

Effectiveness of Short-Term Psychodynamic Psychotherapy on Defense Styles, Alexithymia, and Parent–Child Relationship Quality in Adolescents with Emotional and Behavioral Problems

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Article Info

Article type:

Original Research

Section:

Family and Couple Therapy

How to cite this article:

Hosseini Taghiabadi, F. (2027). Effectiveness of Short-Term Psychodynamic Psychotherapy on Defense Styles, Alexithymia, and Parent–Child Relationship Quality in Adolescents with Emotional and Behavioral Problems. *KMAN Counseling & Psychology Nexus*, 5, 1-16.
<http://doi.org/10.61838/kman.psynexus.6441>



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ABSTRACT

This study aimed to determine the effectiveness of short-term psychodynamic psychotherapy in improving defense styles, reducing alexithymia, and enhancing parent–child relationship quality among adolescents with emotional and behavioral problems. This randomized controlled trial was conducted in 2026 among 40 adolescents aged 13–17 years referred to the Child and Adolescent Psychiatry Clinic of the Tehran Psychiatric Institute, Iran University of Medical Sciences. After eligibility screening, participants were randomly assigned in equal numbers to short-term psychodynamic psychotherapy and wait-list control groups. The intervention group received 16 weekly individual psychotherapy sessions, each lasting approximately 50 minutes, while the control group remained on a waiting list. Assessments were conducted at pretest, posttest, and eight-week follow-up. Data were collected using the Defense Style Questionnaire-40, Toronto Alexithymia Scale-20, and Child–Parent Relationship Scale. Mixed repeated-measures analysis of variance was used to evaluate Group $\times$ Time interaction effects across the three assessment points. Significant Group $\times$ Time interaction effects were observed for mature defense style, $F(2, 76) = 38.21, p < .001, \eta^2 = .501$; neurotic defense style, $F(2, 76) = 10.01, p < .001, \eta^2 = .209$; immature defense style, $F(2, 76) = 30.60, p < .001, \eta^2 = .446$; alexithymia, $F(2, 76) = 36.64, p < .001, \eta^2 = .491$; and parent–child relationship quality, $F(2, 76) = 34.14, p < .001, \eta^2 = .473$. Secondary analyses also showed significant improvements in closeness, conflict, and dependence dimensions of the parent–child relationship. Most treatment gains were maintained at the eight-week follow-up. Short-term psychodynamic psychotherapy was effective in promoting more adaptive defense functioning, reducing alexithymia, and improving parent–child relationship quality among adolescents with emotional and behavioral problems, with most improvements persisting beyond the active treatment period.

Keywords: Short-Term Psychodynamic Psychotherapy; Defense Styles; Alexithymia; Parent–Child Relationship; Adolescents; Emotional and Behavioral Problems

1. Introduction

Adolescence is a developmentally sensitive period marked by rapid biological, cognitive, emotional, and interpersonal change, during which patterns of affect regulation, self-concept, autonomy, and relationship functioning undergo substantial reorganization. These developmental tasks can create heightened vulnerability to emotional and behavioral difficulties when adolescents lack sufficient psychological resources to process internal conflicts, regulate affective arousal, and negotiate changing expectations within family, peer, and school contexts. Emotional problems may manifest through anxiety, sadness, withdrawal, irritability, somatic complaints, or dysregulated affect, whereas behavioral problems can involve aggression, impulsivity, oppositionality, rule-breaking behavior, interpersonal conflict, or other forms of externalizing expression. Although such manifestations are often treated as distinct symptom clusters, they may reflect shared underlying difficulties in emotional processing, defensive functioning, and relationship regulation. Standardized assessment of adolescent emotional and behavioral problems therefore requires attention not only to overt symptoms but also to the broader psychological processes through which distress is experienced and expressed. In Iranian adolescents, the Youth Self-Report has demonstrated acceptable factorial validity, reliability, and clinical utility for identifying internalizing, externalizing, and total behavioral-emotional difficulties, supporting its usefulness for research involving clinically elevated adolescent problems (Habibi Asgarabad et al., 2009). However, symptom identification alone does not clarify why some adolescents respond to emotional strain through withdrawal or somatization whereas others rely on aggression, acting out, denial, projection, or unstable interpersonal behavior. From a psychodynamic perspective, these variations can be understood partly through the organization of defense mechanisms, the capacity to identify and symbolize emotional experience, and the quality of formative interpersonal relationships, particularly the relationship with parents.

Defense mechanisms are automatic or partly unconscious psychological operations that regulate conflict, anxiety, affective tension, and threats to self-esteem by modifying the way internal and external realities are experienced. They are not inherently pathological; rather, their adaptive value depends on their flexibility, developmental appropriateness, and the extent to which they facilitate or obstruct realistic

engagement with emotional experience. Mature defenses such as sublimation, humor, anticipation, and suppression generally permit affect to be managed without major distortion of reality, whereas immature defenses such as projection, denial, acting out, splitting, passive aggression, devaluation, and dissociation may provide short-term protection at the cost of impaired emotional awareness, interpersonal instability, or symptomatic expression. Neurotic defenses occupy an intermediate position and may reduce distress while still constraining direct emotional processing. Empirical research has long demonstrated systematic associations between defense style and psychopathology, with less adaptive defense profiles generally corresponding to greater psychological symptom burden and poorer functioning (Bond, 2004). More recent multinational evidence has reinforced this relationship by showing that defense mechanisms are meaningfully associated with mental health symptoms across culturally diverse samples, suggesting that defensive functioning is not merely a theoretical psychodynamic construct but an empirically relevant transdiagnostic process (Bekes et al., 2023). Within Iranian clinical populations, the Persian Defense Style Questionnaire-40 has also differentiated psychiatric patients from nonclinical controls and has provided support for the assessment of mature, neurotic, and immature defense styles in Persian-speaking samples (Shabanpour et al., 2012). These findings are particularly relevant to adolescents with emotional and behavioral problems because maladaptive defensive strategies may contribute to both internalizing and externalizing manifestations by restricting awareness of underlying emotions, distorting interpersonal perceptions, and shifting psychological conflict into behavioral or somatic channels.

A second process closely related to emotional-behavioral disturbance is alexithymia, which refers to persistent difficulties in identifying, differentiating, and describing emotional states together with a tendency toward externally oriented thinking. Adolescents with elevated alexithymia may experience physiological arousal or diffuse distress without being able to identify the corresponding emotion, distinguish one affective state from another, or communicate emotional needs effectively. Such limitations can undermine adaptive emotion regulation because successful regulation generally presupposes at least some capacity to recognize what one is feeling and to represent that experience symbolically. The psychometric structure of the Toronto Alexithymia Scale has been extensively examined across languages and cultures, and meta-analytic confirmatory

evidence has supported the broad validity of its multidimensional structure, particularly the dimensions of difficulty identifying feelings, difficulty describing feelings, and externally oriented thinking (Schroeders et al., 2022). The Farsi version has likewise demonstrated satisfactory reliability and factorial validity in Iranian participants, supporting its use for assessing alexithymia in Persian-speaking populations (Besharat, 2007). In adolescence, alexithymia has particular developmental significance because emotional differentiation and verbalization are still maturing at the same time that affective intensity, interpersonal sensitivity, and pressures for autonomy increase. Longitudinal evidence indicates that alexithymia may contribute to subsequent mental health symptoms through impaired emotion regulation, suggesting that difficulty understanding and articulating emotional experience is not merely a concurrent feature of adolescent distress but may participate in mechanisms that sustain or intensify psychopathology (Brett et al., 2025). A recent systematic review examining alexithymia among young people and their parents further underscores the importance of considering alexithymia in a relational and developmental framework rather than viewing it solely as an isolated intrapersonal trait (Davies & Griffin, 2025).

The parent-child relationship constitutes another central context within which emotional regulation, defensive patterns, and psychological adaptation develop. During adolescence, the relationship with parents typically shifts from childhood dependency toward greater autonomy, negotiation, and reciprocal recognition. This transition can be developmentally productive, but it can also intensify conflict when adolescents experience parental control as intrusive or when parents experience adolescent differentiation as rejection or defiance. Relationship quality is therefore not adequately captured by the simple presence or absence of conflict; rather, it involves the balance among emotional closeness, communication, dependence, autonomy, warmth, and recurrent negative interaction. Longitudinal evidence indicates that characteristics of the parent-child relationship emerging early in development can predict the later onset and type of mental disorders in childhood and adolescence, highlighting the enduring developmental relevance of relational quality (Nilsson et al., 2025). Research has also shown that parent-child relational patterns are associated with coping responses and behavioral problems, supporting the view that behavioral symptoms may be embedded within recurring relational processes rather than located exclusively within the child (Taghizade,

2022). In Iranian contexts, studies of parent-child interaction have demonstrated that interventions targeting relational functioning can improve parental self-efficacy and mother-child relationship quality (Abareshi et al., 2010), while more recent work has emphasized the mediating and explanatory role of parenting patterns within associations between parent-child relationships and adolescent psychological functioning (Abedi Barzi, 2025). Evidence from intervention research has similarly shown that changes in child anxiety-related symptoms can occur alongside improvements in mother-child relational functioning, further illustrating the clinical relevance of relational processes in child and adolescent treatment (Mohammadian et al., 2024). Taken together, these findings suggest that interventions for adolescents with emotional-behavioral problems may be strengthened when they address not only symptom reduction but also the adolescent's internal representations of close relationships, defensive responses to interpersonal stress, and capacity to recognize and communicate affect.

Short-term psychodynamic psychotherapy is particularly suited to this multidimensional formulation because it conceptualizes symptoms as meaningful expressions of recurrent conflicts involving affect, anxiety, defense, and interpersonal expectations. Rather than focusing exclusively on overt symptom control, short-term psychodynamic approaches seek to help patients identify avoided or poorly differentiated emotions, recognize defensive operations as they occur, understand recurrent relational patterns, and develop more flexible ways of responding to internal and interpersonal stress. In adolescents, this work must be developmentally adapted so that interpretation does not exceed the young person's reflective capacity and so that therapeutic exploration supports autonomy without unnecessarily undermining appropriate parental involvement. The evidence base for psychodynamic psychotherapy with children and adolescents has expanded considerably. A meta-analysis of short-term psychodynamic models reported beneficial treatment effects across child and adolescent psychological problems and supported the clinical utility of time-limited psychodynamic approaches (Abbass et al., 2013). A subsequent narrative synthesis concluded that the empirical literature provides a substantive evidence base for psychodynamic psychotherapy with children and adolescents across a range of clinical presentations, while also identifying the need for more methodologically rigorous research examining mechanisms and specific outcomes (Midgley et al., 2021). Large-scale randomized evidence has further shown that short-term

psychoanalytical psychotherapy can be an effective treatment for adolescent depression, with outcomes comparable to other established interventions within pragmatic clinical settings (Goodyer et al., 2017). These findings challenge earlier assumptions that psychodynamic psychotherapy is unsuitable for time-limited treatment or difficult to evaluate empirically and instead position short-term psychodynamic approaches as potentially relevant interventions for adolescents whose difficulties involve both symptomatic distress and maladaptive emotional-interpersonal functioning.

More recent research has also refined understanding of how psychodynamic psychotherapy may produce change. Therapeutic effects appear to involve both common factors, such as alliance, empathy, treatment engagement, and a coherent therapeutic framework, and specific psychodynamic factors, including attention to affect, clarification and interpretation of defenses, exploration of repetitive relationship patterns, transference-focused observation, and increased reflective awareness. An overview of psychodynamic psychotherapy for children and adolescents has emphasized the importance of distinguishing these common and specific therapeutic processes when attempting to explain clinical improvement (Sammer-Schreckenthaler et al., 2025). This process-oriented perspective is important because the expected effects of short-term psychodynamic psychotherapy extend beyond reductions in symptom severity. By helping adolescents recognize when they defensively distance themselves from feelings, therapy may facilitate movement from immature or rigid defensive operations toward more adaptive forms of psychological regulation. By repeatedly linking bodily arousal, behavior, interpersonal events, and subjective affective states, treatment may also strengthen emotional identification and verbal symbolization, thereby reducing alexithymic tendencies. In addition, exploration of recurrent expectations within the therapeutic relationship may provide a setting in which adolescents can examine assumptions about criticism, control, abandonment, rejection, or dependency that are also activated in relationships with parents. From this perspective, changes in defense style, alexithymia, and parent-child relationship quality are theoretically connected rather than independent outcomes: greater awareness of affect may reduce the need for defensive distortion, reduced defensive rigidity may facilitate clearer interpersonal communication, and improved emotional communication may decrease conflict

and promote more adaptive closeness and autonomy within the parent-child relationship.

Contemporary evidence on experiential and dynamic therapies further supports the proposition that interventions emphasizing emotional processing can produce clinically meaningful psychological change. A recent systematic review and meta-analytic update of experiential dynamic therapies reported continued evidence for their efficacy across psychological conditions, reinforcing the broader empirical foundation for treatments that work directly with affect, defense, and interpersonal processes (Lilliengren, 2025). These developments are especially relevant for adolescents with mixed emotional and behavioral problems because such adolescents often present with diagnostic heterogeneity and overlapping internalizing and externalizing symptoms. A treatment model organized around transdiagnostic psychological processes may therefore offer advantages over approaches that are tightly restricted to one diagnostic syndrome. Defense mechanisms, alexithymia, and relationship functioning are plausible process variables because each cuts across conventional diagnoses and can contribute to multiple forms of psychopathology. An adolescent who cannot identify anger may, for example, experience diffuse tension, somatic distress, withdrawal, or sudden aggression depending on the defensive and relational context in which the affect emerges. Similarly, an adolescent who expects criticism from caregivers may rely on projection, oppositionality, emotional detachment, or denial to maintain psychological distance, thereby increasing parent-child conflict and reducing opportunities for supportive emotional communication. Psychodynamic treatment attempts to intervene precisely at these points of intersection by making emotional and relational patterns more thinkable and less dependent on automatic defensive enactment.

Despite the growing evidence base for psychodynamic treatment in young people, several limitations remain in the existing literature. Many studies have focused primarily on symptom-level outcomes such as depression, anxiety, or overall psychological distress, whereas comparatively fewer randomized studies have simultaneously examined theoretically central psychodynamic and relational variables such as defense style, alexithymia, and parent-child relationship quality. This is an important gap because symptom improvement does not necessarily reveal the psychological processes through which treatment operates or whether changes generalize to family relationships. Moreover, adolescent emotional-behavioral problems often

involve multidimensional dysfunction that cannot be adequately represented by a single symptom measure. Examination of defense style may clarify whether psychotherapy is associated with a shift from maladaptive toward more adaptive modes of regulating conflict and affect; assessment of alexithymia can indicate whether adolescents become better able to identify and express emotional experience; and measurement of parent-child relationship quality can determine whether intrapsychic changes are accompanied by improvements in a central developmental relationship. The concurrent study of these outcomes therefore provides a more theoretically coherent evaluation of short-term psychodynamic psychotherapy than symptom measurement alone and is consistent with current calls for research that integrates treatment effectiveness with mechanisms and developmental context (Midgley et al., 2021; Sammer-Schreckenthaler et al., 2025).

The need for such research is particularly relevant in Iranian clinical settings, where validated Persian measures are available for each of the main psychological domains under investigation but intervention evidence remains comparatively limited. The Persian YSR provides a culturally evaluated method for identifying adolescents with clinically elevated emotional and behavioral problems (Habibi Asgarabad et al., 2009); the Persian DSQ-40 permits assessment of mature, neurotic, and immature defense styles (Shabanpour et al., 2012); the Farsi TAS-20 provides an established measure of alexithymic characteristics (Besharat, 2007); and Iranian work on parent-child relationships supports the relevance and assessability of relational functioning within the local cultural context (Abareshi et al., 2010). At the same time, evidence linking parent-child relationships with adolescent psychological outcomes emphasizes that treatment effects should be interpreted within family and developmental systems rather than only at the level of individual symptom reduction (Abedi Barzi, 2025; Taghizade, 2022). Because psychodynamic psychotherapy explicitly addresses affective experience, defense mechanisms, and internalized relational patterns, it provides a conceptually appropriate intervention for testing whether change can occur simultaneously across these domains. Such investigation can also contribute to a more culturally grounded evidence base concerning whether short-term psychodynamic treatment can be effectively implemented for adolescents with broad emotional-behavioral difficulties rather than only for narrowly defined psychiatric diagnoses.

Accordingly, the aim of the present study was to determine the effectiveness of short-term psychodynamic psychotherapy in improving defense styles, reducing alexithymia, and enhancing parent-child relationship quality among adolescents with emotional and behavioral problems.

2. Methods and Materials

2.1. Study Design and Participants

This study was conducted as a two-arm randomized controlled trial with three assessment points, including pretest, posttest, and an eight-week follow-up, to examine the effectiveness of short-term psychodynamic psychotherapy (STPP) on defense styles, alexithymia, and parent-child relationship quality among adolescents with emotional and behavioral problems. The study was conducted between January and September 2026 at the Child and Adolescent Psychiatry Clinic of the Tehran Psychiatric Institute affiliated with Iran University of Medical Sciences, Tehran, Iran. The research procedures were designed in accordance with the ethical principles of the Declaration of Helsinki and the CONSORT recommendations for randomized controlled trials. Ethical approval was obtained from the relevant institutional ethics committee [Ethics committee and approval code], and trial registration information, where applicable, should be reported as [registration number]. The target population consisted of adolescents aged 13–17 years who had been referred to the clinic because of clinically significant emotional and/or behavioral difficulties. Participants were initially recruited through consecutive convenience sampling from adolescents referred to the clinic, after which eligible participants were randomly assigned to the intervention or control condition. An a priori power analysis for a two-group repeated-measures interaction across three assessment occasions, assuming an alpha level of .05, statistical power of .80, a moderate effect size of $f = .25$, and an estimated within-participant correlation of .50, indicated that approximately 34 participants would be required. To compensate for possible participant attrition during treatment and follow-up, 40 adolescents were recruited and randomly allocated in equal numbers to the STPP intervention group and the wait-list control group. Eligibility criteria included being between 13 and 17 years of age, demonstrating clinically elevated emotional or behavioral problems on the Persian version of the Youth Self-Report (YSR), defined as a borderline or clinical elevation on the Total Problems, Internalizing Problems, or Externalizing Problems broadband scales

accompanied by confirmation of clinically significant impairment during a psychologist-led diagnostic interview, having sufficient Persian-language ability to participate meaningfully in individual psychotherapy, residing with at least one parent or primary caregiver who was able to complete the parent-child relationship assessment, and providing written adolescent assent together with parental informed consent. Adolescents were excluded if they had a current psychotic disorder, manic episode, severe substance-use disorder, acute suicide risk requiring a higher level of psychiatric care, or an intellectual disability severe enough to interfere with participation in psychotherapy or completion of the research instruments. Concurrent participation in another structured psychotherapy program and a major change in psychotropic medication during the six weeks preceding enrollment were also exclusion criteria. Participants receiving psychotropic medication were permitted to enter the study when their medication dose had remained stable and was expected to remain unchanged during the active treatment phase. Following completion of baseline assessments, eligible participants were randomly allocated in a 1:1 ratio to either the STPP or wait-list control condition by means of a computer-generated randomization sequence using randomly permuted blocks of four. Allocation assignments were placed in sequentially numbered, opaque envelopes prepared by a research assistant who was not involved in participant assessment or treatment. Given the nature of psychotherapy, blinding of therapists and participants was not feasible; however, outcome data entry and the primary statistical analyses were conducted using coded group labels so that group identity remained concealed until the main statistical models had been finalized. Participants and their parents received detailed explanations regarding study procedures, confidentiality, voluntary participation, the right to withdraw from the study, and the limitations of confidentiality in circumstances involving significant safety concerns. Baseline questionnaires were completed before randomization, posttest assessment was conducted within seven days following the final treatment session or the corresponding waiting period, and follow-up assessment was performed eight weeks later. The same parent or primary caregiver was asked to complete the parent-child relationship instrument at all three measurement points whenever possible in order to maintain consistency of informant reporting.

2.2. Data Collection Tools

The Youth Self-Report (YSR), which is part of the Achenbach System of Empirically Based Assessment, was used as the principal screening instrument for identifying clinically significant emotional and behavioral problems among adolescents. The YSR is a self-report measure developed for adolescents and provides scores for several syndrome scales as well as the broader Internalizing Problems, Externalizing Problems, and Total Problems dimensions. These broadband indices allow for the identification of emotional problems such as anxiety, depressive symptoms, withdrawal, and somatic complaints as well as behavioral difficulties involving aggression, rule-breaking behavior, and related externalizing manifestations. In the present study, the YSR was used primarily to determine eligibility rather than as a principal treatment outcome. Adolescents were required to demonstrate a borderline or clinical elevation on at least one of the Total Problems, Internalizing Problems, or Externalizing Problems scales, with the presence of clinically meaningful functional impairment additionally confirmed during a psychologist-led diagnostic interview. Previous psychometric investigations of the Persian version have supported its factorial structure, reliability, and applicability among Iranian adolescents. Habibi Asgarabad et al. (2009) reported satisfactory psychometric characteristics for the Persian adaptation, while subsequent Iranian studies have reported high internal consistency coefficients of approximately .92 and .91 for the Internalizing and Externalizing broadband scales, respectively. The use of both standardized questionnaire scores and clinical confirmation was intended to reduce the likelihood of including adolescents whose questionnaire elevations reflected transient or clinically insignificant difficulties.

The Defense Style Questionnaire-40 (DSQ-40), developed by Andrews et al. (1993), was employed to assess the adolescents' characteristic defense mechanisms and broader defense styles. The DSQ-40 is a 40-item self-report questionnaire assessing 20 defense mechanisms, with each mechanism represented by two items. Responses are provided on a 9-point rating scale, and the individual defense mechanisms are organized into three broader dimensions comprising mature, neurotic, and immature defense styles. The mature defense style includes sublimation, humor, anticipation, and suppression; the neurotic defense style includes undoing, pseudo-altruism, idealization, and reaction formation; and the immature defense style

comprises projection, passive aggression, acting out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, and somatization. Higher scores within each dimension indicate greater reliance on the corresponding category of psychological defenses. The DSQ-40 was selected because short-term psychodynamic psychotherapy explicitly addresses habitual defensive operations and seeks to promote greater recognition and modification of maladaptive defensive patterns while facilitating more adaptive regulation of affect. The Persian version of the DSQ-40 was translated and psychometrically evaluated by Shabanpour et al. (2012), who reported satisfactory content validity and an overall Cronbach's alpha coefficient of .716, and the instrument has subsequently been used in Iranian clinical and psychological research. In the present study, the internal consistency coefficients were .73 for the mature defense style, .70 for the neurotic defense style, and .82 for the immature defense style, indicating acceptable to good internal consistency for the principal defense-style dimensions.

Alexithymia was assessed using the 20-item Toronto Alexithymia Scale (TAS-20), developed by Bagby et al. (1994a, 1994b). The TAS-20 is one of the most widely used self-report measures of difficulties related to recognizing, describing, and cognitively processing emotional experiences. The instrument consists of 20 statements rated on a 5-point Likert-type scale ranging from 1, indicating strong disagreement, to 5, indicating strong agreement. It generates a total alexithymia score and scores for three theoretically related dimensions: Difficulty Identifying Feelings, which reflects problems in distinguishing and recognizing emotional states; Difficulty Describing Feelings, which assesses difficulty communicating emotions verbally to others; and Externally Oriented Thinking, which reflects a cognitive style characterized by limited attention to internal emotional experiences and a greater focus on external events. Total scores range from 20 to 100, with higher scores representing greater alexithymic characteristics. The original scale demonstrated satisfactory internal consistency, test-retest reliability, and convergent and discriminant validity. Besharat (2007) evaluated the Farsi version of the TAS-20 among 587 Iranian participants and provided evidence supporting its internal consistency, temporal stability, concurrent validity, and three-factor structure, with an overall Cronbach's alpha coefficient of approximately .85 and acceptable reliability coefficients for its subscales. Additional cross-language psychometric evidence has also supported the factorial validity of the Farsi

TAS-20 (Schroeders et al., 2022). In the present sample, Cronbach's alpha for the TAS-20 total score was .86, indicating good internal consistency. The instrument was particularly relevant to the study because one of the central therapeutic aims of STPP was to facilitate the identification, differentiation, verbalization, and psychological processing of emotional experiences that might previously have been avoided, somatically experienced, or behaviorally expressed.

Parent-child relationship quality was evaluated using the Child-Parent Relationship Scale (CPRS), originally developed by Pianta (1992). The long form of the scale consists of 30 items rated on a 5-point Likert-type response format and assesses several dimensions of the relationship between the child or adolescent and the parent, principally closeness, conflict, and dependence. The closeness dimension reflects warmth, emotional availability, open communication, affection, and positive reciprocal interaction, whereas conflict captures tension, anger, disagreement, and negative exchanges within the parent-child relationship. Dependence reflects excessive reliance and difficulties in maintaining developmentally appropriate relational autonomy. For the purposes of the present study, an overall positive relationship-quality index was calculated by reverse-scoring negatively oriented conflict and dependence components and combining them with the closeness dimension, such that higher overall scores represented a more positive and supportive parent-child relationship. Given that dependence has demonstrated comparatively weaker reliability in some psychometric investigations, this dimension was treated as a secondary indicator rather than as an independent primary outcome. The Persian adaptation of the CPRS has been used in Iranian family and developmental research. Abareshi et al. (2010) reported reliability coefficients of approximately .84 for conflict, .69 for closeness, and .46 for dependence, together with evidence supporting the instrument's content validity, while subsequent Iranian investigations have generally reported reliability estimates of approximately .80-.86 for overall relationship-quality measures. In the current sample, Cronbach's alpha coefficients were .84 for the overall positive relationship index, .79 for conflict, .78 for closeness, and .62 for dependence. To reduce common-method bias, the CPRS was completed by a parent or primary caregiver, whereas the defense-style and alexithymia measures were completed by the adolescent. The same caregiver was retained across the three assessment occasions whenever possible.

2.3. *Intervention*

Participants assigned to the experimental condition received 16 weekly sessions of individual short-term psychodynamic psychotherapy, with each session lasting approximately 50 minutes. The intervention was based on central short-term psychodynamic principles and was developmentally adapted for adolescents. During the initial sessions, therapeutic work focused on establishing a secure and collaborative therapeutic alliance, explaining the treatment frame and boundaries of confidentiality, identifying the adolescent's principal emotional and interpersonal difficulties, and developing a focal psychodynamic formulation linking affect, anxiety, defensive responses, and recurring interpersonal patterns. During the subsequent early phase of treatment, the therapist closely monitored moment-to-moment changes in emotional experience and helped the adolescent recognize defensive operations that interfered with awareness or expression of affect, including intellectualization, projection, withdrawal, denial, rationalization, acting out, isolation, and other relevant defenses. Clarification and, when developmentally and clinically appropriate, interpretation of defenses were used to increase awareness of the psychological functions served by these patterns while gradually improving the adolescent's capacity to tolerate emotional experiences. In the middle phase of treatment, therapeutic attention increasingly focused on recurrent interpersonal-affective patterns occurring in relationships with parents, peers, teachers, and other authority figures. The therapist explored expectations of rejection, criticism, abandonment, excessive control, or emotional unavailability and linked these expectations with corresponding emotions and defensive strategies. Similar dynamics emerging within the therapeutic relationship were examined through carefully paced attention to transference, with interpretations tailored to the adolescent's developmental level and capacity for affect regulation. Sessions also emphasized differentiating emotional states such as anger, sadness, shame, guilt, fear, affection, and dependency needs, thereby facilitating emotional symbolization and verbal expression rather than avoidance, somatization, or behavioral discharge. During later sessions, emphasis shifted toward consolidating more adaptive defense mechanisms, strengthening reflective functioning, improving communication within close relationships, and assisting the adolescent in negotiating autonomy while maintaining emotional connection with parents and significant others. The final sessions were

devoted to working through treatment gains, identifying situations likely to reactivate previous defensive patterns, processing emotional reactions associated with termination, strengthening strategies for maintaining psychological improvements, and integrating newly developed capacities into family, school, and peer contexts. Parents did not receive simultaneous psychotherapy; however, two brief parent meetings were conducted, one near the beginning of treatment and another close to termination, to clarify the treatment framework, coordinate safety issues, and support the adolescent's treatment plan without revealing confidential therapeutic material. The treatment was delivered by a clinical psychologist trained in psychodynamic psychotherapy and experienced in working with adolescents. Weekly clinical supervision was provided to ensure adherence to the psychodynamic treatment focus, appropriate developmental adaptation, maintenance of the therapeutic frame, and management of clinical risk. With informed consent, a subset of treatment sessions was audio-recorded and evaluated using a brief treatment-adherence checklist addressing affect focus, recognition and clarification of defenses, exploration of recurrent relationship patterns, appropriate use of the therapeutic relationship, and avoidance of directive skills-based interventions inconsistent with the assigned psychodynamic model. Adolescents allocated to the control group remained on a waiting list for the 16-week treatment period and continued to have access to routine nonpsychotherapy clinical monitoring when required for safety. Initiation of another structured psychotherapy during the waiting period constituted grounds for discontinuation from the study protocol. Following completion of the posttest assessment, participants in the control condition were offered referral for psychological treatment; however, the eight-week study follow-up assessments were completed before initiation of any psychotherapy arranged through the research project.

2.4. *Data Analysis*

Data were analyzed using descriptive and inferential statistical procedures with a two-sided significance level of .05. Descriptive statistics, including means, standard deviations, frequencies, and percentages as appropriate to the measurement level of each variable, were calculated to summarize participants' demographic and baseline clinical characteristics as well as scores on the primary outcome variables across the pretest, posttest, and follow-up assessments. Baseline comparability between the STPP and

wait-list control groups was evaluated using independent-samples *t* tests for continuous variables and chi-square tests or appropriate exact tests for categorical variables. Prior to the primary inferential analyses, the data were examined for coding errors, missing values, influential outliers, and distributional abnormalities. Assumptions relevant to repeated-measures analysis were evaluated through examination of residual distributions, variance and covariance patterns, and the sphericity assumption. When the assumption of sphericity was violated, the Greenhouse–Geisser correction was applied to adjust the degrees of freedom. The effectiveness of STPP was evaluated using mixed repeated-measures analyses in which Group, consisting of the STPP and control conditions, served as the between-participants factor and Time, consisting of pretest, posttest, and eight-week follow-up, served as the within-participants factor. Separate models were estimated for mature, neurotic, and immature defense styles, alexithymia, and parent–child relationship quality. The principal inferential parameter was the Group $\times$ Time interaction, because a statistically significant interaction would indicate that changes across the three measurement occasions differed between adolescents receiving STPP and those assigned to the wait-list control condition. When significant interaction effects were identified, within-group and between-group pairwise comparisons were examined with appropriate adjustment for multiple comparisons to determine the temporal pattern of treatment-related changes. Partial eta squared (η^2) was reported as the principal effect-size measure for repeated-measures effects, with values of approximately .01, .06, and .14 interpreted conventionally as small, moderate, and large effects, respectively. The principal analyses retained all randomized participants for whom outcome measurements were available, and sensitivity analyses based on change scores were also examined to determine whether the principal findings remained substantively consistent under alternative analytic specifications.

3. Findings and Results

Seventy-three adolescents were initially screened for eligibility. Of these, 23 adolescents were excluded because they either failed to meet the inclusion criteria or met at least one exclusion criterion, while 10 eligible adolescents and their families declined participation because of scheduling difficulties or travel-related constraints. Accordingly, 40 adolescents entered the study and were randomly assigned in equal numbers to the short-term psychodynamic psychotherapy group ($n = 20$) and the wait-list control group ($n = 20$). All randomized participants completed the posttest and eight-week follow-up assessments, resulting in no loss to follow-up. The mean age of participants was 15.20 years ($SD = 1.24$) in the intervention group and 15.10 years ($SD = 1.29$) in the control group, with no statistically significant difference between the groups, $p = .804$. Females constituted 55.0% of the intervention group and 50.0% of the control group, $p = .752$. The mean baseline YSR Total Problems T score was 68.00 ($SD = 6.30$) in the STPP group and 68.40 ($SD = 6.60$) in the control group, $p = .846$. Clinically elevated internalizing problems were identified in 65.0% of adolescents in the intervention group and 60.0% of those in the control group, whereas clinically elevated externalizing problems were observed in 60.0% and 65.0% of participants, respectively; neither comparison was statistically significant, $ps = .744$. Three adolescents in each group (15.0%) were receiving stable psychotropic medication, $p = 1.000$, while 75.0% of adolescents in the STPP group and 70.0% of those in the control group lived in two-parent households, $p = .723$. Within the intervention group, participants attended a mean of 14.80 of the 16 psychotherapy sessions ($SD = 1.20$), and 17 of the 20 participants attended at least 14 sessions. No serious adverse events attributable to psychotherapy were recorded. Overall, the absence of statistically significant baseline differences indicated that the two groups were comparable with respect to demographic characteristics and initial clinical severity.

Table 1

Means and Standard Deviations of Primary Outcomes at Pretest, Posttest, and Follow-Up

Outcome	Group	Pretest M (SD)	Posttest M (SD)	Follow-Up M (SD)
Mature defense style	STPP	4.54 (0.68)	5.88 (0.93)	5.81 (0.77)
	Control	4.64 (0.81)	4.60 (1.02)	4.56 (1.01)
Neurotic defense style	STPP	5.03 (0.60)	4.33 (0.71)	4.54 (0.73)
	Control	5.20 (0.83)	5.32 (0.84)	5.19 (1.12)
Immature defense style	STPP	5.69 (0.69)	4.45 (0.74)	4.37 (0.64)
	Control	5.74 (0.92)	5.63 (1.07)	5.62 (1.22)

Alexithymia	STPP	63.00 (8.62)	48.93 (10.65)	53.10 (9.70)
	Control	63.11 (7.43)	62.72 (8.45)	61.66 (8.97)
Parent-child relationship quality	STPP	88.66 (8.58)	106.27 (11.98)	101.08 (10.33)
	Control	88.86 (8.70)	91.04 (8.53)	88.83 (9.76)

As shown in Table 1, the two groups demonstrated highly similar mean scores on all primary outcome measures at pretest, indicating satisfactory baseline comparability. Following the intervention, however, a clear pattern of improvement emerged among adolescents receiving short-term psychodynamic psychotherapy. The mean mature defense style score in the STPP group increased from 4.54 (SD = 0.68) at pretest to 5.88 (SD = 0.93) at posttest and remained elevated at 5.81 (SD = 0.77) at the eight-week follow-up, whereas the corresponding scores in the control group remained relatively unchanged across the three assessment occasions. In contrast, the mean neurotic defense style score in the intervention group declined from 5.03 (SD = 0.60) at baseline to 4.33 (SD = 0.71) after treatment and was 4.54 (SD = 0.73) at follow-up, while no comparable reduction was evident in the control group. An even more pronounced pattern was observed for immature defense style, with the STPP group decreasing from a pretest mean of 5.69 (SD = 0.69) to 4.45 (SD = 0.74) at posttest and 4.37 (SD = 0.64) at follow-up, whereas the control group

remained near its baseline level. Alexithymia also declined markedly among adolescents receiving STPP, from 63.00 (SD = 8.62) before treatment to 48.93 (SD = 10.65) immediately after treatment; although the mean increased somewhat to 53.10 (SD = 9.70) at follow-up, it remained substantially below the baseline value. The control group's alexithymia scores showed little change across assessments. Parent-child relationship quality demonstrated the opposite and therapeutically desirable trajectory, increasing in the STPP group from 88.66 (SD = 8.58) at pretest to 106.27 (SD = 11.98) at posttest and remaining comparatively high at 101.08 (SD = 10.33) at follow-up. The control group showed only a modest temporary increase at posttest followed by a return to approximately its baseline level. Overall, these descriptive findings suggest that STPP was associated with increased use of mature defenses, decreased reliance on neurotic and immature defenses, reduced alexithymia, and improved parent-child relationship quality, with most improvements remaining evident eight weeks after completion of treatment.

Table 2

Mixed Repeated-Measures Analysis of Variance for Group × Time Interaction Effects

Outcome	F	df	p	Partial η^2	Effect Size
Mature defense style	38.21	2, 76	< .001	.501	Large
Neurotic defense style	10.01	2, 76	< .001	.209	Large
Immature defense style	30.60	2, 76	< .001	.446	Large
Alexithymia	36.64	2, 76	< .001	.491	Large
Parent-child relationship quality	34.14	2, 76	< .001	.473	Large

The mixed repeated-measures analyses of variance presented in Table 2 demonstrated statistically significant Group × Time interaction effects for all five primary study outcomes, indicating that changes over the three assessment occasions differed significantly between adolescents receiving STPP and those in the wait-list control group. A significant interaction was found for mature defense style, $F(2, 76) = 38.21$, $p < .001$, $\eta^2 = .501$, indicating that approximately 50.1% of the variance associated with change over time was attributable to the differential trajectories of the two groups. Neurotic defense style also demonstrated a significant Group × Time interaction, $F(2, 76) = 10.01$, $p < .001$, $\eta^2 = .209$, reflecting a substantial reduction in neurotic defenses among adolescents receiving STPP compared with

the control condition. The interaction effect for immature defense style was likewise statistically significant and large, $F(2, 76) = 30.60$, $p < .001$, $\eta^2 = .446$, confirming that the decline in maladaptive defensive functioning was substantially greater in the intervention group. Alexithymia showed a strong interaction effect, $F(2, 76) = 36.64$, $p < .001$, $\eta^2 = .491$, indicating that STPP produced a marked reduction in difficulties identifying and expressing emotions relative to the control group. Finally, parent-child relationship quality demonstrated a significant and large Group × Time interaction, $F(2, 76) = 34.14$, $p < .001$, $\eta^2 = .473$, showing that the improvement in perceived relationship quality was substantially greater among participants who received STPP. Secondary analyses of the

dimensions of parent-child relationship quality were consistent with the overall finding: closeness increased significantly in the STPP group relative to the control group, $F(2, 76) = 34.23$, $p < .001$, $\eta^2 = .47$; conflict decreased significantly, $F(2, 76) = 21.99$, $p < .001$, $\eta^2 = .37$; and dependence showed a smaller but statistically significant interaction effect, $F(2, 76) = 4.48$, $p = .014$, $\eta^2 = .11$. Because the dependence subscale demonstrated comparatively lower internal consistency, this latter effect was interpreted with greater caution. Taken together, the inferential results confirmed that short-term psychodynamic psychotherapy produced statistically significant and clinically meaningful improvements across defense functioning, alexithymia, and parent-child relationship quality, and inspection of the follow-up means indicated that most treatment gains were maintained eight weeks after completion of the intervention, despite modest attenuation in alexithymia and relationship-quality scores after the end of weekly therapeutic contact.

4. Discussion

The present study examined the effectiveness of short-term psychodynamic psychotherapy on defense styles, alexithymia, and parent-child relationship quality among adolescents with emotional and behavioral problems. The findings demonstrated that adolescents who received short-term psychodynamic psychotherapy showed significantly greater improvement than those in the wait-list control group across all primary outcomes. Specifically, the intervention group exhibited an increase in mature defense style, decreases in neurotic and immature defense styles, a substantial reduction in alexithymia, and a marked improvement in overall parent-child relationship quality. The statistically significant Group $\times$ Time interactions across all outcomes indicate that these changes were not attributable to general developmental fluctuation or repeated assessment, but rather reflected differential trajectories associated with participation in the intervention. The magnitude of the observed effects was particularly notable. Mature defense style, immature defense style, alexithymia, and parent-child relationship quality all demonstrated large interaction effects, while neurotic defense style also showed a substantial treatment-related effect. Moreover, the follow-up findings indicated that most gains were maintained eight weeks after treatment termination, although some attenuation was evident in alexithymia and parent-child relationship quality. Overall, these results support the

hypothesis that short-term psychodynamic psychotherapy can produce meaningful changes not only in overt emotional and behavioral functioning but also in underlying affective, defensive, and relational processes among adolescents with clinically significant problems.

The improvement in defense styles is consistent with the theoretical foundations of psychodynamic treatment, in which defense mechanisms are viewed as central processes through which individuals manage anxiety, conflict, unacceptable affect, and threats to self-coherence. The increase in mature defenses alongside reductions in neurotic and immature defenses suggests that adolescents in the intervention group developed more adaptive ways of regulating emotional tension. This pattern is theoretically important because psychodynamic psychotherapy does not merely aim to suppress maladaptive behaviors; rather, it seeks to help individuals recognize automatic defensive operations, understand the emotional conflicts that activate them, and replace rigid or maladaptive defenses with more flexible forms of regulation. The present findings are consistent with earlier evidence showing that defense styles are closely associated with psychopathology and with therapeutic change. Bond demonstrated that mature defenses are generally associated with healthier psychological functioning, whereas immature defenses are more strongly related to psychiatric symptoms and poorer adaptation (Bond, 2004). More recent cross-national evidence has similarly shown robust associations between defense mechanisms and mental health symptoms across different cultural contexts, supporting the idea that defensive functioning represents a transdiagnostic dimension of psychological health (Bekes et al., 2023). The present findings therefore extend this literature by suggesting that short-term psychodynamic psychotherapy may actively modify the defensive profile of adolescents with emotional and behavioral problems rather than merely reducing symptom severity.

The significant reduction in immature defenses is particularly consistent with the therapeutic focus of the intervention. Throughout treatment, adolescents were encouraged to observe how they shifted away from difficult affect through mechanisms such as projection, denial, acting out, withdrawal, rationalization, or splitting. By identifying these patterns in real time and linking them to underlying emotional states and recurrent interpersonal conflicts, therapy may have reduced the need for defensive avoidance or behavioral discharge. Adolescence is a developmental period in which acting out and externalization can become

prominent responses to unprocessed affect, particularly when reflective capacity is still developing. The reduction in immature defenses may therefore represent an important mechanism through which behavioral dysregulation improved. The Persian version of the DSQ-40 has previously demonstrated its ability to distinguish maladaptive defense profiles in Iranian psychiatric samples (Shabanpour et al., 2012), and the present study suggests that the same construct is sensitive to therapeutic change in adolescents. The concurrent increase in mature defenses may reflect improved use of suppression, anticipation, humor, and other adaptive processes that allow emotional experience to be acknowledged without overwhelming the individual or distorting interpersonal reality.

The decrease in neurotic defense style also deserves attention. Although neurotic defenses are generally considered less maladaptive than immature defenses, excessive reliance on mechanisms such as reaction formation, idealization, pseudo-altruism, or undoing can still interfere with direct emotional recognition and authentic interpersonal communication. The reduction observed in the present study suggests that STPP may have enabled adolescents to approach emotional conflict with less indirect psychological management. This interpretation is consistent with the broader psychodynamic proposition that therapeutic change involves increased tolerance for ambivalence and affective complexity. Rather than needing to convert one feeling into its opposite or manage guilt and anxiety through compensatory mental operations, adolescents may have become more capable of experiencing conflicting emotions directly and reflecting on their meaning. This is compatible with the broader evidence base showing that psychodynamic psychotherapy with children and adolescents can produce change across domains of internal functioning, emotional regulation, and interpersonal adaptation (Midgley et al., 2021). It also aligns with findings from meta-analytic work indicating that short-term psychodynamic approaches can yield meaningful clinical benefits in younger populations (Abbass et al., 2013).

The significant reduction in alexithymia represents another central finding of the study. Adolescents receiving STPP showed a substantial decrease in alexithymia from pretest to posttest, with improvement remaining evident at follow-up despite some partial rebound. This finding is theoretically coherent with the treatment model because much of the therapeutic work was directed toward recognizing, differentiating, naming, and communicating emotional states. Adolescents with alexithymic

characteristics may experience affect primarily as bodily tension, irritability, action tendencies, or diffuse distress without being able to identify or verbalize the underlying emotional state. Psychodynamic treatment attempts to transform such poorly symbolized affect into psychologically representable experience. The therapist's repeated attention to moment-to-moment changes in emotion, anxiety, defense, and relational meaning may therefore have strengthened emotional awareness and verbal expression. The present result is consistent with the conceptualization of alexithymia as a clinically relevant difficulty in emotional processing and with psychometric evidence supporting its multidimensional structure (Schroeders et al., 2022). It is also consistent with the established validity of the Farsi TAS-20 as a measure of difficulties in identifying and describing feelings in Iranian populations (Besharat, 2007).

The observed reduction in alexithymia also aligns with emerging longitudinal evidence concerning the role of emotional awareness in adolescent mental health. Brett et al. reported that alexithymia can contribute to mental health symptoms in adolescence through impaired emotion regulation, indicating that difficulties in identifying and describing emotions may represent a mechanism through which psychopathology is maintained (Brett et al., 2025). From this perspective, the decline in alexithymia observed in the present study may have broader implications than improvement on a single outcome measure. Greater emotional awareness may allow adolescents to regulate affect more effectively, communicate distress before it escalates, and rely less heavily on avoidance, acting out, or somatization. The systematic review by Davies and Griffin further highlights the importance of alexithymia in young people and their parents, emphasizing that emotional processing difficulties may be embedded in family and developmental contexts rather than existing solely as individual traits (Davies & Griffin, 2025). This perspective is especially relevant to the present findings because reductions in alexithymia occurred simultaneously with improvements in parent-child relationship quality, suggesting that increased capacity to identify and articulate feelings may have facilitated more constructive interpersonal exchanges within the family.

The improvement in parent-child relationship quality was also substantial. Adolescents in the STPP group demonstrated a marked increase in overall relationship quality immediately after treatment, and although the mean score declined somewhat at follow-up, it remained

considerably better than baseline and the control-group trajectory. Secondary analyses further showed increased closeness, decreased conflict, and a smaller but significant improvement in dependence. These results are clinically meaningful because the intervention was delivered primarily to adolescents rather than as a family-based treatment, yet relational improvement was still detected in caregiver reports. This suggests that changes in the adolescent's emotional awareness, defensive functioning, and interpersonal expectations may have generalized beyond the therapy room and altered everyday interactions with parents. The findings are consistent with longitudinal evidence indicating that the quality of the parent-child relationship is strongly associated with later mental health outcomes in childhood and adolescence (Nilsson et al., 2025). They also align with research showing that parent-child relationship functioning is associated with behavioral problems and coping responses, reinforcing the idea that emotional and behavioral difficulties are shaped within relational systems (Taghizade, 2022).

One plausible mechanism for the improvement in parent-child relationship quality is that reduced reliance on immature defenses may have altered the adolescents' interpretation and response to parental behavior. For example, an adolescent who previously reacted to perceived criticism through projection, withdrawal, devaluation, or acting out may, after treatment, become better able to identify underlying feelings of shame, anger, fear, or dependency and express them more directly. This could reduce cycles of escalation and misunderstanding within the family. Similarly, improvements in alexithymia may enhance the adolescent's ability to communicate internal states in language rather than through oppositional behavior, silence, or somatic complaints. Prior Iranian research has demonstrated that improving parent-child interaction can strengthen relational functioning and parental self-efficacy (Abareshi et al., 2010), while more recent studies have emphasized the importance of parenting style and parent-child relationship quality in adolescent psychological functioning (Abedi Barzi, 2025). Intervention research has also shown that improvement in child emotional symptoms can occur alongside better mother-child relationship functioning (Mohammadian et al., 2024). The present study adds to this literature by suggesting that individual psychodynamic treatment of the adolescent may indirectly improve relational functioning even without a parallel parent psychotherapy program.

The durability of treatment gains at the eight-week follow-up provides additional support for the clinical significance of the intervention. Mature defense style remained clearly above baseline, while immature defense style and alexithymia remained lower than their initial levels. Parent-child relationship quality also remained substantially improved despite some attenuation after treatment termination. This pattern suggests that STPP may produce internal changes that persist beyond the period of weekly therapeutic contact. Psychodynamic theory proposes that when patients develop greater reflective awareness of recurring emotional and interpersonal patterns, treatment effects may continue through the internalization of new ways of understanding and regulating experience. The persistence of gains is consistent with evidence from psychodynamic treatment research showing that benefits can extend beyond the active intervention period (Abbass et al., 2013; Midgley et al., 2021). In adolescent depression, short-term psychoanalytical psychotherapy has also demonstrated meaningful outcomes in randomized clinical research, supporting the viability of developmentally adapted psychodynamic interventions within time-limited formats (Goodyer et al., 2017). The present findings therefore complement previous work by showing that short-term psychodynamic treatment can influence transdiagnostic process variables in adolescents presenting with broader emotional and behavioral problems.

The magnitude and multidimensionality of the treatment effects are also consistent with recent conceptualizations of psychodynamic psychotherapy as involving both common and specific therapeutic mechanisms. Common factors such as the therapeutic alliance, empathic understanding, and a coherent treatment frame may create the conditions necessary for change, whereas more specific psychodynamic processes include clarification of defenses, attention to affect, exploration of recurring relational patterns, and use of the therapeutic relationship as a source of information about interpersonal expectations. Sammer-Schreckenthaler et al. emphasized the importance of both common and specific therapeutic factors in psychodynamic treatment for children and adolescents (Sammer-Schreckenthaler et al., 2025). The present findings fit this framework because improvements were observed across multiple domains that correspond closely to the intervention's specific targets. Furthermore, recent meta-analytic evidence on experiential dynamic therapies has continued to support the efficacy of treatments that emphasize emotional processing, defense work, and interpersonal experience (Lilliengren, 2025). The current

study extends this evidence to a sample of Iranian adolescents with mixed emotional and behavioral problems and suggests that these therapeutic principles may be applicable across cultural settings.

5. Conclusion

An additional strength of the findings is that they support a transdiagnostic understanding of adolescent emotional-behavioral problems. The adolescents in the study were not restricted to a single diagnostic category but were selected on the basis of clinically elevated emotional and/or behavioral difficulties. This is important because defense style, alexithymia, and relational dysfunction cut across traditional diagnostic boundaries. The findings therefore suggest that STPP may be useful for adolescents whose difficulties are heterogeneous but share underlying problems in emotional processing, defensive regulation, and interpersonal functioning. This interpretation is consistent with contemporary psychodynamic research emphasizing mechanisms rather than diagnosis alone (Midgley et al., 2021). It is also consistent with the broader evidence that defense mechanisms and alexithymia are associated with diverse forms of psychopathology rather than a single syndrome (Bekes et al., 2023; Brett et al., 2025). The current results therefore support the clinical value of targeting transdiagnostic processes in adolescent psychotherapy.

Several limitations should be considered when interpreting the present findings. First, the sample size was relatively small and was recruited from a single specialized clinical setting in Tehran, which limits the generalizability of the findings to adolescents from other regions, cultural contexts, socioeconomic backgrounds, or treatment settings. Second, although random allocation strengthened internal validity, the nature of psychotherapy made participant and therapist blinding impossible, creating potential expectancy effects. Third, the follow-up period was limited to eight weeks, preventing conclusions about whether the observed gains remain stable over longer periods. Fourth, defense styles and alexithymia were assessed using adolescent self-report instruments and may therefore have been influenced by response style, insight, or social desirability. Although parent-child relationship quality was assessed by caregivers, the study did not include observational measures of family interaction or independent clinician ratings of relational change. Fifth, the wait-list control condition did not control for nonspecific treatment factors such as attention, therapeutic contact, expectancy, and alliance. Finally,

although treatment adherence was monitored, therapist effects could not be separated from model-specific effects because the intervention was delivered within a limited therapist structure.

Future research should replicate the study with larger and more diverse samples drawn from multiple clinical and community settings. Multicenter randomized controlled trials would improve external validity and allow subgroup analyses based on sex, symptom profile, baseline severity, medication status, and dominant defensive pattern. Future studies should also include longer follow-up periods, such as six months and one year, to determine whether gains in defense functioning, alexithymia, and parent-child relationship quality are maintained over time. Comparison with an active treatment condition would help distinguish specific psychodynamic effects from common therapeutic factors. It would also be useful to examine mediational models to determine whether reductions in immature defenses or alexithymia account for later improvements in emotional-behavioral symptoms and family relationships. Incorporating observational family assessments, clinician-rated defense measures, ecological momentary assessment, and multi-informant outcome data could further reduce reliance on self-report and provide a more comprehensive evaluation of change processes. Future studies may also compare different lengths or intensities of psychodynamic treatment and investigate whether selected parent sessions enhance or sustain treatment gains.

In clinical practice, the findings support consideration of short-term psychodynamic psychotherapy as a structured treatment option for adolescents presenting with combined emotional and behavioral difficulties, particularly when problems appear to involve limited emotional awareness, maladaptive defenses, recurrent interpersonal conflict, or strained parent-child relationships. Clinicians may benefit from assessing defense styles and alexithymia at the beginning of treatment so that therapy can be tailored to the adolescent's capacity for emotional recognition, reflection, and affect tolerance. Interventions should use developmentally appropriate language and carefully pace interpretations so that emotional exploration does not exceed the adolescent's regulatory capacity. Attention to family relationships is also important even when treatment is primarily individual, and brief parent meetings may help support safety, treatment continuity, and appropriate parental involvement while preserving the adolescent's therapeutic confidentiality. Clinical services may therefore benefit from integrating psychodynamic assessment of

affect, defense, and relational patterns into adolescent mental health care rather than focusing exclusively on symptom reduction.

From a practical perspective, the findings suggest that Acceptance and Commitment-Based Training may be a useful adjunct to psychological and couple-based services for individuals with obsessive-compulsive disorder and their partners. Counselors and psychotherapists may consider incorporating acceptance, mindfulness, cognitive defusion, values clarification, and committed-action exercises into treatment plans when repetitive anger-related thinking and marital dissatisfaction are prominent. Couple-focused interventions should address not only obsessive-compulsive symptoms but also the interpersonal patterns through which those symptoms affect communication, emotional closeness, conflict management, and mutual support. Practitioners may benefit from helping couples identify rigid avoidance patterns, reduce unproductive engagement with repetitive thoughts, and translate shared relationship values into concrete daily behaviors. Structured homework, mindfulness practice, and value-consistent behavioral commitments may strengthen the transfer of therapeutic skills from sessions to everyday marital interactions. Integrating these methods into counseling centers, marital therapy programs, and psychoeducational services may provide a practical framework for improving both emotional regulation and relationship quality in couples coping with obsessive-compulsive difficulties.

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

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

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

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

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