From personality pathology to relational pathology

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Parikh and Sharp (2026) argue that debates over treatment dose for "personality disorder" are too narrow, and that care should shift toward earlier clinical support during developmentally sensitive periods.[1] We share their argument that prevention is better than intervention, and welcome their reframe from dose to development. At the same time, however, we wonder whether the early life difficulties Parikh and Sharp propose to address are best understood as difficulties of "personality".[1]

To briefly elaborate, the constructs on which Parikh and Sharp[1] build their case (namely, self-functioning and interpersonal functioning) primarily encode a relational rather than personal form of psychopathology, because they are derived from relational perspectives (object relations, attachment, and mentalizing).[2] According to these perspectives, "personality-related" difficulties can be more specifically viewed as "relational" difficulties because they primarily involve maladaptive ways of relating to the self (e.g., self-harming) and to others (e.g., intimacy difficulties) that emerge within specific relational contexts (e.g., caregiving, peer, or educational contexts).[2]

Importantly, this relational framing of "personality pathology" does not contradict but rather enriches the authors' perspective by offering at least three additional points.

First, this relational reframe of personality pathology highlights that interventions should target not only an adolescent's psychopathology but also their broader social ecology, an assumption already supported from clinical trials of mentalization-based and systemic treatments, which indicate that combining individual and family therapy effectively reduces emerging borderline features in adolescents.[3]

Second, this relational reframe has already been shown to be more humane and clinically accurate than a "personality focused" framing, with clinicians self-reporting a preference for the term "relational disorder" over "personality disorder"[4] and patients expressing a preference for a "relational framing" of their life problems.[5]

Finally, and most importantly, the relational reframe of these clinical difficulties actively facilitates the earlier detection and prevention that Parikh and Sharp call for by removing the diagnostic exclusion that the "personality disorder" framing has long imposed in both adolescent and adult care services.

In summary, then, while we share the authors' aim for developmental prevention, we believe that this aim may only be possible when we recognise personality pathology for what it actually is: a developmental pathology of relationships.

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