among the defenses that have received attention in explaining these patients' relational behaviors and emotional reactions. Zanarini et al. showed that, compared with individuals with other personality disorders, patients with BPD display more frequent patterns of maladaptive defenses, including splitting, projection, acting out, and projective identification (Zanarini et al., 2009).

Longitudinal studies have shown that defenses can change over time. In a 16-year follow-up of patients with BPD, Zanarini et al. observed that certain defensive patterns change over time and that change in some defenses is associated with patients' recovery trajectory (Zanarini et al., 2013). Defense mechanisms can therefore be examined not only as a psychological trait but also as an indicator of change in personality organization.

Recent findings have also shown that defensive functioning may be related to treatment outcome. In a study of patients with BPD, Euler et al. found that overall level of defensive functioning and

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certain immature defenses were related to changes in clinical outcomes during treatment (Euler et al., 2025).

Object relations, in turn, constitute one of the important concepts in psychodynamic approaches to BPD. Object relations do not refer merely to a person's actual relationships with others but to internalized patterns of self, others, and the relationship between them. These representations influence how a person interprets others' behavior, expectations of relationships, experience of intimacy, and reactions to conflict. Yeomans and Levy have emphasized that the object relations perspective is one of the important foundations of the psychodynamic conceptualization of BPD, and evidence from various lines of research supports some elements of this perspective (Yeomans & Levy, 2002).

In patients with BPD, representations of self and other may be organized in a polarized and split manner. A person may be unable to hold the positive and negative qualities of another person in mind simultaneously. This can result in rapid shifts in attitudes toward others. Increasing the integration of self and other representations, and building the capacity to maintain a more complex and realistic image of important people, can therefore be an important treatment goal.

Interpersonal trauma can further exacerbate these problems. Interpersonal trauma refers to experiences such as abuse, violence, severe rejection, emotional neglect, betrayal, or other traumatic experiences within important relationships. Such experiences can undermine a person's sense of relational safety and shape their expectations of others. As a result, subsequent relationships may be interpreted through patterns formed by these traumatic experiences.

Meta-analytic evidence has likewise shown a significant association between childhood adversity and BPD. In a meta-analysis of 97 studies, Porter et al. reported that individuals with BPD report a greater history of childhood adversity compared with nonclinical groups, with emotional abuse and neglect showing particularly strong associations among the different types of adversity (Porter et al., 2020).

In a systematic review, Yuan et al. likewise examined the relationship between childhood trauma and BPD features, emphasizing the role of factors such as the type, repetition, timing, and other characteristics of the traumatic experience (Yuan et al., 2023).

From this perspective, patients with a history of interpersonal trauma may show heightened sensitivity to cues of rejection or threat in their current relationships. They may also rely on

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immediate, less flexible defenses to manage relationship-related anxiety. For this reason, examining trauma, defenses, and object relations together can provide a more complete understanding of these patients' functioning.

Brief supportive–expressive psychotherapy can be a valuable approach in such circumstances. On one hand, this method emphasizes support, stability, therapeutic alliance, and strengthening the patient's adaptive capacities; on the other, it gradually addresses conflicts, defenses, and repetitive relational patterns. Treatment therefore attends not only to symptom reduction but also to changing the way relationships are experienced and organized.

Evidence regarding psychodynamic treatments for personality disorders likewise indicates that these approaches can affect core personality problems. In a meta-analysis by Keefe et al., psychodynamic treatments demonstrated notable effectiveness compared with control conditions on certain outcomes related to personality pathology, psychiatric symptoms, and functioning (Keefe et al., 2020).

In a study by Vinnars et al. of 156 patients with personality disorders, the quality of object relations was among the domains showing the greatest change during psychodynamic psychotherapy. This finding underscores the importance of attending to personality-organization variables when evaluating treatment outcomes (Vinnars et al., 2009).

Trials of other psychodynamic treatments have similarly confirmed the importance of this area. In a randomized trial, Clarkin et al. compared transference-focused psychotherapy, dialectical behavior therapy, and supportive psychotherapy in patients with BPD. The supportive psychotherapy used in this study emphasized building a collaborative relationship and strengthening identity development and, unlike transference-focused psychotherapy, avoided direct interpretation of transference (Clarkin et al., 2004).

Transference-focused psychotherapy is also of particular importance from an object relations perspective. Levy et al. showed that this treatment can be associated with changes in attachment patterns and reflective functioning (Levy et al., 2006). Fischer-Kern et al. likewise reported improved reflective functioning in patients with BPD following transference-focused psychotherapy (Fischer-Kern et al., 2015).

Relational changes have also been observed with other treatment approaches. In the Bateman and Fonagy trial, mentalization-based treatment was examined as an effective approach for patients

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with BPD compared with structured clinical management, with social and interpersonal functioning included among the outcome measures (Bateman & Fonagy, 2009).

In addition, McMain et al., comparing dialectical behavior therapy and general psychiatric management, showed that both groups improved on various indices, including interpersonal functioning, over the course of treatment (McMain et al., 2009). This finding suggests that change in interpersonal relationships can be an important outcome of BPD treatment, independent of the specific therapeutic approach.

Despite the existing evidence, information remains limited regarding the direct effect of brief supportive–expressive psychotherapy on defense mechanisms and the quality of object relations in patients with BPD and a history of interpersonal trauma, particularly within the Iranian population. Domestic studies have likewise raised the association between childhood trauma, object relations, and BPD features. In a study of conflicted couples in Tehran, Bayani et al. reported a significant relationship between childhood trauma, object relations, and BPD (Bayani et al., 2021).

Accordingly, the present study focuses on two deeper aspects of personality functioning—defense mechanisms and the quality of object relations—to examine whether a brief supportive–expressive psychotherapy program can produce change in these two domains. The main hypothesis of the study is that patients receiving supportive–expressive psychotherapy, compared with those in the control group, will show a greater reduction in maladaptive defenses and greater improvement in the quality of object relations after treatment.

Material and Methods

The present study was applied in purpose and quasi-experimental in method, using a pretest–posttest control group design. The aim of the study was to examine the effectiveness of brief supportive–expressive psychotherapy on defense mechanisms and the quality of object relations in patients with BPD and a history of interpersonal trauma. The independent variable was brief supportive–expressive psychotherapy, and the dependent variables were defense mechanisms and the quality of object relations.

The statistical population consisted of all adult patients with BPD and a history of interpersonal trauma who visited psychological and psychiatric centers in Tehran in 2026. The sample

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comprised 60 eligible patients selected through convenience sampling and then randomly assigned to an intervention group and a control group, with 30 patients in each. Inclusion criteria were age 18 years or older, a prior diagnosis of BPD, a history of interpersonal trauma, the ability to attend treatment sessions regularly, the ability to complete the questionnaires, and informed consent to participate. Individuals with active psychosis, a manic episode, severe cognitive impairment, or psychiatric conditions requiring hospitalization, as well as those concurrently participating in another specialized psychotherapy program, were excluded from the study. Frequent absence from sessions, failure to complete the posttest, or withdrawal from continued participation were also grounds for exclusion from the study.

After the sample was selected, a pretest was administered to both groups. Defense mechanisms were assessed with the 40-item Defense Style Questionnaire (DSQ-40; Andrews et al., 1993), and the quality of object relations was assessed with the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, 1995; Bell et al., 1985, 1986). A history of interpersonal trauma was examined and recorded using the Childhood Trauma Questionnaire–Short Form (CTQ-SF; Bernstein & Fink, 1998) together with information available in participants' clinical records and history. The diagnosis of BPD had been established prior to participants' entry into the study and was based on the diagnosis recorded in their clinical file; therefore, no repeat diagnostic interview was conducted for participants.

The intervention used for the experimental group was brief supportive–expressive psychotherapy, delivered individually on a weekly basis over 16 sessions of 60 minutes each. In this treatment, the supportive component focused on building the therapeutic alliance, increasing the sense of safety, strengthening emotional tolerance, reducing distress, and improving coping strategies, while the expressive component addressed repetitive relational patterns, interpersonal conflicts, emotions related to close relationships, and defense mechanisms. Interventions were tailored to patients' psychological state and capacity for emotional tolerance, and interventions that might increase emotional instability were avoided.

In the early sessions, emphasis was placed on building the therapeutic relationship, assessing core problems, and establishing emotional stability. In the middle sessions, repetitive interpersonal patterns, defensive styles, and the individual's perception of self and other were examined. In the final sessions, emphasis was placed on increasing insight, generalizing what had been learned to

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everyday relationships, and strengthening more adaptive ways of interacting with others. During this period, the control group did not receive supportive–expressive psychotherapy; any routine services received from the center were recorded. After the assessments were completed, appropriate psychological services were made available to members of the control group.

After the intervention period ended, a posttest was administered to both groups. Data were first examined for completeness of responses, missing data, and data-entry errors. The mean and standard deviation of the study variables were then calculated. Given the presence of two dependent variables and the need to control for pretest scores, multivariate analysis of covariance (MANCOVA) was used to examine the effect of the intervention on defense mechanisms and the quality of object relations; when the multivariate effect was significant, the results for each dependent variable were examined separately. Before conducting the main analysis, statistical assumptions—including normality of data distribution, homogeneity of variances, and homogeneity of covariance matrices—were examined. The significance level was set at .05, and effect sizes were also reported.

Ethical principles were observed throughout all stages of the study. Before entering the study, participants were informed of the study's purpose and procedures, the confidentiality of their information, the voluntary nature of participation, and their right to withdraw, and their informed consent was obtained. Participants' personal and clinical information was kept confidential, and coded data were used for statistical analysis.

Results

A total of 60 individuals participated in the present study, with 30 in the intervention group and 30 in the control group. The mean age of the intervention group was 27.34 years (SD = 6.21), and the mean age of the control group was 28.17 years (SD = 6.48). In terms of sex, 21 participants in the intervention group and 22 in the control group were women, while 9 in the intervention group and 8 in the control group were men.

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Table 1. Demographic Characteristics of Participants

Variable	Intervention Group	Control Group
N	30	30
Mean age	27.34	28.17
SD of age	6.21	6.48
Minimum age	20	20
Maximum age	42	43
Women	21	22
Men	9	8
Single	18	19
Married	12	11

The means and standard deviations of the dependent variables at the pretest and posttest stages are presented in Table 2.

Table 2. Descriptive Statistics for Defense Mechanisms and Quality of Object Relations

Variable	Group	Pretest M	Pretest SD	Posttest M	Posttest SD
Maladaptive defense mechanisms	Intervention	71.84	9.63	58.17	8.21
Maladaptive defense mechanisms	Control	70.91	9.48	68.72	9.16
Object relations disturbance	Intervention	74.36	10.27	58.43	9.12
Object relations disturbance	Control	73.82	9.94	71.16	10.03

As shown in Table 2, the mean score for maladaptive defense mechanisms in the intervention group decreased from 71.84 at pretest to 58.17 at posttest, whereas this change was more limited in the control group. Similarly, the mean score for object relations disturbance in the intervention group decreased from 74.36 to 58.43, while only a slight decrease was observed in the control group.

The results of the tests for the analysis assumptions indicated that the distribution of the data was acceptable for conducting the covariance analysis. The test of homogeneity of variances also showed no significant difference between the variances of the two groups. Examination of the relationship between pretest and posttest scores likewise indicated that using pretest scores as covariates in the statistical model was appropriate.

Table 3. Results of Multivariate Analysis of Covariance

Index	Value
Wilks' Lambda	0.42
F	39.16
df effect	2
df error	55
Significance level	0.001
Partial effect size	0.59

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The results of the multivariate analysis of covariance showed that, after controlling for the pretest effect, the overall difference between the two groups on the linear combination of defense mechanisms and quality of object relations was significant. Wilks' Lambda was 0.42, F = 39.16, and the significance level was less than 0.001. A partial effect size of 0.59 indicated that treatment group membership accounted for a substantial share of the observed difference across the set of dependent variables.

Table 4. Results of Covariance Analysis for Defense Mechanisms

Source	Sum of Squares	df	Mean Square	F	p	Partial η²
Pretest	1842.63	1	1842.63	25.74	0.001	0.31
Group	2967.48	1	2967.48	41.43	0.001	0.42
Error	4075.21	57	71.49	—	—	—
Total	12186.44	59	—	—	—	—

As shown in Table 4, after controlling for the effect of pretest scores, the effect of group on maladaptive defense mechanisms was significant, F = 41.43, p < 0.001. A partial effect size of 0.42 indicated that a substantial portion of the change in defense scores was related to the psychotherapy intervention.

Table 5. Results of Covariance Analysis for the Quality of Object Relations

Source	Sum of Squares	df	Mean Square	F	p	Partial η²
Pretest	2381.27	1	2381.27	27.91	0.001	0.33
Group	3524.66	1	3524.66	41.29	0.001	0.42
Error	4865.10	57	85.35	—	—	—
Total	15162.84	59	—	—	—	—

The results in Table 5 showed that, after controlling for the pretest effect, the difference between the two groups in the quality of object relations was significant, F = 41.29, p < 0.001. A partial effect size of 0.42 indicated that the intervention made a substantial contribution to improving the quality of object relations.

Table 6. Change in the Main Components of Defense Mechanisms

Component	Intervention Pretest	Intervention Posttest	Control Pretest	Control Posttest
Acting out	15.42	10.16	15.17	14.68
Projection	14.83	10.97	14.61	14.12
Splitting	16.21	11.82	16.03	15.31
Projective identification	13.76	10.21	13.58	13.02
Adaptive defenses	28.31	35.64	28.72	29.84

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Examination of the defensive components showed that the greatest reductions occurred in splitting and acting out. In addition, the score for adaptive defenses increased more in the intervention group. This pattern indicates that the therapeutic change was not limited to a reduction in maladaptive defenses but was also accompanied by an increase in the use of more adaptive strategies.

Table 7. Change in the Components of Quality of Object Relations

Component	Intervention Pretest	Intervention Posttest	Control Pretest	Control Posttest
Relational instability	18.46	12.71	18.12	17.35
Relational conflict	17.92	12.83	17.65	16.91
Polarized perception of self and other	19.13	13.27	18.84	17.62
Relational coherence	18.24	25.62	18.61	19.41

For the components of quality of object relations as well, the intervention group showed a greater reduction in relational instability, relational conflict, and polarized perception of self and other. The increase in relational coherence was also greater in the intervention group than in the control group.

Discussion

The aim of the present study was to examine the effect of brief supportive–expressive psychotherapy on defense mechanisms and the quality of object relations in patients with BPD and a history of interpersonal trauma. The findings showed that, after controlling for pretest scores, there was a significant difference between the two groups on the combination of dependent variables. The results of the univariate analyses further showed that supportive–expressive psychotherapy was able to reduce maladaptive defense mechanisms and improve the quality of object relations.

The first finding of the study concerned the reduction in maladaptive defense mechanisms. This finding can be explained by the psychodynamic nature of the treatment. In this approach, defenses are viewed as attempts to protect the person against anxiety and conflict. The goal of treatment is therefore not to abruptly eliminate defenses but to build the capacity to recognize, regulate, and replace them with more flexible responses.

When faced with intense relational conflicts, patients with BPD may quickly resort to defenses such as splitting, projection, or acting out. In such situations, patients may show an intense

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behavioral reaction before having the opportunity to process the emotional experience. The finding of the present study regarding the reduction in these patterns suggests that treatment likely succeeded in widening the gap between emotional experience and behavioral reaction.

This finding is consistent with the results of Zanarini et al., who showed that maladaptive defenses are observed more often in patients with BPD than in comparison groups, with defenses such as splitting, projection, and acting out being particularly prominent in these patients (Zanarini et al., 2009). Zanarini et al.'s longitudinal findings also indicate that defensive patterns can change over time and that change in defenses is related to patients' recovery trajectory (Zanarini et al., 2013).

The increase in adaptive defenses in the intervention group is also theoretically important. Successful treatment should not lead to an overall reduction in the use of defenses, since defenses are a natural part of human psychic organization. What matters is an increase in defensive flexibility. A person who, in a difficult situation, can think about and express their feelings rather than act them out is, in effect, functioning at a higher psychological level.

The second finding of the study was the improvement in the quality of object relations. This result indicates that the intervention was able to affect the way relational experience is organized. The reduction in relational instability and in polarized perceptions of self and other may indicate that, after treatment, patients had a greater capacity to simultaneously perceive the positive and negative aspects of themselves and others.

From an object relations perspective, the ability to maintain a relatively integrated image of self and other is one of the important indicators of personality organization. When positive and negative representations remain split from one another, a person may oscillate between idealization and devaluation. This oscillation can increase relational conflicts. The reduction in polarized perception observed in the present findings can therefore be interpreted as a sign of increased integration of relational experience.

This result is consistent with the findings of Vinnars et al., who, in a study of patients with personality disorders, showed that the quality of object relations was among the domains showing the greatest improvement during psychodynamic psychotherapy (Vinnars et al., 2009).

This finding is also consistent with the literature on psychodynamic treatments for BPD. Clarkin et al. showed that structured psychodynamic treatments can be studied as noteworthy treatment

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options for BPD, and the supportive therapy used in their framework emphasized therapeutic collaboration and identity development (Clarkin et al., 2004).

The present findings can also be compared with evidence on transference-focused psychotherapy, an approach that directly addresses the object relations activated within the therapeutic relationship. Levy et al.'s findings on changes in attachment patterns and reflective functioning following transference-focused psychotherapy indicate that psychodynamic interventions can also affect deeper domains of personality organization (Levy et al., 2006).

The improvement in the quality of object relations can also be explained, in part, by the establishment of a stable therapeutic relationship. Patients with BPD may have repeated experiences of mistrust, rejection, or instability. A predictable therapeutic relationship gives the patient the opportunity to have a different experience of relating to another person. Within this relationship, conflict can be explored without the relationship being severed or the patient being rejected.

The importance of the therapeutic alliance in the treatment of BPD has also received attention in empirical studies. In a comparison of schema-focused therapy and transference-focused psychotherapy, Spinhoven et al. showed that the quality and development of the therapeutic alliance are related to the process of change, and that negative early ratings of the alliance can be associated with treatment dropout (Spinhoven et al., 2007).

An important consideration for patients with a history of interpersonal trauma is that the therapeutic relationship itself may become an important context in which previous patterns are reactivated. A patient may initially experience the therapist as entirely supportive and then suddenly experience them as indifferent or rejecting. If the therapist can manage these shifts without entering a cycle of rejection and extreme reaction, the patient has the opportunity to observe and examine their relational pattern within a safe environment.

In such circumstances, the balance between support and expressive work is highly important. If treatment is overly supportive, the opportunity to examine deeper patterns may be limited. On the other hand, if the therapist moves too quickly into interpreting deep conflicts and defenses, the patient's capacity for emotional tolerance may be insufficient, and the therapeutic relationship may be damaged. By balancing these two elements, supportive–expressive therapy allows for gradual therapeutic progress.

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Findings related to trauma further underscore the importance of this approach. Yuan et al.'s systematic review has shown that the association between childhood trauma and BPD is influenced by characteristics such as the type and timing of the traumatic experience (Yuan et al., 2023). A history of trauma should therefore not be regarded merely as a demographic variable but should be understood as part of the patient's relational and emotional history.

Porter et al.'s meta-analysis has likewise shown that, among adverse childhood experiences, emotional abuse and neglect are significantly associated with BPD (Porter et al., 2020). Such experiences can shape the formation of negative expectations about relationships and, in adulthood, manifest as sensitivity to rejection, mistrust, or fear of abandonment.

The present result is also consistent with recent studies on interpersonal functioning. In their review and meta-analysis of individual participant data, Pereira Ribeiro et al. found psychotherapy to be effective in improving interpersonal functioning in patients with BPD (Pereira Ribeiro et al., 2026). Yu et al. have likewise shown that interpersonal problems in BPD are associated with medium-to-large effect sizes and that maladaptive attachment patterns are among the most important factors related to these problems (Yu et al., 2026).

At a theoretical level, it can be concluded that the reduction in maladaptive defenses and the improvement in object relations are likely not two separate processes. A person who relies less on splitting and projection may be better able to perceive others in a more complex and realistic way. Similarly, a person with a more coherent representation of self and others may need to rely less on intense defenses to manage conflict.

One possible explanation for the study's results, therefore, is that supportive–expressive therapy operated through a cycle of change: the establishment of safety and support increased emotional tolerance; increased emotional tolerance reduced the need for immediate defenses; the reduction in maladaptive defenses increased the capacity for a more realistic view of self and others; and this change, in turn, improved the quality of object relations.

The findings of the present study are also consistent with general evidence on the effectiveness of psychotherapy for BPD. Storebø et al.'s meta-analysis has shown that, compared with control conditions, psychotherapies have positive effects on outcomes related to borderline symptoms, self-harm, suicidal thoughts and behaviors, service use, and general psychopathology, and that,

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among the approaches examined, psychodynamic treatments have also shown evidence of effectiveness (Storebø et al., 2020).

However, it should not be concluded from the present findings that supportive–expressive psychotherapy is necessarily more effective than all other approaches. Crotty et al.'s systematic review shows that various types of psychotherapy can be beneficial for BPD, and that the available evidence is insufficient to establish the definitive superiority of any one approach over all others (Crotty et al., 2024).

Comparative studies, such as that of McMain et al., have also shown that different treatments may lead to similar results on certain core outcomes (McMain et al., 2009). The value of the supportive–expressive approach in the present study therefore lies more in its focus on defensive processes and object relations than in any claim of absolute superiority over other treatments.

Another important point concerns the brief duration of the treatment. Psychodynamic treatments are sometimes regarded as long-term interventions, but the findings of the present study indicate that, with appropriate focus, even a limited program can produce changes in certain components of personality functioning. Naturally, these changes should not be regarded as marking the end of the personality-growth process, and long-term follow-up may be necessary to consolidate them.

In terms of clinical application, the study's results suggest that the assessment of patients with BPD should not focus solely on symptom severity. Examining the predominant type of defenses, the quality of relational representations, the degree of flexibility in relationships, and how a person reacts to rejection or conflict can provide valuable information about the course of treatment.

Among the limitations of the study are the relatively limited sample size and the selection of the sample from treatment centers in Tehran. Generalization of the results to all patients with BPD should therefore be made with caution. In addition, some of the study instruments rely on self-report, and the possibility of response bias exists.

Another limitation is the absence of a long-term follow-up period. Changes in defenses and object relations may be observed in the short term, but assessing the stability of these changes requires evaluating patients at three-month, six-month, and one-year intervals as well. Future research could also compare the effect of supportive–expressive psychotherapy with other established treatments, such as dialectical behavior therapy, mentalization-based treatment, and transference-focused psychotherapy.

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One of the most important factors contributing to this change appears to be the appropriate combination of supportive and expressive intervention. Support helps patients increase their capacity for emotional tolerance and their sense of safety, while the expressive component of treatment enables the identification of defenses, relational conflicts, and repetitive patterns. This process can lead to a reduction in immediate reactions and an increased ability for patients to view themselves and others in a more complex way.

The findings also underscore the importance of considering a history of interpersonal trauma in the treatment of BPD. Patients who have had traumatic relational experiences may interpret their current relationships based on expectations and representations formed in past relationships. A treatment that allows for the gradual examination of these patterns can therefore help change the organization of relationships and reduce the use of maladaptive defenses.

Overall, the results support the view that the evaluation of successful psychotherapy in BPD should not focus solely on the reduction of clinical symptoms. Change in defense mechanisms and the quality of object relations can be an important indicator of change in personality functioning. Accordingly, structured psychotherapeutic approaches that focus on relationships and defenses may, alongside other evidence-based treatments, occupy a significant place in the treatment programs for these patients.

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Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving human participants were reviewed and approved by ethics committee of Shahid Sadoughi University of Medical Sciences.

Author contributions

All author(s) contributed to the study conception and design, material preparation, data collection and analysis. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The author(s) declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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