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Interventions for Emotional Dysregulation and Interpersonal Deficits- A Narrative Review

Dr. R. Sakthi Prabha[1], Dr. M. Amirtha[2], Ms. Lourdu Sofia J[3]

[1]Dean & Head, Department of Social Work
[2]Head, Department of Psychology
[3]Assistant Professor,
Department of Social Work
[1,2,3]Hindustan College of Arts & Science, Chennai

ABSTRACT

Emotional dysregulation refers to difficulty in understanding, managing and responding appropriately to one's emotions. It involves difficulty the intensity, duration or expression of emotional responses, particularly when facing stressful or challenging situations. Emotional dysreuglation has been linked with a variety of interpersonal problems For instance, the use of maladaptive emotion regulation strategies like emotional suppression is associated with reduced sociability, as indexed by lower scores on indices of openness, agreeableness and extroversion . Emotional dysregulation and interpersonal deficits co-occur across a wide range of clinical presentations, including borderline personality disorder (BPD), depression, eating disorders, autism spectrum conditions, and attention-deficit/hyperactivity disorder (ADHD). Because these two problem domains are functionally linked poor regulation of intense affect frequently undermines the capacity to initiate, repair, and sustain relationships interventions that address both together tend to outperform those that treat them as separate targets. This review synthesizes systematic reviews, meta-analyses, and randomized controlled trials (RCTs) examining psychological interventions for emotional dysregulation and interpersonal deficits, with particular attention to Dialectical Behavior Therapy (DBT), Mentalization-Based Treatment (MBT), Interpersonal Psychotherapy (IPT), and Social Skills Training (SST). Across 20 sources retrieved through a structured search of PubMed, Cochrane Library, PsycINFO, and related databases. DBT shows the most consistent evidence for reducing emotion dysregulation and improving interpersonal functioning in BPD and transdiagnostic samples, while MBT shows comparable efficacy with a stronger theoretical emphasis on social cognition. SST produces small-to-moderate effects on interpersonal skills, particularly when skill-building and cognitive-emotional components are combined. IPT variants show efficacy for depression with interpersonal deficits as an explicit treatment target. The review concludes that combined, transdiagnostic, and skills-based approaches are best supported by current evidence, while noting persistent limitations including small samples, high attrition, and heterogeneous outcome measures across the literature.

Keywords: Emotion Dysregulation, Interpersonal Deficits, Dialectical Behavior Therapy, Mentalization-based treatment, interpersonal psychotherapy, social skills training

1. Introduction

Emotional dysregulation refers to difficulty identifying, tolerating, and modulating the intensity or duration of emotional responses in ways that support goal-directed behavior. Emotional dysregulation has been associated with heightened interpersonal sensitivity and ambivalence, as well as with aggression and violent behaviour (Garofalo et. al, 2017). Interpersonal deficits refer to a reduced capacity to initiate, negotiate, and maintain satisfying relationships, often stemming from deficits in perspective-taking, communication, or conflict resolution. These two constructs are not merely comorbid, they are mechanistically entangled. Difficulty regulating affect frequently manifests interpersonally—through withdrawal, hostility, or impulsive rupture of relationships—while interpersonal stressors are among the most potent triggers of emotional dysregulation. This bidirectional relationship is most explicitly modeled in the bio social theory underlying DBT, but is echoed in mentalization-based, interpersonal, and social-cognitive treatment frameworks.

The clinical relevance of this pairing spans several diagnostic categories. It is a defining feature of BPD, where affective instability and unstable relationships are core diagnostic criteria. It is a transdiagnostic feature seen in depression, eating disorders, PTSD, and disruptive behavior presentations. It also appears in neurodevelopmental populations, including autism spectrum disorder and ADHD, where social-communication deficits and emotional reactivity frequently co-occur and interact to worsen functional outcomes. Given the breadth of populations affected, a considerable and fragmented literature has emerged evaluating interventions that target emotional dysregulation, interpersonal deficits, or both. This review synthesizes that literature, organizing it by treatment modality, and evaluates the comparative strength of evidence for each.

The guiding research question was: What are the psychological interventions show the evidence for improving emotional dysregulation and interpersonal functioning?

2. Methods

A structured search was conducted across PubMed/MEDLINE, the Cochrane Library, PsycINFO, and Google Scholar, supplemented by citation tracking from key reviews. Search terms combined the concepts of emotional/emotion dysregulation, interpersonal deficits or interpersonal effectiveness, and treatment-modality terms (dialectical behavior therapy, mentalization-based treatment, interpersonal psychotherapy, social skills training, cognitive behavioral therapy, schema therapy). No date restriction was applied, though priority was given to reviews and meta-analyses published within the last fifteen years to reflect the current evidence base. Eligible sources included systematic reviews, meta-analyses, and randomized controlled trials published in peer-reviewed journals that evaluated a defined psychological intervention against an active or waitlist comparator, and reported outcomes related to emotion regulation, affective symptoms, or interpersonal/social functioning. Protocol papers, conference abstracts without outcome data, and studies focused exclusively on pharmacological treatment were excluded unless they contextualized psychotherapy findings. Given the heterogeneity of populations, outcome measures, and effect-size metrics across the retrieved literature, a narrative synthesis organized by treatment modality was used rather than a pooled quantitative meta-analysis. Where multiple meta-analyses examined the same modality, effect sizes are reported as given in the original source without re-computation.

3. Theoretical Framework

Emotional dysregulation and interpersonal difficulties are closely connected psychological processes that can influence an individuals emotional well-being, social functioning and quality of interpersonal relationships.The present paper is theoretically based on emotion regulation theory, cognitive behavioural theory, and social learning theory. Together these perspectives provides an integrated understanding of the development and interpersonal difficulties and the mechanisms through which interventions may facilitate positive change. Emotional regualtion theory was profounded by Gross. According to the theory individuals regulate emotions through different processes, including situation selection, situation modification, attentional deployment, cognitive change and response modulations. Difficulty at any of these stages can contribute to maladaptive emotional responses. The cognitive behavioural perspective further explain how thoughts, emotions and behaviours interact in interpersonal situation. Negative interpretation of social events may generate intense emotional responses, which can subsequently lead to avoidance, aggression, withdrawal or other maladaptive behaviours. These behaviour can create further interpersonal conflict and reinforce negative beliefs. Finally, social learning theory suggests that emotional and interpersonal behaviour can be acquired through observation, modelling, reinforcement and social interaction (Bandura, 1977). Invention incorporate modelling role play, behavioural rehearsal, feedback and peer interaction can therfore help individuals learn healthier emotional and interpersonal responses. Overall, these theories suggest a reciprocal relation between emtoional dysregulation and interpersonal deficits. Emotional difficulties contribute to interpersonal conflict, while negative interpersonal expereinces can further intensify emotional dysregulations. Interventions that simulataneoulsy address emotion regulation, cognitive processes, interpersonal skills, and relational experiences may therefore be particularly effective in promoting psychological well-being and healthier social functioning.

4. Results

Twenty sources met inclusion criteria, reflecting the substantially larger evidence base for structured, manualized therapies relative to general social-skills programs targeting nonclinical or developmental populations.

5. Dialectical Behavior Therapy

DBT remains the most extensively studied intervention for co-occurring emotional dysregulation and interpersonal deficits, reflecting its origin as a treatment for chronically suicidal individuals with BPD, a population defined by both features. The 2020 Cochrane review of psychological therapies for BPD, an update of two earlier Cochrane reviews, remains the most comprehensive synthesis of RCT evidence in this area, evaluating DBT alongside MBT, schema-focused therapy, and transference-focused psychotherapy against treatment-as-usual and other comparators. A subsequent focused systematic review and meta-analysis by Stoffers-Winterling and colleagues built on this Cochrane dataset to examine effects separately for therapies delivered as primary versus adjunctive treatment.

Earlier influential syntheses established the empirical foundation for DBT's mechanism of action. Neacsiu, Rizvi, and Linehan (2010) demonstrated that DBT skills use statistically mediated reductions in suicidal behavior, anger, and depression among BPD patients, providing direct evidence that the skills-training component—covering mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness—is not incidental to outcome but causally implicated in it. A pilot RCT by Neacsiu,

Eberle, Kramer, Wiesmann, and Linehan (2014) extended this logic by testing a stand-alone DBT skills group (without full DBT) across a transdiagnostic sample with high emotion dysregulation, finding that skills training alone produced meaningful reductions in dysregulation and associated symptoms, suggesting the modular skills curriculum has utility beyond BPD. Kliem, Kröger, and Kosfelder (2010) conducted an early meta-analysis using mixed-effects modeling across sixteen studies and found moderate overall effects of DBT on BPD symptom severity, alongside reductions in parasuicidal and self-injurious behavior, though the analysis noted inconsistent measurement of affective and interpersonal outcomes specifically. More recent condition-specific applications have extended DBT beyond BPD: a 2021 systematic review and meta-analysis of eleven studies found that DBT produced greater improvement in emotion regulation, depressive symptoms, and eating-disorder psychopathology relative to control conditions in binge eating disorder and bulimia nervosa, though improvements in eating-specific emotion regulation were not statistically significant, indicating that general affect-regulation gains do not automatically transfer to disorder-specific regulatory processes. Taken together, this body of evidence positions DBT as the intervention with the broadest and most mechanistically explicit support for treating emotional dysregulation, with its interpersonal-effectiveness module offering a directly relevant, skills-based route to improving relational functioning.

6. Mentalization-Based Treatment

MBT approaches emotional dysregulation and interpersonal deficits through a social-cognitive lens, positing that both arise from an impaired capacity to accurately represent one's own and others' mental states—particularly under conditions of high arousal, when this capacity is most likely to collapse. Bateman, O'Connell, Lorenzini, Gardner, and Fonagy (2016) reported an RCT comparing MBT to structured clinical management in patients with comorbid BPD and antisocial personality disorder, finding MBT effective in reducing anger and aggression, symptoms with clear interpersonal consequences, in a population for whom mentalizing deficits are especially pronounced.

A randomized trial conducted within a mainstream public mental health service compared eighteen months of MBT to enhanced therapeutic case management in adults with BPD, evaluating outcomes including non-suicidal self-harm and suicide attempts; this pragmatic trial design is notable for testing MBT's effectiveness outside specialist research clinics, addressing a common criticism that structured BPD therapies are validated only in resource-intensive settings. The NOURISHED trial extended MBT to eating disorders with comorbid borderline features, comparing MBT-ED to specialist supportive clinical management, though the study was limited by substantial attrition, with only 22% of participants completing eighteen-month follow-up—a recurring challenge across trials in this population.

A broader naturalistic study examined MBT across a wider range of personality disorders beyond BPD, noting that while nineteen RCTs have evaluated MBT and related therapies specifically for BPD, evidence for cluster A and cluster C personality disorders remains comparatively sparse. Collectively, MBT evidence supports its efficacy for reducing self-harm, aggression, and affective instability, with its distinctive contribution being an explicit focus on restoring the social-cognitive capacities that underlie interpersonal functioning, rather than treating interpersonal skill as a separate, trainable module as DBT does.

7. Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) and its adolescent adaptation (IPT-A) treat interpersonal deficits as one of several explicit problem areas, alongside grief, role disputes, and role transitions, distinguishing it from DBT and MBT in that it does not primarily target emotion regulation as a standalone skill but addresses it through the resolution of concrete relational problems. Zheng, Xu, Qu, Sun, Xu, and Sun (2023) conducted a systematic review and meta-analysis of six RCTs of Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST), a preventive, campus-delivered adaptation of IPT-A, finding a significant reduction in depressive symptoms that remained significant at six-month follow-up, though the moderate-to-high heterogeneity across studies suggests variation in program fidelity or population characteristics. The authors noted that traditional individual IPT-A requires professional delivery settings that may limit accessibility for some adolescents, motivating group- and school-based adaptations. This body of evidence supports IPT as a viable, if more circumscribed, intervention when interpersonal deficits are the primary or sole clinical concern, particularly in depression, though direct evidence of its impact on emotion dysregulation specifically is comparatively thinner than for DBT or MBT.

8. Social Skills Training

Social skills training (SST) directly targets interpersonal deficits through structured, often manualized practice of discrete behaviors such as initiating conversation, reading nonverbal cues, and resolving conflict. The evidence for SST is more heterogeneous than for DBT or MBT, reflecting its application across markedly different populations, from nonclinical children to individuals with autism spectrum disorder, learning disabilities, and ADHD.

De Mooij, Fekkes, Scholte, and Overbeek (2020) conducted a multilevel meta-analysis of ninety-seven studies and 839 effect sizes, examining SST programs in nonclinical child and adolescent samples. They found a positive overall effect on interpersonal and emotional skills ($d = 0.369$), and—critically for the question of which components drive change—tested whether specific training elements (psychoeducation, psychophysical exercises, skill-building, and cognitive-emotional components) were independently associated with outcome, testing the 'specificity hypothesis' that particular ingredients, rather than generic program exposure, account for effectiveness. This is one of the few studies in the literature to move beyond overall program efficacy toward identifying which active ingredients matter.
Earlier work by Kavale and Forness (1996) conducted a meta-analysis of SST for students with specific learning disabilities and found only a small overall effect, with limited differentiation in perceived efficacy across teachers, peers, and the students themselves, raising early concerns about the modest and inconsistent yield of social skills programs in some populations. Consistent with this caution, a meta-analysis of school-based SST for children with autism spectrum disorder using single-subject designs concluded that interventions were only minimally effective, though effectiveness varied considerably by specific participant, setting, and procedural characteristics, suggesting that population-specific tailoring—rather than generic protocols—may be necessary to produce clinically meaningful gains in populations with core social-communication deficits.

By contrast, reviews of SST for students with emotional and behavioral disorders have been more favorable: a review and analysis of six meta-analyses found that SST produced improvement in behavior

consistent with roughly a 64% improvement rate relative to controls, and that effects generalized across aggression, externalizing behavior, and internalizing symptoms, although the social validity of outcome measures—that is, whether gains were meaningful in real-world social contexts rather than only on rating scales—was flagged as a persistent weakness. Taken together, the SST literature suggests that structured skills training reliably improves measurable interpersonal behaviors, with effect sizes ranging from small to moderate, but that the magnitude and durability of these effects depend heavily on population, the specific components delivered, and whether gains are assessed by objective, ecologically valid measures rather than self- or teacher-report alone.

Across modalities, several patterns emerge. First, interventions with an explicit, manualized skills-training component—DBT's interpersonal effectiveness and emotion regulation modules, and behaviorally specific SST protocols—produce more consistent, replicable effects than approaches relying primarily on insight or relational process, though MBT and IPT retain strong evidence for reducing self-harm, aggression, and depressive symptoms respectively. Second, evidence quality is strongest for BPD, where numerous RCTs and multiple Cochrane-level syntheses exist, and comparatively weaker for other populations such as autism spectrum disorder, where SST evidence remains inconsistent. Third, treatment effects on emotion regulation do not automatically generalize to domain-specific regulatory processes, as illustrated by the finding that DBT improved general emotion regulation in eating disorder populations without improving eating-specific emotion regulation. This suggests that comprehensive treatment protocols may need explicit, disorder-specific adaptations rather than assuming transfer from general skills training.

9. Discussion

This review supports the conclusion that emotional dysregulation and interpersonal deficits are best addressed by interventions that explicitly integrate both targets rather than treating them as separable problems. DBT's biosocial model, which frames interpersonal dysfunction as both a cause and consequence of emotional dysregulation, appears to be borne out empirically skills-use mediation studies show that the same DBT skills curriculum that reduces affective symptoms also improves interpersonal outcomes, consistent with a shared underlying mechanism rather than two independently treated problems. MBT offers a complementary account, locating the shared mechanism in mentalizing capacity, and produces comparable clinical gains especially for anger, aggression, and self-harm.

The success of stand-alone DBT skills groups across a transdiagnostic sample supports the value of a generalizable skills curriculum, yet the limited transfer of general emotion regulation gains to eating-disorder-specific regulation, and the inconsistent SST findings in autism spectrum disorder, indicate that some populations require tailored content rather than off-the-shelf protocols. Clinically, this suggests that treatment selection should be guided not only by diagnosis but by whether the person's difficulties reflect a skills deficit never having learned to regulate affect or navigate a social situation versus a performance deficit, in which the relevant skill exists but is inaccessible under emotional load, a distinction with direct implications for whether treatment should emphasize psycho-education and skill acquisition or in-the-moment regulation and generalization support. Much of the strongest evidence comes from specialist research settings with rigorous inclusion criteria, and pragmatic trials conducted in routine public mental health services are comparatively rare, though the few that exist such as the MBT

trial embedded in a mainstream public health service are valuable precisely because they test whether efficacy findings hold under real-world constraints such as caseload, staff training variability, and lower-resource settings.

10. Conclusion

Emotional dysregulation and interpersonal deficits are functionally intertwined problem domains best addressed through interventions that treat them jointly. DBT currently holds the broadest and most mechanistically supported evidence base, with its skills-training components directly implicated in both affective and interpersonal improvement across BPD and transdiagnostic populations. MBT offers strong complementary evidence, particularly for self-harm and aggression, through its focus on mentalizing capacity. IPT provides a well-supported, more circumscribed option when interpersonal deficits are the primary concern in the context of depression. SST reliably improves discrete interpersonal behaviors with small-to-moderate effects, though its impact varies considerably by population and specific training components, and is least consistent in populations with core social-cognitive deficits such as autism spectrum disorder. Future research should prioritize pragmatic, real-world-setting trials, disorder-specific adaptations of transdiagnostic skills protocols, and longer follow-up periods to clarify the durability of treatment gains.

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