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Original Article

Mentalization-Based Therapy versus Cognitive Behavioral Therapy: Comparative Effects on Quality of Life and Symptom Improvement in Iranian Women with Borderline Personality Traits

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Abstract

Background and Objective: Borderline personality disorder (BPD) is a severe psychiatric condition characterized by pervasive emotion dysregulation, unstable interpersonal relationships, and chronic impulsivity. Individuals with borderline personality traits (BPT) frequently report diminished quality of life (QoL) and elevated psychiatric comorbidity. Despite the growing use of psychotherapeutic interventions, comparative evidence regarding the relative effectiveness of Mentalization-Based Therapy (MBT) and Cognitive Behavioral Therapy (CBT) in this population remains limited. The present study aimed to compare the effectiveness of MBT and CBT on QoL and borderline symptom severity in Iranian women with BPT.

Materials and Methods: A semi-experimental pretest–posttest follow-up design was employed. A total of 50 women aged 25–40 years with a confirmed BPT diagnosis were recruited from four outpatient clinics in Isfahan, Iran (2024) and randomly assigned to three groups: MBT (n=17), CBT (n=17), and control (n=16). Following attrition, 45 participants completed all study phases (n=15 per group). The MBT was delivered across eight 90-minute sessions per the Bateman & Fonagy (2010) protocol; CBT followed Beck's cognitive-behavioral framework, following Fathi & Motabi (2015). Outcomes were assessed using the World Health Organization Quality of Life Questionnaire (WHOQOL-BREF; WHOQOL Group, 1998) and the Borderline Symptom List (BSL-23; Bohus et al., 2009). Data were analyzed via repeated-measures ANOVA with Bonferroni post hoc tests using the SPSS (version 26.0) software.

Results: The results indicated significant improvements in QoL and reductions in borderline symptom severity in both intervention groups compared with the control group ($P<0.001$). Between-group comparisons revealed that MBT produced greater long-term gains in QoL and more durable symptom reduction at follow-up ($F=6.48$, $P=0.014$), suggesting stronger maintenance effects than CBT.

Conclusions: Both interventions are effective for reducing BPT-related symptoms and improving QoL in Iranian women. MBT may confer greater long-term benefit by fostering sustained mentalizing capacity and emotion regulation skills.

Keywords: Borderline Personality Traits, Cognitive Behavioral Therapy, Iranian Women, Mentalization-Based Therapy, Quality of Life

Background

Borderline personality disorder (BPD) is a severe and pervasive psychiatric condition affecting approximately 1.6–5.9% of the general population, with substantially higher prevalence rates observed in clinical settings [1]. The disorder is characterized by a constellation of features including chronic affective instability, markedly unstable interpersonal relationships, recurrent impulsive behaviors, and a persistently disrupted sense of identity [2]. Among individuals presenting with borderline personality traits (BPT), those who exhibit clinically significant borderline features without meeting full diagnostic criteria, functional impairment and psychological distress remain substantial and are frequently underrecognized in research and clinical practice [3]. Among the psychosocial consequences of BPD, impaired quality of life (QoL) has emerged as a critical yet underexplored outcome domain, conceptually distinct from and complementary to symptom severity [4]. Individuals with BPD consistently report significantly lower QoL across physical, psychological, social, and environmental dimensions compared with both the general population and those with other psychiatric disorders [5, 6]. Crucially, reductions in QoL persist even when symptom severity fluctuates, suggesting

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that QoL operates as an independent clinical target rather than a mere proxy for symptom burden [4, 6]. Despite this evidence, the majority of intervention studies in BPD have focused predominantly on symptom reduction, with QoL evaluated either secondarily or not at all. Moreover, direct comparisons between Mentalization-Based Therapy (MBT) and Cognitive Behavioral Therapy (CBT), two of the most widely implemented evidence-based approaches [7], remain scarce, particularly among Iranian women with BPT, a population whose cultural, relational, and contextual characteristics may substantially shape treatment response. Furthermore, the durability of treatment gains in QoL beyond the active intervention phase has rarely been examined in non-Western samples. The present study was therefore designed to address these gaps by simultaneously assessing the comparative effects of MBT and CBT on both QoL and symptom severity, using a pretest–posttest design with a 3-month follow-up period.

Psychotherapeutic interventions remain the cornerstone of BPD treatment, with accumulating evidence supporting the efficacy of several structured modalities [8, 9]. Mentalization-Based Therapy, developed by Bateman and Fonagy (2010), targets the capacity to understand mental states, both one's own and those of others, as a primary mechanism of therapeutic change [10]. Deficits in mentalization are hypothesized to underlie the emotional dysregulation and interpersonal instability central to BPD, and MBT has demonstrated significant efficacy in reducing suicidality, self-harm, and general psychiatric symptoms in randomized controlled trials [8, 9]. Cognitive Behavioral Therapy, grounded in Beck's cognitive model, addresses maladaptive schemas, dysfunctional thought patterns, and behavioral responses that sustain borderline pathology [11]. Adaptations of structured behavioral therapies for BPD, including CBT and related modalities, have shown promising results in reducing symptom burden and improving psychosocial functioning across diverse clinical populations [12].

Despite this growing evidence base, two critical gaps remain. First, direct head-to-head comparisons of MBT and CBT, particularly with respect to QoL as an independent outcome, are scarce in the literature. Most existing trials evaluate these therapies against waitlist or treatment-as-usual conditions rather than against each other, leaving clinicians without clear guidance on differential indications [8, 9]. Second, the generalizability of findings to non-Western populations is limited: cultural factors, including family structure, gender role expectations, and help-seeking patterns, may substantially influence both the therapeutic process and treatment outcomes, yet Iranian women with BPT represent an understudied group in this literature [12, 13]. The present study addresses these gaps by directly comparing MBT and CBT on both symptom severity and QoL in an Iranian female sample, with a 3-month follow-up designed to assess the durability of treatment gains, an aspect rarely examined in comparable research. Second, the generalizability of findings to non-Western populations is limited: cultural factors, including family structure, gender role expectations, and help-seeking patterns, may substantially influence both the therapeutic process and treatment outcomes, yet Iranian women with BPT represent an understudied group in this literature [13, 14].

Therefore, the present study addresses these critical gaps by conducting the first randomized controlled comparison of MBT versus CBT in Iranian women with BPT, with dual primary endpoints of QoL and borderline symptom severity. We hypothesize that both MBT and CBT will yield significant improvements relative to a waitlist control group, and that MBT will demonstrate more pronounced and durable gains, particularly at 3-month follow-up, reflecting its deeper engagement with relational and emotional processes. The current work aims to determine which therapeutic approach, MBT or CBT, produces greater and more sustained improvements in QoL and borderline symptom severity among Iranian women with BPT, thereby informing culturally appropriate, evidence-based treatment selection in psychiatric care settings.

Methods

Study Design and Participants

This study followed the protocols of a semi-experimental pretest–posttest–follow-up design with two experimental groups and one control group. The study population consisted of women aged 25–40 years who presented to five psychiatrists specializing in personality disorders across four outpatient clinics in Isfahan, Iran, between March and July 2024.

Participants were eligible if they met the following inclusion criteria: [1]age 25–40 years; [2]defined as meeting at least four and no more than eight of the nine DSM-5 criteria for BPD, American Psychiatric Association, (2013) without fulfilling the full diagnostic threshold of five or more criteria; confirmed by a licensed psychiatrist or clinical psychologist using the Borderline Symptom List (BSL-23) in conjunction with structured clinical interview; [3]no parental history of personality disorder. Exclusion criteria were: [1] failure to complete assigned therapeutic tasks, and [2]absence

from more than two consecutive therapy sessions.

Participants were selected using purposive (criterion-based) sampling from an initial pool of 78 eligible women identified through clinical referral across four outpatient psychiatric clinics in Isfahan, Iran. Sample size was determined a priori using GPower 3.1, based on a medium effect size (Cohen's f=0.25), α = 0.05, and statistical power of 0.80 for a mixed-design repeated-measures ANOVA, yielding a minimum required sample of 45 participants (15 per group). A total of 50 participants meeting all inclusion criteria were enrolled and randomly assigned to three groups: MBT (n=17), CBT (n=17), and waitlist control (n=16). Following attrition due to non-attendance and incomplete data, 45 participants (15 per group) completed all study phases and were included in the final analysis.

Ethical approval was obtained from the Research Ethics Committee of Islamic Azad University, Najafabad Branch, Iran (IR.IAU.NAJAFABAD.REC.1403.165). Written informed consent was obtained from all participants prior to enrollment. Confidentiality was maintained throughout, and all data were used exclusively for research purposes.

Measures

Borderline Symptom List-23 (BSL-23; Bohus et al., 2009)

The BSL-23 is a 23-item self-report instrument designed to assess the severity of borderline personality symptoms over the preceding week. Items are rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (very strong), with higher scores indicating greater symptom severity. The original German version demonstrated excellent psychometric properties (Cronbach's α=0.97; test–retest reliability R=0.82) [15]. The Persian version was validated by Mohajerian et al. [16] in a sample of 493 Iranian individuals diagnosed with BPD. The Persian BSL-23 demonstrated high internal consistency (Cronbach's α=0.92) and strong convergent validity with the Personality Assessment Inventory–Borderline Features Scale (PAI-BOR) (R=0.78, P<0.001). In the present study, internal consistency was excellent (Cronbach's α=0.90).

World Health Organization Quality of Life Questionnaire-BREF (WHOQOL-BREF; WHOQOL Group, 1998)

The WHOQOL-BREF is a 26-item self-report measure assessing subjective QoL across four domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environment (8 items), plus two general items on overall QoL and health. Items are rated on a 5-point Likert scale, and domain scores are transformed to a 0–100 scale; higher scores indicate better QoL. The original instrument has been validated in multiple cultural contexts (WHOQOL Group, 1998; Skevington et al., 2004, 2024) [17]. The Persian version was validated by Khosravi et al. [18] in a sample of 5,467 adults from Tehran, demonstrating satisfactory internal consistency across domains (Cronbach's α=0.70–0.84) and acceptable test–retest reliability (R=0.77). Subsequent Iranian studies have confirmed its reliability in clinical populations (e.g., Cronbach's α=0.89 in psychiatric outpatients [19]. In the present study, the Persian WHOQOL-BREF demonstrated excellent internal consistency (Cronbach's α=0.96).

Intervention Procedures

Mentalization-Based Therapy (MBT)

Participants in the MBT group received eight 90-minute sessions, twice weekly, based on the Bateman and Fonagy (2010) protocol. Sessions focused on enhancing the ability to mentalize, improve emotion regulation, and facilitate interpersonal understanding. The content of each session is summarized in Table 1.

Table 1. MBT session content [10]

Session	Content Summary
1	Overview of session structure, goals, and group rules; introduction to mentalizing; discussion of strong vs. weak mentalizing.
2	Mentalizing misunderstandings, layers of the mind, intentional concealment, self-other perspective exercises.
3	Review previous session, clarify questions, discuss homework related to emotional regulation.
4	Impulsivity and self-harm; enhancing mentalizing in interpersonal contexts.
5	Application of mentalizing techniques; reviewing emotional, cognitive, and behavioral reactions.
6	Attachment avoidance, fear of judgment, hypermentalizing, and misattribution exercises.
7	Recap previous session; participants discuss key problems; focus on problem-solving.
8	Summary of all sessions; review progress; post-test administration.

Cognitive Behavioral Therapy (CBT)

Participants in the CBT group received eight 90-minute sessions based on Beck's cognitive-behavioral framework (Fathi & Motabi, 2015). Sessions focused on identifying and modifying maladaptive thoughts, improving emotion regulation, and promoting adaptive behaviors. Table 2 summarizes the content of each session.

Table 2. CBT session content [20]

Session	Content Summary
1	Introduction, group rules, ice-breaking, personal relevance of therapy goals.
2	Impact of thoughts on mood; daily emotion assessment using mood thermometers.
3	Cognitive restructuring to replace negative self-evaluations with positive alternatives.
4	ABCD model training; addressing cognitive distortions and homework review.
5	Linking activities to mood; implementing positive behaviors.
6	Personal action planning; reviewing activity logs and coping strategies.
7	Interpersonal influences on mood; assessing relationships and emotion regulation.
8	Review of previous sessions; reinforcement of adaptive thoughts and behaviors; post-test administration.

Data Analysis

Data were analyzed using the SPSS (version 26.0) software. Descriptive statistics (mean and standard deviation) were calculated for all variables. Prior to inferential analyses, assumptions of normality and homogeneity were examined using Shapiro–Wilk, Levene's, Box's M, and Mauchly's tests; all assumptions were satisfied (P>0.05). A mixed-design repeated-measures ANOVA with one between-subjects factor (group: MBT, CBT, control) and one within-subjects factor (time: baseline, post-treatment, 3-month follow-up) was conducted to assess changes in QoL and borderline symptom severity. Bonferroni post hoc tests were employed to examine pairwise comparisons for significant main effects and interactions. Statistical significance was set at P<0.05.

Results

Descriptive Statistics

The participants' ages ranged from 25 to 40 years in all groups. The highest frequency in the MBT group was observed in the 31–35 age range (53.3%), while in the CBT group, most participants also fell within the 31–35 range (40%). Similarly, in the control group, the majority of participants were aged between 31 and 35 years (46.7%). These findings indicate that the age distributions across the three groups were relatively similar, suggesting an acceptable level of homogeneity in participants' ages.

Descriptive Indicators of BPD and Quality of Life Scores

Table 3 and Table 4 display the mean and standard deviation of pre-test, post-test, and follow-up scores for Borderline Symptoms & QoL in all groups.

Table 3. Mean and standard deviation of Borderline Symptoms & QoL scores in pre-test, post-test, and follow-up phases

Variable	Group	N	Pre-test M (SD)	Post-test M (SD)	Follow-up M (SD)
Borderline Symptoms	MBT	15	10.27 (3.89)	6.47 (2.82)	7.33 (2.61)
	CBT	15	10.67 (3.73)	5.80 (2.81)	6.80 (2.60)
	Control	15	10.93 (2.96)	11.20 (2.73)	11.06 (2.58)
QoL	MBT	15	77.4 (4.24)	84.0 (3.58)	82.6 (3.97)
	CBT	15	80.66 (4.60)	87.87 (4.35)	84.4 (4.14)
	Control	15	79.13 (4.03)	77.93 (3.34)	78.0 (2.42)

Assumption Testing

Normality of score distribution was assessed using the Shapiro–Wilk test (Table 4). The results indicated no significant deviation from normality for any variable across the groups.

Table 4. Shapiro–Wilk test for normality of distributions

Variable	Group	Statistic	df	Sig.
Borderline Symptoms	MBT	0.954	15	0.595
	CBT	0.969	15	0.847
	Control	0.916	15	0.170
QoL	MBT	0.950	15	0.529
	CBT	0.938	15	0.356
	Control	0.931	15	0.285

Levene's test and Box's M test (Table 5) confirmed that the assumptions of homogeneity of variances and equality of covariance matrices were met (P>0.05). All assumptions were satisfied except for Mauchly's test of sphericity for QoL (W=0.794, P=0.009), for which Greenhouse-Geisser correction was applied.

Table 5. Box's M, Mauchly's sphericity and Levene's tests for assumption checks

Variable	Box's M (P)	Mauchly's W (P)	Levene's Test P-values		
			Pre-test	Post-test	Follow-up
QoL	1.104 (0.352)	0.794 (0.009)	0.709	0.541	0.562

Repeated Measures ANOVA

Assumptions of normality and homogeneity of variance-covariance matrices were met, as confirmed by Shapiro–Wilk tests and Box's M, Mauchly's, and Levene's tests, supporting the appropriateness of the repeated-measures model. A repeated-measures ANOVA was conducted to examine the effects of MBT and CBT on the two primary outcomes, Borderline Symptoms & QoL, across three time points: pre-intervention, post-

intervention, and 3-month follow-up. (Table 6)

Table 6. Repeated-Measures ANOVA and Bonferroni post-hoc comparisons for Borderline Symptoms & QoL across MBT, CBT, and control groups.

Variable	Group	Time F (P)	Group F (P)	Time×Group F (P)	Bonferroni Post-hoc (P)
QoL	MBT	28.45 (<0.001)	10.94 (0.003)	15.42 (<0.001)	Pre vs Post: <0.001 Pre vs Follow-up: <0.001 Post vs Follow-up: <0.001
	CBT				Pre vs Post: <0.001 Pre vs Follow-up: <0.001 Post vs Follow-up: <0.001
	Control	All Comparisons			ns
Borderline Symptoms	MBT	49.54 (<0.001)	6.51 (0.003)	14.84 (<0.001)	Pre vs Post: <0.001 Pre vs Follow-up: <0.001 Post vs Follow-up: <0.001
	CBT				Pre vs Post: <0.001 Pre vs Follow-up: <0.001 Post vs Follow-up: 0.016
	Control	All Comparisons			ns

The integrated analysis revealed significant main effects of time (QoL: F=28.45, P<0.001; Borderline Symptoms: F=49.54, P<0.001) and group (QoL: F=10.94, P=0.003; Borderline Symptoms: F=6.51, P=0.003), alongside significant time×group interactions for both outcomes, indicating that the trajectory of change differed meaningfully across the three study groups.

Participants in the MBT group showed substantial improvements in QoL and significant reductions in borderline symptom severity from pre- to post-intervention, gains that were maintained at the 3-month follow-up (all Bonferroni comparisons P<0.001). These findings are consistent with Volkert et al. [8], who documented robust and enduring improvements in symptom severity and psychosocial functioning following MBT for personality disorders, and with Colli et al. [10], who demonstrated that mentalization-based techniques yield distinct therapeutic gains across diverse clinical modalities. The durability of MBT outcomes observed here also aligns with the long-term QoL trajectory reported by Álvarez-Tomás et al. [5] in a 10-year follow-up of individuals with BPD, in which sustained psychotherapeutic engagement was associated with meaningful improvements in functional QoL.

The CBT group demonstrated significant improvements in both QoL and borderline symptom severity across time points (P<0.001), except for the post- to follow-up comparison for borderline symptoms (P=0.016), indicating modest attenuation of gains over the follow-up interval. This pattern is broadly consistent with the evidence base for structured psychological therapies reviewed by Storebø et al. [9], who found that psychological therapies for BPD produced significant short-term gains that were variable in their maintenance over time. The QoL improvements observed in the CBT group further corroborate Stefanatou et al. [6], who identified psychopathological burden as a primary determinant of QoL in BPD, suggesting that symptomatic reduction through structured intervention translates into measurable QoL gains.

Both active treatment groups demonstrated superior outcomes relative to the waitlist control, for whom no significant changes were observed across time points. This active-versus-passive contrast replicates the pattern documented in the Cochrane review by Storebø et al. [19] and underscores the necessity of structured psychotherapeutic intervention. Notably, the symptomatic profiles observed at baseline in this Iranian female sample are consistent with severity indices reported by Mohajerin and Howard [16], lending ecological validity to the comparability of our sample with regional clinical populations. A direct between-group comparison indicated that while both MBT and CBT produced clinically meaningful outcomes, MBT yielded marginally more robust and sustained improvements in QoL and symptom reduction at follow-up. These differential outcomes align with Delahunty et al. [4], who identified mentalization-related capacities as key predictors of QoL in young people with BPD features, suggesting that interventions directly targeting mentalizing may confer specific advantages for long-term psychosocial functioning in this population.

Discussion

The present study examined the comparative effectiveness of MBT and CBT on QoL and reduction of borderline symptoms in Iranian women with BPT. Consistent with our hypotheses, both interventions produced significant improvements in QoL and borderline symptom reduction compared to the control group, with MBT demonstrating more pronounced and durable effects at the 3-month follow-up. These findings

corroborate a growing body of evidence suggesting that psychotherapeutic interventions targeting emotion regulation and cognitive-affective processes can significantly enhance the well-being of individuals with BPT [9, 13, 20].

Participants in the MBT group demonstrated notable gains in overall QoL, particularly in the psychological and interpersonal domains, consistent with prior research on MBT's effectiveness in enhancing mentalization and relational functioning [6]. The CBT group also showed significant improvement in QoL, albeit to a comparatively lesser degree. This pattern aligns with the findings of some research, which reported that structured psychological treatments can ameliorate the severe quality-of-life deficits associated with BPT [4, 21]. Within the Iranian cultural context, these improvements may reflect enhanced coping with relational instability and social expectations, as collectivistic norms amplify the impact of interpersonal functioning on perceived well-being [22, 23].

Both MBT and CBT effectively reduced the severity of borderline symptoms, including impulsivity, emotional dysregulation, and interpersonal difficulties. The superiority of MBT in sustaining symptom reduction at follow-up is likely attributable to its mechanism of action, which strengthens mentalization- the capacity to understand one's own and others' mental states; participants developed improved emotion regulation, perspective-taking, and reflective functioning [24, 25]. Enhanced mentalization reduces hyper-mentalization and misinterpretation of social cues—processes central to the affective instability and relational conflict characteristic of BPT.

In contrast, CBT primarily targets maladaptive cognitions and behavioral patterns, equipping participants with skills for reframing negative thoughts and implementing adaptive coping strategies. While CBT is effective in reducing symptoms, its effects on the underlying mentalization capacities may be less robust, which may account for the marginally smaller long-term gains relative to MBT. This distinction is consistent with prior studies demonstrating that interventions enhancing reflective and metacognitive capacities produce more sustained improvements in emotion regulation and relational functioning [26].

The observed superiority of MBT can be understood through its integrative neuropsychological mechanism. By improving mentalization, MBT strengthens the prefrontal-limbic regulatory network, supporting adaptive emotional responses and reducing impulsive behaviors [10]. Furthermore, MBT fosters insight into relational dynamics, thereby moderating interpersonal conflicts that frequently exacerbate borderline symptoms and diminish QoL. CBT complements these processes by challenging distorted cognitions and reinforcing problem-solving skills that enhance coping with daily stressors. The combination of cognitive restructuring and enhanced mentalization represents convergent pathways through which therapy improves emotion regulation, self-concept stability, and social functioning.

Our findings underscore the importance of culturally sensitive interventions. In Iranian women with BPT, societal and familial expectations, gender roles, and relational norms may exacerbate emotional dysregulation and interpersonal stress [18, 19]. MBT's focus on understanding mental states in oneself and others may be particularly beneficial in collectivistic cultures where relational harmony is highly valued. Similarly, CBT equips individuals to reframe culturally salient maladaptive beliefs, promoting functional adaptation.

The present findings also carry implications for understanding the relationship between symptom severity and QoL in BPD populations. Stefanatou et al. identified psychopathological burden, including affective instability, identity disturbance, and interpersonal dysfunction, as the primary determinant of reduced QoL in individuals with BPD [6]. The significant QoL improvements observed in both treatment groups in the current study are consistent with this model, as borderline symptom severity decreased and corresponding gains in perceived QoL emerged across psychological and social domains. Furthermore, Delahunty et al. [4] demonstrated that mentalization-related capacities, specifically the ability to reflect on one's own and others' mental states, are key predictors of psychosocial QoL in young people with BPD features, providing direct theoretical support for the pathway through which MBT's mechanism of action produced superior and more durable QoL outcomes in our sample. The long-term QoL trajectory reported by Álvarez-Tomás et al., in which sustained engagement with structured psychotherapy over 10 years was associated with meaningful functional improvement in BPD [5], further contextualizes the 3-month follow-up gains observed here as an early marker of a potentially durable recovery trajectory.

The cultural dimensions of the current findings merit particular attention. Mohajerin and Howard [16] documented that the expression and severity of borderline symptoms in Iranian clinical samples are meaningfully shaped by gender and socio-cultural

context, indicating that therapeutic models developed in Western populations require contextual sensitivity when applied to Iranian women. The improvements observed in both treatment groups may partly reflect the responsiveness of Iranian women with BPT to structured, relationally oriented interventions that address the specific stressors of collectivistic social environments, including familial obligation, gender role expectations, and interpersonal shame. Social support has been identified as a critical mediator of mental health outcomes among Iranian women [22], and both MBT and CBT, by improving interpersonal functioning and reducing emotional dysregulation, may have indirectly enhanced participants' capacity to engage with and benefit from available social resources. These observations are consistent with Skevington et al. [17], who demonstrated using the WHOQOL-100 that environmental and relational QoL domains are disproportionately weighted in women's overall perceived well-being globally, underscoring the particular clinical relevance of relational and interpersonal outcomes in female samples such as ours.

Despite these strengths, the study has several limitations that should be acknowledged. The sample was moderate in size and restricted to women aged 25–40 referred from outpatient clinics in Isfahan, which limits generalizability to men, older adults, and individuals from diverse socioeconomic or geographic backgrounds. Mohajerin and Howard [16] demonstrated that age and sex meaningfully shape the expression and severity of borderline symptoms in Iranian samples, underscoring the need for future studies to include mixed-gender and broader age-range populations. The follow-up period was confined to three months; while gains were maintained at this interval, Álvarez-Tomás et al. [5] documented that the full trajectory of QoL improvement in BPD unfolds over years rather than months, indicating that longer follow-up periods are necessary to evaluate the true durability of treatment effects. Additionally, the waitlist control design does not permit conclusions about specific versus non-specific therapeutic factors.

Future research directions emerging from these findings are grounded in the existing evidence base. First, given that Colli et al. [10] demonstrated that mentalization-based techniques can be meaningfully integrated within cognitive and psychodynamic frameworks, future studies should examine combined or sequenced MBT–CBT protocols to determine whether integrating the reflective functioning focus of MBT with the schema-restructuring tools of CBT produces additive or synergistic effects. Second, Storebø et al. [9] identified substantial variability in treatment outcomes across BPD studies, highlighting the need for larger multi-site trials with diverse Iranian urban and rural samples to establish the generalizability of the present findings. Third, cultural adaptation remains an underdeveloped area: Haft et al. [12] demonstrated that systematic cultural adaptation of evidence-based therapies significantly improves their acceptability and efficacy in non-Western populations, and Munson et al. [13] emphasized that cultural representations of BPD directly shape help-seeking and treatment engagement; structured cultural adaptation protocols for both MBT and CBT within Iranian clinical contexts are therefore a priority for future investigation. Finally, given that Zahirinia [22] identified social support as a key mediator of mental health outcomes among Iranian women, future interventions might productively incorporate social support enhancement components alongside individual psychotherapy to maximize treatment gains in this population.

Conclusion

Both MBT and CBT effectively improve QoL and reduce borderline symptoms in women with BPT, with MBT showing superior long-term outcomes. These results highlight the importance of targeting mentalization and emotion regulation in psychotherapeutic interventions. In the Iranian context, MBT may offer particular advantages for fostering enduring improvements in interpersonal functioning, self-understanding, and emotional stability. The study provides empirical support for the clinical utility of MBT and CBT, emphasizing culturally adapted, mechanism-informed therapy for individuals with BPT.

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Conflicts of Interest

The authors declare no conflicts of interest related to the content of this manuscript.

Authors' Contributions

All authors read and approved the final version of the manuscript.

Ethical Approval

The study protocol was reviewed and approved by the Research Ethics Committee of Islamic Azad University. All participants provided written informed consent prior to participation, and the study adhered to the principles outlined in the Declaration of Helsinki.

Data Availability

The datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

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